

Setting the boundaries and scope of practice for the two sister specialities of dentistry: Operative dentistry-endodontics and prosthodontics

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Abstract

Dental academia in Pakistan has recently achieved an important milestone. The name of Operative Dentistry speciality has been changed to Operative Dentistry & Endodontics (ODE). It was a much-needed change that was first felt about two decades ago. However, with the correction of name, there are certain challenges that this speciality has to manage now. These include improving the curriculum, setting up standards, and lastly, setting up its boundaries and scope of practice as some of its scope overlaps with a sister speciality called Prosthodontics. This overlapping of the boundaries of dental disciplines is a problem that is unique to Pakistan, India, and some East Asian countries where Operative Dentistry or Conservative Dentistry is combined with Endodontics. This paper aims to discuss the objective delineation of dental procedures and suggest a model of peaceful co-existence of sister dental specialities.

Keywords: Scope-of-practice regulation, Appointment, Credentialing, Group practice.

DOI: <https://doi.org/10.47391/JPMA.9692>

Introduction

One of the biggest milestones that have been achieved by Operative Dentistry specialists and its academic faculty in Pakistan is the correction of the nomenclature of their speciality.¹ In Pakistan, the system of structured residency programme in this discipline of dentistry was established by the College of Physicians & Surgeons of Pakistan (CPSP) in 1995.² CPSP is the premier body that oversees the teaching, training, and assessment of medical and dental specialities in the country.³ From the beginning, the nomenclature of the speciality of Operative Dentistry was a matter of concern amongst the trainees and trainers in this discipline. The primary reason was an obsolete name that was given to the speciality at the time of its inception at CPSP. The major component of the speciality, i.e. Endodontics was missing in the previous name.

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Submission complete: 17-04-2023

Review began: 15-06-2023

Acceptance: 16-09-2023

Review end: 16-09-2023

Endodontics alone accounts for around 75% of the discipline's syllabus and scope of practice.^{4,5} This resulted in identity crises among the specialists of the discipline. Several voices were raised at different forums to get this corrected, but no tangible change was observed until the professional association of the academic faculty and fellows was established. Finally, with the advocacy of the association, the newly appointed dental faculty councillor, representing over 1,000 fellows in the five specialities of dentistry, at CPSP highlighted the issue. The matter was discussed before the college academic council, which was finally convinced with the case put forward by over 200 Operative Dentistry fellows to rename the speciality as Operative Dentistry & Endodontics (ODE).

It was a great academic achievement with long-term clinical and professional implications. With this decision, Endodontics finally got its identity.¹ This corrective measure not only opened the doors of international examination for the graduate fellows of the CPSP in this discipline but also created job opportunities for the Pakistani trained specialists to get employment in UAE, Saudi Arabia, and other GCC countries.⁶ This demonstrates that advocacy done in the right direction before the right forum, yields productive outcomes.

Now, what are the current challenges faced by the speciality and what is the way forward? Following are the main challenges. The first challenge is improving the standard of care in the speciality. For Endodontics training in the contemporary world, it is imperative to have dental operating microscope. All trainees should be trained using this gadgetry. This will not only improve the standards of care in the discipline but also bring more confidence among the practitioners. Better clinical outcomes, improved patient satisfaction and ability to present cases at international forums will be the additional by-products. However, there are challenges such as cost implications for procuring operating microscope in accredited FCPS training centres and a bigger challenge of improving the capacity of existing practitioners who received their training in the pre-microscope era. Not all cases would qualify for treatment under a microscope but a certain proportion of cases (for example endodontic retreatment, separated instruments, or surgical endodontics) will

certainly qualify for care under magnification. The learning curve for practicing under a microscope is something that should be discussed at the faculty meetings and a way forward be planned.

The second challenge is upgrading the curriculum and assessment methods in the subject of ODE. These should be made in line with (and of similar or higher standards) the other centres of excellence in world. The standards of training and assessment practiced at the dental faculties of Royal Surgical Colleges in UK⁷ and Ireland, or the American Boards of Endodontics⁸ be taken as examples. This will not only open the door of reciprocity of qualifications for Pakistani trained specialists but also create opportunity for the exchange of examiners with the centres mentioned above.

Discussion

The delineation of the scope of practice of the dental specialities is an imperative issue. The Operative Dentistry component of the ODE speciality overlaps with the discipline of Fixed Prosthodontics. This becomes an issue at academic workplace where two cadres of specialists are employed and there is a potential for conflict of interests. A clear delineation of scope of practice is clearly needed for the overlapping procedures. ODE focusses on the prevention, diagnosis, and treatment of the diseases of tooth enamel, dentine, pulp, and periapical tissues.^{9,10} On the other hand, the discipline of Prosthodontics is all about the replacement of congenital and/or acquired loss of dental tissues and associated structures. For the pulpal and periapical components, there are no conflicts between the two specialities as these clearly fall in the domain of ODE. Similarly, dentures, obturators, and maxillofacial prosthesis are clear-cut Prosthodontics' domain. The issue arises with the procedures involving enamel and dentine. These include bleaching, veneers, single crowns, bridges, and implants. The best solution for this is to devise some objective criteria and working formula for conflict resolution between the practitioners of the two disciplines. A simple but tangible approach is to adopt the cut-off of the change in the vertical dimension of occlusion, that is conformational versus reorganised occlusal intervention criteria. All the crowns, bridges, and implants in patients whose vertical dimension of occlusion need a raise must be referred to a Prosthodontist. Full arch rehabilitation cases requiring complex laboratory procedures should also be referred to Prosthodontists. Lastly, temporomandibular joint (TMJ) patients needing occlusal splints therapy are also Prosthodontists' domain. Procedures such as fillings, pinned restorations, pulpotomy, pulpectomy, periapical surgery, post-core build-up, inlays, onlays, veneers, micro or macro abrasion of teeth, bleaching, full coverage

restoration after root canal therapy, endo-crowns, single or multiple full coverage crowns, or even fixed bridges that do not need altering the vertical dimension of occlusion should be the scope of ODE practice. This formula will be helpful in delineating competencies, referral, and devising compensation plans in practices that have specialists of the two genres.

The distribution of clinical cases is imperative in institutions and hospitals where multiple faculty members with overlapping clinical skillsets and clinical competence practice.¹¹ Credentialing and assignment of clinical privileges should be modelled on procedure-specific list. Credentialing should involve the review of qualifications, active licensure, training, education, experience, and track record of performance (logbook) of the dentists.¹²

There are some other challenges faced by the discipline of ODE in Pakistan. The unwanted intrusion of the components of other dental specialities in ODE's curriculum is a significant problem. A substantial part of Periodontology and Paediatric Dentistry has disfigured the true boundaries of the ODE as a speciality. The contamination of the sister dental specialities into ODE has adversely affected the growth and development of this speciality. The practitioners of ODE in Pakistan have largely become glorified general dentists. Interestingly, this problem is exclusive to Pakistan.⁶ Other countries have well-demarcated delineation of dental subject boundaries. Fortunately, in the last decade, Periodontology has become a distinct discipline in the country.¹³ This development has helped in a gradual elimination of the Periodontology components out of the ODE syllabus.

The next big challenge is the establishment of Paediatric Dentistry as a distinct subject speciality. Hospitals and dental institutions face an acute dearth in hiring specialist practitioners in Paediatric Dentistry. Almost all specialists in this field have been trained abroad. It is both alarming and sad to observe that in a country where 46.8% of the population comprises children aged ≤ 19 years or less, there are no FCPS residency programmes in Paediatric Dentistry.¹⁴

Another development that dental academia is keenly looking forward to is the establishment of Community Dentistry as a dental speciality.¹⁵ It will certainly improve the manpower for dental health and education projects in the country and will also strengthen the dental research capacity of the institutions.

It would be correct to state that dentistry, especially the discipline of ODE, is at the crossroads in our country. The path taken now will have a long-term effect on the academia and practice.

Conclusion

In dental practices and institutions where practitioners of both specialities (Prosthodontics and Operative Dentistry-Endodontics) are employed, clinical cases that need fixed restorative care (crowns, bridges, and implant prosthetics) can be undertaken by either cadre of the specialists. However, the cases which require change in the vertical dimension of occlusion should only be undertaken by Prosthodontists.

Disclaimer: None.

Conflict of interest: None.

Funding disclosure: None

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Author Contribution:

FRK: Conceived the idea, writing the manuscript, accuracy of facts, integrity of data, opinions.