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1 June 2013

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SUBMISSION
Dental Board Public Consultation Paper
Scope of practice registration standard

I refer to the Draft Scope of practice registration standard and guidelines dated 8 May 2013 and wish to make the following submission:

The draft makes references to a statement that dental practitioners must only perform those dental procedures for which the have been 'formally educated and trained in programs of study approved by the National Board' ("The Requirement"). I practice exclusively in the area of dental implants and have a number of concerns in relation to this requirement as follows:

a) Education for dental implants has only been introduced into formal training programs in the late 1990's. Traditionally, training in the field of dental implants was undertaken in private settings that were NOT formal university programs or specifically approved by the current National or prior State Boards.

b) Formal post-graduate training today is still limited in a number of ways:
    i. Only the surgical aspect of this treatment is being taught within the specialities of Periodontics and Oral Surgery and only the restorative aspect of the treatment is being taught within the speciality of Prosthodontics. That is, a specialist prosthodontist is not being trained to place implants and a specialist periodontist is

not being trained the restorative aspects of treatment, whereas both the restorative and the surgical aspects of this treatment modality are intimately inter-related, thus an intricate appreciation of the overall technical and clinical parameters are a crucial part of attaining success.

ii. In ANY of the specialities that currently cover dental implants within their curricula there is NO specific emphasis on Dental Implants.

iii. There is currently NO speciality that is concerned exclusively or predominantly with Dental Implants.

c) The requirement has the potential to mislead the public into believing that those who had dental implants covered within their formal training (such as the more recently graduated specialists), regardless of the extent of their clinical exposure /expertise, are better trained to work within this field of practice than others who received their training in other ways. That said, it is relevant that **the majority of practicing specialists in Oral Surgery, Periodontics and prosthodontics have themselves never been formally educated in implant dentistry by Board approved programs**.

d) Any restriction on practitioners to place or restore dental implants, regardless of their experience or success rates, has the potential to disadvantage the public in terms of convenience and cost and potentially the end result, because among other things, a patient would be unable to undertake both the surgical and restorative aspects of implant treatment in the one place / clinical setting. The requirement has the likely potential to negatively affect:

i. Access to dental treatment by the public; and,

ii. The expected standard of care

e) Any restriction on practitioners to place or restore dental implants, regardless of their experience or success rates, has the potential to be anti-competitive with legal ramifications at a potentially high cost to AHPRA and the taxpayer.

f) Apart from oral implantology, the requirement will affect <u>any</u> practitioners who have undertaken further training in other areas of dentistry outside the formal university setting, and who have expanded the scope of their practice accordingly. As such this will draw a

strong opposition lobby by the overwhelming majority of registered dentists and specialists, regardless of their area of practice, at a significant expense to AHPRA and the taxpayer.

g) Nowhere in the western world is there this sort of restriction on clinicians. Development of skills and acquaintance with new techniques and technology can only be acquired through continued professional development that is outside of the university or formal setting. In many cases such training can only be attained overseas, and would therefore be unlikely to be specifically approved by our local board despite the fact that these courses often provide an educational value and development of skills that are well beyond what might be offered locally, or in a 'formal' settings.

Dental Implants Overview and Training Paths

1. Dental implant work has been undertaken for over 40 years. In Australia, the first patients to receive implants were during the early 1980s. Implant placement has two components: the **surgical** component whereby the implants are placed into the bone and permitted to integrate into the bone, and the **restorative** component whereby the supra-structure are fitted to the integrated implants. The connection of the supra-structure is described as the "loading" of the implant. However, apart from the installation of the surgical and restorative components of dental implants, there are numerous other factors that come into play both in the planning as well as the execution of treatment. Thus, whilst Oral Implantology is not a recognized specialty Australia and in most parts of the world, **it is certainly a specialized field that requires cross-disciplinary understanding and skills**.

2. Dental Implants offer success rates that compare favorably to almost any other day-to-day procedures dentists perform. In 2004 the American Dental Association has reported, "The average survival rates of multiple implant designs placed in various clinical situations are more than 90%". They also reported findings that implants may provide a "more predictable outcome" than alternative therapies [13].

3. In today's day and age osseointegration alone is not necessarily a measure of success. We know that implants osseointegrate, the challenge is making this treatment successful by

today's aesthetic and functional standards and for today's patient of high expectations. Ensuring such success today requires cross-disciplinary understanding, and the type of training and education that leads to a gradual attainment of skill that is based on clinical experience.

4. There has been a push by certain individuals, particularly within the specialist disciplines of periodontics and oral surgery, to restrict the practice of oral implantology to those specialties and to prevent dentists from placing implants. It is fair to suspect that this push is commercially driven for a number of reasons, including:

    a. Implants are more lucrative then other services within the scope of work of those specialties;

    b. Dental Implants often offer more predictable, aesthetic, functional and definitive solutions in fewer appointments compared to what certain specialists (such as periodontists, endodontists, or prosthodontists) may offer as an alternative treatment. This has resulted in a significant drop in referrals, especially because many general dentists are able to offer dental implants within their own practices. According to the American National Institute Of Health [7] the number of dental implants placed increased fourfold between 1983 and 1987 in the United States and an addition 73% between 1986 and 1990 [14]. By 1996, a reported 65% of general dentists were using implants in their routine practices [16,17]. In 2002, the percentage of general practitioners who surgically place implants increased 50% in just 1 year [12].

5. When it comes to dental implants, the specialist is quite likely to be disadvantaged by a lack of cross-disciplinary skill and experience, when compared to a practitioner who relies on their own surgeries for the eventual restorative and aesthetic success of their cases, unless they had undertaken such cross disciplinary training OUTSIDE the setting of their formal post graduate program.

6. General Dentists <u>with adequate cross-disciplinary training and experience</u> are favorably positioned to undertake surgical implant placement, due to not only having a first hand appreciation of the aesthetic, functional and general requirements of their patients, but importantly the laboratory and technical constraints that may apply in the course of treatment that could result from inadequate placement. Being armed with this sort of insight can only be advantageous to any decisions made during planning or judgment

calls at the time of surgery. In a 1995 study evaluating osseointegrated dental implants for single tooth replacement in general practice the success rate of treatment compared favourably with results reported from centers using the specialist team approach to treatment [2]. I note that the training for the General Dentists in that study performing both the surgical and restorative aspects of treatment was NOT university based or board approved.

7. Bone or soft tissue augmentation procedures often go hand-in-hand with implant surgery. In the past, bone grafting techniques involved autogenous bone that was harvested from a distant donor site, such as the hip, and was certainly outside the scope of general dentists. However, with advances in technology and clinical research, the surgical techniques have evolved to the utilization of non-autogenous material for bone augmentation. Apart from lower incidence and severity of complications, these techniques can be **quite predictably performed simultaneously with implant placement** [9,1,8,3,10,20,15,11]. Thus, advances in technology provide today's dentists with a wider spectrum of safe alternatives to overcome certain challenges in different clinical circumstances in their own office. **Acquaintance with evolving or new technologies can only be relied upon with continued professional education that is outside the formal or university settings.**

8. Formal training pathways for the discipline of oral implantology are yet to be defined. Implant education for either dentists or specialists has traditionally been provided through conferences, lectures, and informal meetings. Specific advanced techniques are generally learnt through separate hands-on courses or clinical residency programs taught by experts on these techniques.

9. There are a number of associations that offer training that is in some cases assessment-based. The International Congress of Oral Implantologists (ICOI), Australian Society of Implant Dentistry (ASID), Implant Team Academy (ITA), Australian Osseointegration Society (AOS), and International Team for Implantology (ITI) are all such organisations. My accreditation by the ASID and fellowship with the ICOI were assessment-based, and required not only examinations, but in the case of ICOI, submission of documentation of treated cases in an examinable format, and documentation of 75 hours of implant education. This is an example of how dentists like myself, as well as specialists, would

typically pursue training in this field to supplement any form of private clinical mentoring they might receive from more experienced colleagues, outside of any formal training.

10. In a 2001 survey of clinical members of the Association of Dental Implantology in the United Kingdom, under 3% of respondents revealed academic qualification in oral implantology. 44% of respondents had a basic dental degree alone, and 3.3% had an additional ICOI diploma [18]. With respect to experience, 47.8% of the entire member pool (including dentists, oral surgeons, prosthodontists, periodontists) had inserted under 100 implants. Of those members who utilised simultaneous grafting technique, two thirds performed under 10 procedures [19].

11. Whilst there is little published data on the positive correlation of experience on implant success, it is natural to suspect that success rates improve with experience. Cumulative implant survival rates have been reported to increase from 94% to 97% after the operator has completed 9 cases [5]. In the same study, surgeons who placed 50 individual implants or more were considered 'experienced surgeons', and with that level of experience, the failure rate was as low as 1.8% [5].

12. In a separate study on the survival of implants placed by first year residents in a general dentistry residency program, residents performed a variety of simple and complex procedures. With respect to the more complex procedures, 29% of the patients had undergone bone grafting, 12% of patients had sinus lifts, and 12% of patients received 5 or more implants. The cumulative implant survival was 98.2%. This was unexpected in light of the residents' limited clinical experience [6]. This compared favorably to another study where a cumulative implant survival rate of 96% was reported for implants placed by periodontic, prosthodontic, and oral surgical resident-faculty teams [4].

13. Whilst some aspects of implant dentistry have been gradually introduced into the curricula of specialities such as periodontics, OMFS and prosthodontics, this has only been the case in more recent times. To my knowledge exposure to dental implants and associated procedures remains very limited. Oral implantology is not regarded a major part of any specialist training. For example, I am aware that in the OMFS residency program in Melbourne a resident may perform as few as 3 sinus augmentation procedures for implant placement throughout the 4 years of the postgraduate training course. Exposure to implants, soft tissue augmentation and other procedures that often go hand-in-hand with dental implants is also alarmingly low or non-existant.

14. The practice of dentistry, and particularly technique-sensitive procedures such as dental implants and associated augmentation procedures, relies substantially on manual dexterity. Manual dexterity relies to a degree on 'natural skill'. Natural skill varies from person to person in the same way that talent does. It can be said that a diligent clinician with a certain focus of interest and a high level of 'natural skill' can more readily achieve clinical competence within his field of interest. However, the alternative will also apply in the reverse. Therefore, the efficacy of having completed10 implant cases in a postgraduate university training program will vary greatly from person to person. Thus a clinician cannot be labeled fit to perform a certain procedure based purely on whether the same was covered within the curriculum.

15. The type of procedures that clinicians undertake must be commensurate not only with their level or type of training, but also their personal level of skill and experience. An academic achievement alone cannot substitute skill or experience. The number of formal qualifications or 'board approved' letters next to a clinician's name is certainly reflective of their academic achievement, but in the practice of dentistry which relies significantly on dexterous ability, this may not always be quite reflective of the skill or clinical competence.

16. As most registered dental providers in Australia practice in a private setting it has always been the individual clinicians responsibility to ascertain the types of procedures that they can safely perform, whether a specialist or general dentist.

17. The role of the National Board is to protect the interests of the public by setting standards and guidelines and taking disciplinary action against clinicians, whether general dentists or specialists, who practice outside the scope of their own skills and/or experience, which might result in poor communication with the patient, poor treatment planning, poor workmanship or unusual occurrence or frequency of complications. If the purpose of Guidelines in relation to a clinician's scope of practice is to further safeguard the public, then the focus must be not on only an academic qualification but also on the individual's level of competence and experience. The public would be much better served if there were guidelines for the expansion of a clinician's scope of practice that are based on merit, the attainment and maintenance of skills, as well as building on personal professional and clinical achievements, **irrespective of what type of 'formal' education they might have received**.

18. It may be reasonable, in my view, for the National Board to consider an alternative requirement that when undertaking more complex procedures, the clinician should build on their skills in a gradual manner and with an experienced mentor who can provide guidance and assess the clinicians progress in that regard.

19. Members of the public have no awareness of the common shortfalls within the curricula of formal specialist training programs in relation to dental implants and associated procedures. They often wrongly assume that a 'specialist' who does implants is a specialist implantlogist, even if dental implants were but a minor part of their curriculum. Therefore, in order to perform its role and protect the public it is my view that the National Board should help dispel any such misconceptions, not fuel a political battle to the ultimate disadvantage of the public. **The public would reasonably expect the National Board to protect them against clinicians who might seek to exploit the boundaries of their scope of practice through a 'formal' qualification alone**.

My Own Background

20. I am a dentist registered since 1995. I graduated from the University of Melbourne in the same year.

21. At the time of my graduation there were no university or board-approved post-graduate training programs that were specific to dental implants, or which could provide adequate cross-disciplinary training. I pursued my interest in a manner that would gradually build my knowledge and skills in ALL aspects of implant therapy.

22. The very first step that I could take after my graduation in 1996 was a two-day hands-on course on the Branemark System at the Dandenong Valley Hospital. Many of the participants were periodontists and prosthodontists. However, there were also general dentists like myself. Thus whether specialists or not, all came to learn about dental implants together, **which again highlights the fact that what might be regarded as a National Board Approved program is often not, in itself a sufficient basis for undertaking implant work**.

23. Since that time I have had a number of mentors and had undertaken numerous training programs both in Australia and abroad.

24. For over 5 years my practice has been exclusive to dental implants and reconstructive dento-alveolar surgery. I rely significantly on referrals, - such referrals come from both other dentists as well as specialists.

25. To date, I have placed well in excess of 5,000 implants and performed over 500 sinus grafts, in addition to many hundreds of other related soft and hard tissue augmentation procedures. I have been closely monitoring and documenting various parameters of all my cases since 2007 and put my success rate at above 99%.

26. I have lectured in Australia and abroad, and have personally trained and/or mentored many dentists as well as specialists. Below are very few of the comments that I received about my scope of practice and my training programs so as to help validate the appropriateness of general dentists like myself, who have not received National Board Approved formal training in this field, to undertake implant work:

    - *"Dr Fibishenko displays the extremely rare combination of supurb implant placement surgery coupled with a great insight into the prosthodontics needs and implications. He is a truly gifted clinicians who was happy to share his experiences."* ***Dr Anders Blomberg, SPECIALIST PROSTHODONTIST, Sydney NSW***

    - *"Dr Alex Fibishenko has developed an integrated approach combining surgical, prosthodontic and technical expertise in offering a complete solution for the edentulous patient. The facility is world class with dedicated operating suites, general anaesthetic facilities and teaching areas. He is not only a gifted clinician, but also a very generous and knowledgeable educator that will be able to offer attendees to his courses an insight into implant rehabilitation."****Dr Christopher Ho, IMPLANT DENTIST, Sydney NSW***

    - *"I have been fortunate to have watched many implant surgeons across the world and Alex is up there with the best. His gentle, precise and meticulous surgical technique is beautiful to watch. He is more like an Artist or Master Craftsman of Implant Surgery. Alex has refined many techniques in implant placement and hard and soft tissue management. He has an extensive range of "new age" skills designed to effortlessly address issues and provide more satisfying patient outcomes……there was no drama, just a single-minded focus to create a beautiful outcome. Alex's superb results force us to question the empirical*

traditional "old school" approach still commonly promoted by others" ***Dr Arnis Lidums, SPECIALIST PROSTHODONTIST, Adelaide***

- *"Alex has a relaxed but professional approach in the presentation of his material. He has very good clinical skills and is very generous in sharing his material and ideas. The facility is very well set up and the program is generally well done."* ***Dr. Paul McHugh, SPECIALIST PERIODONTIST, Adelaide SA***
- *"Having attended many courses in US & Europe this one was right up there. Definitely exceeded my expectations. Dr Fibishenko's thorough knowledge, in depth studies and huge clinical experience could be seen in his presentations from introduction of the programme to going in-depth in subject and various surgical options. He seems to have immaculate skill and sound knowledge of what he is doing during surgery, very dexterous with a sharp mind for lateral thinking. The live procedure from A to Z was mind-boggling. Well worth the long trip from India."* **Dr *Kanir Bhatia, IMPLANT DENTIST, Mumbai INDIA***

Despite all the above and my own training, skill, experience, success rates and contributions to the advancement of oral implantology in Australia, the wording of the proposed amendment could potentially place me, and others like me, in a predicament where we are unable to carry on with the surgical placement or restoration of dental implants.

I strongly oppose any move or suggestion that might in any way restrict the practice of skilled and experienced practitioners, such as myself, who have spent tens of thousands of dollars and hundreds of hours away from their homes and families over their years of practice in furthering their professional education and skills, albeit outside what might be referred to as 'formal education' or training 'approved by the national board'.

Nevertheless, I do believe that, at least in oral implantology, there needs to be some tightening of the scope of practice regulations requiring clinicians, whether general dentists or specialists, to undertake more than just didactic training alone in their professional development. Clinicians should also be encouraged engage in mentored or supervised clinical training when acquiring special or new skills, and retain or expand on those skills through experience **in a gradual manner** by being reflective on their personal clinical achievements and success.

I would be prepared to offer my own insight and work with the National Board so as to help achieve more balanced and appropriate wording in relation to the scope of practice and guidelines for clinicians.

Yours Sincerely,

Dr Alex Fibishenko
BDSc (Melb)

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