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The Australasian Sleep Association (ASA) wishes to comment on the Draft Scope of Practice Registration Standard and Guidelines. As the peak scientific body in Australia and New Zealand representing clinicians, scientists and researchers in the broad area of Sleep, our area of expertise is relevant to proposal #3, regarding the use of dental appliances for the treatment of sleep disorders.

The mission of the ASA is to lead and promote sleep health and sleep science across Australia and New Zealand. The ASA promotes education and training and fosters research in sleep health & sleep science. Its many functions include the organization of domestic and international scientific meetings, as well as acting in an advisory capacity to government and industry. Other important functions include drawing up standards and the oversight of training in the area of clinical sleep medicine. We are fortunate to have a broad range of disciplines within our membership and our Dental Group are outstanding contributors to our Association both through their own Special Interest Group of the ASA and via high quality and well attended annual Postgraduate Courses in Dental Sleep Medicine at our Annual Scientific Meeting .

The ASA is concerned that the proposed changes outlined below do not take into account that medical and dental expertise are both required to manage patients who are candidates for dental appliance therapy for snoring and sleep apnoea. There should be greater clarity with regards to the clinical roles of each member of the multidisciplinary treating team. We note with interest the Australian Dental Association in its policy statement 6.7 “Use of Dental Appliances to Treat Sleep-Disordered Breathing” supports this stance as follows: “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. “

In 2010 the Dental Orofacial Special Interest Group of the ASA wrote Guidelines for the dental management of patients with sleep disordered breathing, which are available to the public.

<http://www.sleep.org.au/information/sleep-documents/dental-appliance-therapy-for-treatment-of-sleep-disordered-breathing>

These are extensively referenced in the comments below.

Comments on Section 3. Reducing the prescriptive nature of the standard” p. 8

This is proposed to be altered to read “dentists work as independent practitioners who may practise all parts of dentistry included in the definition of dentistry. Where there is a structured professional relationship or referral relationship then the dentist and/or specialist dentist is the clinical team leader.

Key deletion:

Dentists may supply and fit dental appliances for the treatment of sleep disorders. They must work in cooperation with the patient’s medical practitioner who is responsible for the medical aspects of the management of sleep disordered breathing. **The ASA believes the health practitioner who is responsible for the patient’s sleep health is the Sleep Physician and has grave concerns about the dentist being “the clinical team leader” as proposed.**

It is the Australasian Sleep Association's viewpoint that Obstructive Sleep Apnoea is a very serious disease with important health consequences. We feel the clinical leader of this disease should be by a Sleep Physician. Thus if a patient is moving from one therapy to another, which of course will need to happen, this process needs to be supervised by their Sleep Physician skilled in the management of OSA and in a position to assess the clinical efficacy of the therapy both physiologically and symptomatically.

The current draft document states that dentists who fit and supply dental appliances to treat sleep disorders should work in cooperation with the patient's medical practitioner, who is responsible for the medical aspects of the management of sleep disordered breathing. We would advocate two additions to this:

1. Prior to supplying and fitting a dental appliance, a written referral must be obtained from the treating sleep specialist medical practitioner.
2. This medical practitioner is the clinical team leader.

The proposed changes to the standard do not clearly state that dentists who supply appliances for the treatment of sleep disordered breathing must be trained not only in dentistry but also have some knowledge and understanding of sleep disordered breathing.

The ASA Guidelines state that: "MADs should be fitted by qualified dental practitioners who are trained and experienced in the overall care of oral health, the temporomandibular joint, dental occlusion and associated oral structures. In addition, the dental management of patients provided with a MAD for sleep disordered breathing should be performed by practitioners who have undertaken significant training in sleep medicine and/or sleep-related breathing disorders."

The management of patients with sleep-disordered breathing requires an understanding of the disease. The dentist who supplies, fits and manages the dental appliance must be familiar with the anatomy, physiology and medical co-morbidities of the disease in order to appropriately fit, titrate and manage this long term treatment of a chronic disease, including side-effects and in monitoring treatment effectiveness. Without such knowledge, the patient will be inadequately and perhaps inappropriately treated.

Comments on "Dental Board of Australia Guidelines – Scope of practice registration standard" p. 16, Dental Prosthetists

The proposal states that: "Dental prosthetists who are formally educated and trained in a program of study approved by the National Board may provide various types of splints; **sleep apnoea/anti snoring devices**, immediate dentures and immediate additions to existing dentures. These procedures require written referrals to and from dentists and/or specialist dentists and any appliance or device manufactured under such arrangement must be planned, issued and managed by the treating dentist and/or specialist dentist."

This proposal requires amendment to ensure that it is clearly understood that although an appropriately trained dental prosthetist or technician may manufacture the dental appliance, it is the responsibility of an appropriately and formally educated and trained dentist to manage the dental health of the patient. This includes fitting and titrating of the dental appliance to treat obstructive sleep apnoea and snoring.

As prosthetists already work as independent practitioners, the role of the treating dentist and medical practitioners in the planning, issuing and management of the therapy needs to be clearly articulated within their scope of practice to provide clarity and certainty. Members of the public would not be aware of the substantial difference between a dentist who would be the team leader and the prosthetist who may be fitting the device. There is potential that this proposed change will result in a de-skilled workforce and effectively deregulate the standards, to the detriment of patient care.

The fitting of dental appliances requires more than an understanding of how to mould and fit a device that will hold the mandible in an anterior position during sleep. These devices have the potential for short term and long term side effects to the patient's dentition and supporting orofacial structures. This may be in terms of oral health, malocclusion and temporomandibular joint dysfunction. A dental prosthetist does not have the appropriate level of training or education to recognise and manage these areas of treatment. The ASA Guidelines state that the treating dentist is responsible for:

- a. determining if the patient is a suitable candidate for a MAD
- b. obtaining signed informed consent from the patient
- c. assessing the patient clinically and selecting the optimal MAD, having regard to its efficacy and potential side-effects for each individual patient
- d. prescribing the design and fabrication of the device
- e. fitting and adjusting the device
- f. providing follow-up care which includes:
 - o confirming that the patient is using the device correctly
 - o ensuring the device is properly adjusted and not causing discomfort
 - o monitoring the health of the oral structures and the integrity of the occlusion
 - o assessing if undesirable side effects or complications involving the cranio-facial complex are developing, such as TMJ dysfunction or occlusal changes
 - o arranging follow-up visits to occur at regular intervals for the duration of this therapy including any future replacement devices.
 - o regular written correspondence with all practitioners involved in the patient's sleep disordered breathing treatment, in particular the patient's GP and sleep physician. Correspondence should also be conducted when the patient fails to attend for initial SDB consultations with the treating dental practitioner.

A separate paragraph should deal with the provision of sleep apnoea/antisonoring devices. Our suggestion is:

Dental prosthetists who are formally educated and trained in a program of study approved by the National Board may provide **sleep apnoea/anti snoring devices** for patients referred by a dentist who has been formally educated and trained in the dental management of patients with sleep disorders. The fitting and titration of the device, all clinical care related directly to the oral appliance and follow up is the responsibility of the treating dentist.

General Comments

Prior to the formation of the National Board, the three State Dental Boards of Victoria, Queensland and South Australia had extensive codes of practice for dental appliance therapy for the treatment of sleep disorders. The Dental Practice Board of Victoria Code of practice (C009) has been in place since 2005 and the ASA had input in the Dental Board of Queensland Policy and Procedure (Policy #20). The purpose of these codes was to document the minimum standard of clinical practice required of dental health practitioners in the use of dental appliances to treat sleep disorders, in order to minimize the risk of harm to patients.

The ASA would support the formation of a similar code/policy.

In conclusion, we would like to work with the Dental Board to ensure that our patients continue to receive the highest standard of clinical care for Obstructive Sleep Apnoea and snoring. We believe Dental Practitioners are very important members of the multi-disciplinary teams already in existence around Australia and New Zealand but they should not be the Clinical Team Leaders of these teams. Dentists' prosthetists should work in conjunction with Dentists in constructing oral appliances, not independently.

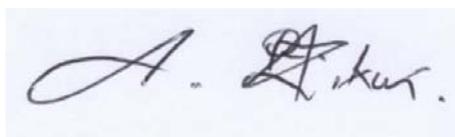
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