



Review of Code of Practice: Practice of Dentistry by Dental Prosthetists



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

March 2007

ADAVB Submission to the Dental Practice Board of Victoria
REVIEW OF DENTAL PROSTHETISTS' CODE
MARCH 2007

KEY POINTS

- The ADAVB supports retention of the current code of practice with a number of clarifying amendments.
- Proposals to expand the duties of prosthetists, especially in relation to implant supported removable prostheses are opposed as they would put the public at undue risk.
- Dental prosthetists are not qualified to ensure that patients are advised of all reasonable treatment alternatives, prognoses, complications and costs, and therefore informed consent is not possible before agreeing to the provision of a prosthetist's services. We therefore urge that the Board reinstate the requirement that dental prosthetists must seek a certificate of oral health from an appropriately trained person before treatment is commenced.
- Prosthetists should be recognised as part of the dental team referred to in the Auxiliaries Code, and consequently should have an obligation to explain to the patient the importance of seeing a dentist regularly, and of obtaining a certificate of oral health before proceeding with supply of a removable appliance.



1. Introduction

The ADAVB welcomes the opportunity to comment on the Board's review of its Code of Practice for Dental Prosthetists.

As we have argued before in submissions to the Board, the Branch believes that any Code of Practice should fulfil the following criteria:

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

In our view, the current Code of Practice generally meets these criteria, however there are a few sections which could be enhanced.

Our primary concern with this review is related to proposals that we understand will be presented to the Board for relaxation of the present provisions within the Code. These proposals would expand the duties able to be performed by dental prosthetists in undesirable ways.

2. Commentary

The Board has asked for comments in response to this code review under a number of headings, not all of which appeared relevant to our submission. While all headings have been included, we have only made comments under those headings that seemed appropriate.

2.1 Demand for service

Decline in the number of edentulous persons means that there is a continuing decline in the need for removable dental appliances, and ultimately a reduced need for dental prosthetists into the future.

The recently published report from the Australian Institute of Health and Welfare, *Australia's Dental Generations: The National Survey of Adult Oral Health 2004-06* (2007: p. xv) noted a dramatic decline in the percentage of people in each age group with inadequate natural dentition, defined as fewer than 21 teeth

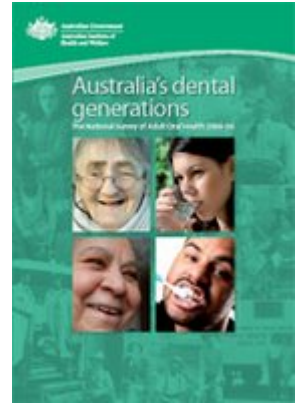
"During the 17 years since the first Australian oral health examination survey, the percentage of Australian adults who had no natural teeth more than halved, from 14.4% to 6.4%.



- *Almost all of the reduction occurred because of the passing of older generations that had experienced an 'epidemic' of dental extractions during the first half of the twentieth century. Within generations, levels of complete tooth loss did not change meaningfully as members of each generation aged 17 years between surveys.*
- *During the next four decades, with the passing of older generations that experienced historically high rates of tooth loss, the decline in prevalence of complete tooth loss is projected to continue, falling to 1% or less by the 2040s.*

Among dentate people (those who had one or more natural teeth), there were similar large reductions in the percentage with an inadequate natural dentition, defined as fewer than 21 teeth.

- *As they aged during the 17 years between 1987–88 and 2004–06, no more than 7% of people in any single generation lost sufficient teeth to leave them with an inadequate natural dentition.”*



2.2 Public safety

The Board's Code allows independent practice for prosthetists in a manner which implies that a person can be provided with a removable dental prosthesis almost entirely without reference to the general health of their mouth.

“PART 1

This Code acknowledges that the dental prosthetist may work as an independent practitioner.

A dental prosthetist who has not completed a course of training approved by the Board in the making, fitting and repairing of partial dentures shall have a condition placed on his or her registration: “Not registered to deal directly with the public in the provision or repair of partial dentures.”

This restriction is a sensible protection of public safety, and is entirely consistent with the requirement that practitioners only practice those skills for which they are registered, formally trained and competent.

We welcome the Board's recognition of the long-established health treatment principle that the practitioner should “first do no harm”. In that vein, we note that while under Part 2, point 2, the prosthetist must ensure that the patient's mouth is fit for provision of a removable dental appliance, the Code needs to recognise that patients seeking these services will increasingly be elderly and **medically compromised**. Given the lack of clinical training about oral and general health issues, the ADAVB maintains that before proceeding with the supply of a removable dental appliance, the prosthetist should be required to obtain a current dental or medical assessment of the patient's health and suitability for such an appliance.

See also remarks under Scopes of Practice below.



2.3 Scopes of practice

"PART 2

This Part sets out the areas of dentistry in which dental prosthetists may practise. It is fundamental to this Code that, within the defined range of competencies, dental prosthetists must practise only those skills for which they are registered and competent."

The current commitment of the Code to ensure that prosthetists only practice those skills for which they are both registered and competent is strongly supported. We note that the current Code highlights the Board's encouragement of "research to examine the boundaries defined by this code". No such research has been published to our knowledge, and we therefore suggest that there is no evidence base on which expansion of the scope of practice could be considered.

"1 A dental prosthetist may work as an independent practitioner in making, fitting, supplying, repairing or taking impressions for:

- a) removable dentures;*
- b) flexible, removable mouthguards of a type used by persons engaged in sporting activities."*

While this text is acceptable, ADAVB suggests that another section should be included which ties the Code to section 3(h) of the Act, i.e. that "providing dental care that the provider is not registered to provide" will constitute unprofessional conduct

2 Before taking any impression or fitting any removable dental appliance a dental prosthetist must take reasonable steps to ensure that the patient's mouth is fit for the purpose, and free of disease, disorder or abnormality.

This is a commendable section of the Code, and it implies that the prosthetist will **screen** the patient for visible lesions or other signs that suggest they should be referred to a dentist or medical practitioner with the diagnostic skills necessary to determine whether a 'disease, disorder or abnormality' are present before proceeding with the supply of a removable prosthesis. This section could perhaps be enhanced by making such a referral obligation more explicit. This does not imply that prosthetists will examine and diagnose patients, as they are not trained to do so. If our recommendation for an oral health certificate was adopted of course, then screening would be less of an issue.

Dental prosthetists are not qualified to ensure that patients are advised of all reasonable treatment alternatives, prognoses, complications and costs, and therefore informed consent is not possible before agreeing to the provision of a prosthetist's services. We therefore urge that the Board reinstate the requirement that dental prosthetists must seek a certificate of oral health from an appropriately trained person before a removable dental appliance is provided.



3 Apart from the use of tissue conditioners and soft lining materials, a dental prosthetist must not adjust, modify or treat the natural dentition, bone, soft tissue or dental restorations.

This sensible guidance recognises that prosthetists are neither trained nor intended to provide dental treatment but rather to supply removable prostheses. Confusion sometimes arises about this matter, especially in the minds of dental patients, and it would be helpful for the Board to provide prosthetists with a simple and clear statement for their use in explaining to the public the nature of their services and the necessary limits placed upon them.

We also suggest that for clarity, it would be helpful for this section to be split to read.

- A dental prosthetist is allowed to use soft liners and tissue conditioners
- A dental prosthetist must not modify or treat the natural dentition, bone, soft tissue or implant structures

4 A dental prosthetist may take impressions for, make, fit or supply removable implant-retained full overdentures on pre-existing implant and abutment structures in cooperation with and to the prescription of a dentist but may not:

- a) remove or replace any implant or abutment component; or*
- b) otherwise deal directly with the public in taking impressions for, making, fitting or supplying any implant-retained prosthesis*

We note that the taking of impressions for, making, fitting or supplying removable implant-retained full overdentures or pre-existing implants is more complex than taking other impressions allowable under the Code. Also, the design of the denture requires knowledge of the implants and abutments' position, design and many other factors. It is therefore essential that this work continue to be done "in cooperation with and under the prescription of a dentist".

The ADAVB is concerned that the community may be exposed to a growing risk due to an ever increasing number of practitioners who, after completing a weekend course, feel they are well equipped to enter the world of implant dentistry. Such concerns apply to both dentists and prosthetists.



This is an area of dentistry that cannot be regarded as mechanistic in nature and does not allow a formulaic approach to case management.

We suggest that, perhaps necessarily, implant dentistry is taught at a very superficial level, even in the BDDSc course. It is not until one gains entry to post-graduate level education that proper and comprehensive training is acquired. For many practitioners of course, implant training was not available at the time they obtained their initial qualification. These comments clearly apply to both dentists and prosthetists.



The placement, restoration and maintenance of dental implants require a thorough understanding of bone physiology, periodontology, microbiology, pharmacology, occlusion and materials science amongst other things. This knowledge can only be attained through extensive accredited training programs. See also comments under 2.5 below.

Specialist prosthodontist members advise that it is not possible to record the position of an implant from a fixture head level without removal of the healing abutment or abutment. There are techniques whereby the surgeon could provide the abutment, but this is not always possible and limits the restorative options and componentry available for restoration. Remaking of an existing appliance where abutments are in place would not necessarily require abutment removal but does require the ability to assess continued implant and abutment stability, and the health of the implant bone interface. Such abilities are not acquired from training to become a dental prosthetist.

The ADAVB therefore opposes the expansion of the prosthetists' scope of practice to incorporate implant dentistry. Although appearing mechanistic, the biology of the system is far from simple and specialists advise that there are already liability issues on the horizon in the way general dentists are managing and trouble shooting this area. Implant surgeons do not take on the role of long term maintenance in implant patients and it falls to the restorative dentist for ongoing monitoring. Unless the existing prosthetists training programme was massively expanded in a number of complex areas it falls far short of the requisite training. In other words, if prosthetists want to do dentists' work, they should train to be dentists. The ADAVB supports lateral entry by allied dental personnel into the BDS course.

2.4 Benefits to patients

No comment

2.5 Abilities of the provider to deliver the service

Further to the above comments about the involvement of prosthetists in the supply of implant supported prostheses, key requirements in the management of restoration, maintenance and monitoring of such prostheses include:

- Increased knowledge of anatomy, pathology and physiology
- An understanding of the biology of osseointegration.
- An ability to correctly assess the suitability of this treatment modality for an individual patient
- An ability to assess indications and contra-indications to implant placement based on a full health assessment
- An ability to assess both success and failure of the integration process
- An ability to not only restore the implants but also to monitor continued performance and diagnose failure
- Radiographic skills to not only allow assessment of the seating of a prosthesis but also to monitor continued stability of the implant/bone interface
- The clinical and technical skills to manage the componentry and prosthesis



- Utilisation of Polyether and Poly vinyl siloxane impression materials
- Maintenance responsibilities including the ability to manage cleaning regimes with the patient.

Removing the requirement that dentists supervise all aspects of implant supported prostheses would therefore expose patients to unreasonable risks.

2.6 Additional training required

In the light of the above listed requirements, there are no currently available training programs would be adequate other than those leading to registration as a dentist or specialist restorative dentist.

The prosthetists' training and job description do not allow management of oral hygiene measures and scaling of implants or teeth in this group.

Prosthetists have no radiography training, nor the diagnostic knowledge and skill to make appropriate use of x-rays. They have no training in anatomy, pathology and physiology.

Restoration of implants is not simply a technical exercise on an inert object, rather it is the functional utilisation of an introduced (foreign graft material) into the body and the monitoring of its continued stability and the health of the individual. The community would be unlikely to view favourably, a technician managing the maintenance of a hip replacement or a prosthetic heart valve for example. Although the technology can appear straightforward and mechanistic, the biology is not, and specialists have reported that we are already "on the tip of an iceberg" when it comes to trouble-shooting poorly managed cases. The general dentist is having enough issues with managing implant dentistry and the training for prosthetists falls far short of that required for the confident management of patient welfare in this area.

Member concerns have also arising with regard to the implant course approved by the Board in 2002 being considered potentially sufficient to permit supply of implant supported prostheses without the involvement of a dentist. Contact has been made with the developers of that course, and they stressed the point that this program gives only adequate training for someone working under the prescription of a dentist/prosthodontist in the provision of the implant retained appliance. It therefore remains the case that there are no training programs available that would fully equip the prosthetist for unsupervised or independent practice in this area i.e. the additional skills and professional judgement that are required to manage such a patient resides with a dentist following an extensive and rigorous five year university course.

2.7 Availability of training providers

The existing school is adequate, however given the decline in demand, there may be more in training than are required in future.



2.8 Economic factors

No comment.

2.9 Successful and unsuccessful innovations introduced by the 2002 code.

No further comment.

3. Other Comments

3.1 Registered Title

We maintain that the title “prosthodontist” is misleading to the public, and that it is indistinguishable in the average person’s mind from “prosthodontist”. The ADAVB suggests that Board conduct a small public poll on its own website to test whether lay visitors to the site can distinguish between these two terms. If the title ‘prosthodontist’ must continue to be used, we suggest that it be expanded to: “prosthodontist (advanced dental technician)”. The internationally recognised title that would actually be preferable is “denturist”. Informal advice from senior national Dental Prosthetist Association representatives suggests that this title may be supported by at least some dental prosthetists.

Given the limits on the services a prosthetist can offer, a patient cannot provide informed consent on all the treatment options that might otherwise be available to them. At the least, patients need to be advised, preferably by reference to a standard explanation, of the limits on services able to be provided by dental prosthetists. If dental service consumers are not given the full range of options, we query how they can provide an effective consent. There is a risk that consumers could be misled, thus raising trade practices issues.

3.2 Identification

As with the Auxiliaries Code, this Code is silent regarding the identification of dental prosthetists. The requirement for dental care providers to be clearly identified by name, and ‘dental title’ should be in this Code with regard to dental prosthetists. However, it could also be the subject of a separate Code or Guideline applicable to Section 64 of the Act. This would not require Governor in Council approval as per Section 66 and would apply to all registered dental care providers.

3.3 The dental team

As noted in our recent submission in response to the Draft Code of Practice for Dental Auxiliaries, the GDC has published a set of guidelines - called ‘Principles of Dental Team Working’ - in which they note a number of key requirements for the effective operation of a team and for the provision of safe and effective dental care. They define the dental team as:



“the group of people who together provide care for a patient. Teamwork means working together to provide good-quality dental care.” (p.4)

(See <http://www.gdc-uk.org/News+publications+and+events/Publications/Guidance+documents/Principles+of+dental+team+working.htm>)

The following extracts from their guidelines emphasise the importance of dentists acting as care coordinators and team leaders. Clinical Dental Technicians, which is the UK name for Dental Prosthetists, are recognised under the GDC Guidelines as members of the dental team. (Note: in the following extracts, the GDC refers to dental auxiliaries as DCPs – or ‘Dental Care Professionals’):

“PRINCIPLES OF TEAM WORKING

1.2 Dental teams can take many different forms, depending on the needs of the patient. The dental team is not just limited to dental professionals working together in the same practice. For example:

- *Most dental technicians work in a laboratory and so will not work in the same place as other team members.*
- *You may have your own practice, but you still work as part of a wider dental team. An example would be when you refer a patient to another dental professional.*

1.3 You may also be part of a wider healthcare team, with members outside your professional group. For example, you may work in a community dental service setting or in a hospital with other healthcare professionals.

2.1 Patients should be seen by a dentist before being treated by other members of the dental team. The only current exception to this is edentulous patients (patients with no teeth), who may be seen by a clinical dental technician without seeing a dentist first, for the supply and maintenance of full dentures only.”

(Emphasis added)

The ADAVB suggests that the Board should also recognise dental prosthetists as part of the dental team, as it does dental therapists and dental hygienists in its current Auxiliary Code. In doing so, a provision similar to the one contained in the GDC principles of team working quoted above would be appropriate.

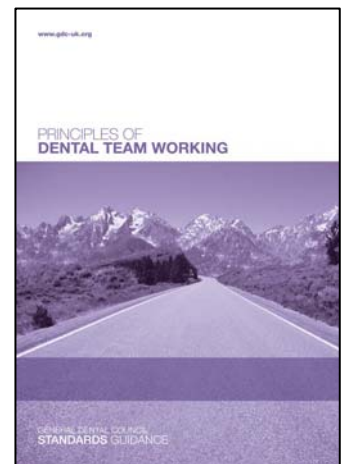
This would also entail provision of advice along the lines of the following extracts from the GDC Principles of Dental Team Working:

“Communicating with patients

4.1 Make sure patients know who makes up the team providing their care.

*4.2 Give patients a clear picture of the important relationships within that team. This includes telling patients **who has overall responsibility for their treatment.***

...





4.10 *If you are a DCP, make sure you understand the circumstances in which you should refer the patient to a dentist and that there is a procedure for doing this. Make this procedure clear to the patient. You have a responsibility to explain to the patient the importance of seeing a dentist regularly.*

4.11 *Make sure that the process of referral is clearly recorded.”*

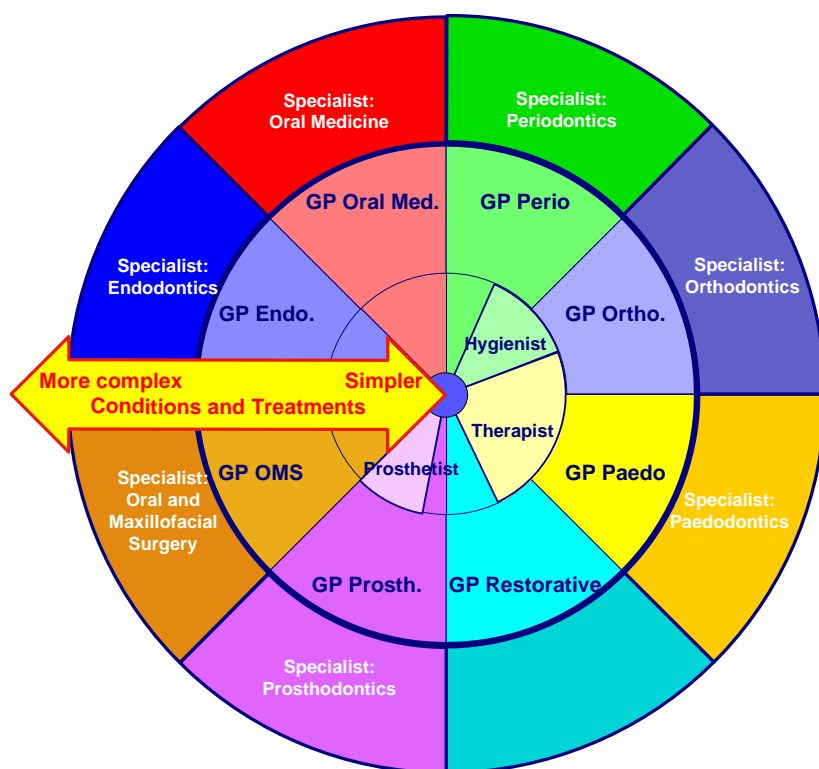
(Emphasis added)

3.4 The Code Title

There was a suggestion from the membership that title of the code ‘Practice of Dentistry by Dental Prosthetists’ is misleading as it implies comprehensive clinical diagnosis and treatment planning rather than simply the supply of removable dental prostheses. We suggest that it should read. ‘The Provision of Removable Dental Appliances by Dental Prosthetists (Denturists)’.

3.5 The underlying model of care

As requested in our previous submission on the Dental Auxiliaries Code, the ADAVB would welcome the Board’s explanation of the model of care which is assumed to underpin the work of members of the dental team, including dental prosthetists. In our view, patient welfare is best served by a model which places general practitioner dentists in the role of care coordinators.



The adjacent schematic chart 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 indicates that simpler problems and treatments are near the centre of the wheel, while dental 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 prosthetists only deliver basic prosthetic services, according to their training and skill, and the limitations imposed by the Code.

As mentioned in our earlier submission, arguments for 'workforce substitution' do not recognise the sound patient welfare basis of this model when they suggest that a lesser trained provider could safely substitute for a general practitioner dentist. Most older and public patients tend to have more complex conditions and therefore require a dentist to provide their treatment, and patients of all ages need a dentist to assess their oral health and oversee their required treatment.

In the case of dental prosthetists who are permitted to work independently of dentists, their supply of removable dental prostheses needs to be recognised as having potential impact on the overall oral health of a patient – for which the general practitioner dentist is responsible. Given these risks, the consumer needs to be reminded to visit a dentist for their overall oral care – as per the GDC guidelines.

END



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



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