

MEDICAL SOCIETY
of the
STATE OF NEW YORK

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Senior Vice President/
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Division of Governmental Affairs

MEMORANDUM IN OPPOSITION

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S.816 (LIBOUS)

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A.3329 (MORELLE)

AN ACT, to amend the education law in relation to amending the definition of the scope of practice of dentistry to authorize dentists who are qualified and certified to perform any procedure in the oral and maxillofacial area; and to amend the public health law and the civil practice law and rules, in relation to the discipline and liability of dentists who are so qualified and certified

This measure would permit certain dental practitioners to perform a wide range of medical surgical procedures involving the hard or soft tissues of the oral maxillofacial area. Specifically, the bill could enable oral and maxillofacial surgeons (dental surgeons) to perform surgical procedures well beyond their current scope of practice which is rooted in the restoration and maintenance of dental health.

This measure would allow *“any oral and maxillofacial surgeon as certified by the department,”* to perform additional surgical procedure involving hard or soft tissues of the oral and maxillofacial area *“provided he or she has been certified by the American Board of Oral and Maxillofacial Surgeons and granted privileges for such procedures by a general hospital”*. The *“additional surgical procedures”* which the oral and maxillofacial surgeons could perform under this proposal would include but not be limited to rhinoplasty (nose jobs), blepharoplasty (eyelid surgery), rhytidectomy (face lift), submental liposuction, otoplasty (ear surgery), dermabrasion, and other procedures of the head and neck. This bill represents yet another in a long line of measures designed to allow non-physicians to practice medicine and perform complex medical procedures. Dentists, however well qualified in oral health, are not physicians. Dental education and training are not equivalent to physician education and training. They should not be permitted to practice medicine and perform surgical procedures unrelated to oral health. **The Medical Society of the State of New York opposes this measure and urges its defeat.**

The differences which exist in the education and training of dentists, including oral and maxillofacial surgeons, and physicians are significant and must be carefully examined. Dental schools require a minimum of two years of college-level education. Colleges of dentistry offer a 4 year program. Graduates receive the degree of Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine

(DMD). In New York, a doctoral degree in dentistry (either a DDS or DMD degree) is required for licensure as a dentist. General dentists typically do not focus their clinical practice on any particular discipline within dentistry, and instead provide basic care within a variety of disciplines. A dentist can further his or her training in one or more specialty areas.

Oral and maxillofacial surgery is one of nine specialties recognized by the American Dental Association and the U. S. Department of Labor. Postdoctoral programs in oral and maxillofacial surgery offer training programs ranging from a minimum of 4 years to a maximum of 6 years. Graduates of the four year program receive a certificate in Oral and Maxillofacial Surgery (OMFS). Graduates of the six year program receive a medical degree (MD) in addition to the certificate of Oral and Maxillofacial Surgery (OMFS).

Typically, oral and maxillofacial surgeons perform oral surgical operations to remove infected, impacted or malposed teeth, prepare jaws for prosthodontic appliances and remove abnormal growths, cysts and foreign bodies from jaws and oral structures.

Dentists have argued that their doctoral training as well as their post-doctoral residency training is equivalent to that which a physician obtains including a board certified plastic surgeon, dermatologist, otolaryngologist or orthopaedic surgeon. This argument is categorically false. If it were true, there would be no need to differentiate post-graduate degrees (DMD/DDS vs MD).

Although the first two years of medical and dental school are comparable, the second two years are very different. The third and fourth years of medical school consist of clinical rotations through surgery, medicine, pediatrics, psychiatry, obstetrics and gynecology and various other electives. The third and fourth year of dental school is primarily spent in the lab where the dentists are trained primarily in the skill of drilling and learning the manual skills that will make them proficient as a dentist. They are not exposed to the hospital setting, nor are they exposed or trained to take care of critically ill patients.

By contrast, a physician practicing a surgical discipline obtains a bachelors or masters degree (four to six years), a doctor of medicine degree (four years) and completes a five year residency training program. Typically, the training programs for specialist surgeons consist of three years of general surgery and two years of focus in a specialty surgical area, such as plastic surgery or otolaryngology (Ear, Nose, and Throat).

Importantly, the post-doctoral residency training received by dentists is not equivalent to that completed by physicians.

The Commission on Dental Accreditation, an arm of the American Dental Association, has established certain standards for accredited Oral and Maxillofacial Surgery residency programs. These standards require instruction in basic sciences, physical diagnosis, anesthesia, surgical head and neck anatomy, and clinical physiology as well as a minimum of thirty months of oral and maxillofacial surgery to be included in clinical services within the four year residency program. They must perform 75 surgical cases in their final year, including at least ten in trauma, pathology, orthognathic and reconstructive and esthetic surgery. **Only ten cases are required in reconstructive and esthetic surgery.** In a survey conducted in California which asked practitioners to rate the relative frequency of 120 tasks, the oral and maxillofacial surgeons responded that the vast majority of the procedures they had performed were primarily in the area of dentoalveolar (the tooth and alveolar bone) with only a handful of cases in reconstruction and cosmetic medical procedures.

In stark contrast, the Accreditation Council for Graduate Medical Education is a private, non-profit council that evaluates and accredits medical residency programs in the United States. In comparison to the standards of

the Commission on Dental Accreditation, the standards of the Accreditation Council of Graduate Medical Education are considerably more stringent and are comparable across surgical specialties whether we are referring to plastic surgery, otolaryngology or orthopedic surgery. Each must demonstrate a number of cases in a variety of subspecialties in each particular specialty. For example, the American Board of Otolaryngology requires a mix of cases demonstrating proficiency in facial plastic surgery, pediatric otolaryngology, head and neck surgery, general otolaryngology and endoscopy. The average resident sitting for a board examination, whether an otolaryngology resident or a plastic surgeon resident, will have completed 2000 surgical procedures over their four year residency program. Moreover, those residents who complete residency and participate in fellowship training in the sub-specialty of Facial Plastic and Reconstructive Surgery, participate as either surgeon or first assistant surgeon on an additional 800 cases, with a total surgical volume of approximately 200 rhinoplastys – one of the most complex cosmetic medical procedures performed.

It is asserted that some dentists with advanced training such as the oral and maxillofacial surgeons, are performing reconstructive trauma surgery. There may be some multi-disciplinary teams in which oral surgeons scrub with trauma surgeons, ophthalmologists, plastic surgeons and otolaryngologists with a combined approach; however, to our knowledge, these large combined procedures are relatively small in number. There may even be occasions in which a surgical specialist will permit an oral and maxillofacial resident to “scrub” on some of these surgical procedures, but they are not performing the surgery. They are acting as an assistant to the surgeon. Even where an oral surgeon in a rare instance may perform mandibular trauma surgery or some mid-facial and bony trauma surgery, we contend that such surgery is of a significantly lower level complexity than virtually all cosmetic medical procedures. Simple “exposure” to surgical cases as an assistant or “experience” with simple surgical procedures does not equate to the competency level of a physician. Dentists, even oral and maxillofacial surgeons, are not trained in the systemic management of disease and, therefore, are not prepared to conduct a proper pre-operative evaluation, assess what surgical approach is most appropriate, or determine how to manage complications which may arise.

Moreover, since the statute does not delineate or circumscribe where these services may be provided, the measure would permit the oral and maxillofacial surgeon “*who has been granted privileges for such procedures by a hospital*” to perform the procedure anywhere, including in his or her office. While it may be that a limited number of dentists perform some reconstructive trauma surgery in the hospital setting, ready access exists in such environment for additional professional and support systems to assist if complications beyond the ability of the dentists arise. At a time when legislation was recently passed in 2007 to implement the recommendations of the Department of Health Task Force on Office Based Surgery, to enhance the regulation of office environments where surgical procedures requiring anesthesia are performed, it certainly would not be appropriate to expand the types of practices and practitioners performing such surgeries without first establishing the parameters under which they are performed. This legislation requires, among other things, that the office setting, and every physician in it who performs office based surgery, be credentialed by one of three national credentialing organizations. The law does not apply to dentists since they are not disciplined by the Department of Health.

Clearly the outcome of your consideration of this measure will have a significant effect on the quality of patient care in New York State. All surgery, including cosmetic surgery, involves risk and should be performed only by qualified physicians. Indeed, this was demonstrated by a survey of physicians performing this type of surgery in the Richmond Virginia area shortly after the State of Virginia had approved legislation to expand the scope of practice of dentists. The survey showed that fifty percent of the physicians performing surgery between March of 2001 and December of 2004 indicated that they had treated a patient with a poor outcome following cosmetic surgery performed by an oral surgeon. This, of course, is not surprising given the fact that the standards of training and experience for performing such surgery for dentists promulgated by the American Board of Oral and Maxillofacial Surgery differ from those approved by the American Board of Plastic Surgery.

The Medical Society of the State of New York is supported in its opposition to this measure by the American Medical Association, the American Society of Plastic Surgeons, the American Academy of Otolaryngology- Head & Neck Surgery, the American Academy of Dermatology, the American College of Surgeons, and the American Academy of Facial Plastic and Reconstructive Surgery. In addition, in New York, several of the State Specialty Medical Societies have agreed to unite on all issues affecting the scope of practice of non-physicians. United with us are the New York Chapter American College of Physicians, the American College of Obstetricians and Gynecologists- District II, the New York State Ophthalmological Society, the New York State Society of Orthopaedic Surgeons, and the New York Chapter of the American College of Surgeons.

Based on the foregoing, the Medical Society opposes this legislation and urges that it be defeated.

2/27/15
LDK/BKE – Oppose

Respectfully submitted,

ELIZABETH DEARS, ESQ.