CDSS GUIDELINES FOR FIXED, REMOVABLE, AND CLEAR ALIGNER ORTHODONTICS

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These are intended as guidelines for registrants of the CDSS in providing orthodontic care for their patient(s) in the province of Saskatchewan.

The CDSS guidelines contain parameters that may be used by the College and other bodies in determining whether appropriate best practices and professional responsibilities were met and maintained.

1. INITIAL EDUCATION REQUIREMENTS

It is to be expected that the dentist has made an effort in taking adequate education and training either at the undergraduate level and/or postgraduate level to become sufficiently knowledgeable from a didactic and theoretical standpoint along with practical clinical experience as applicable. It is advised to have at least undergraduate didactic and clinical training in orthodontics to be able to provide basic space maintenance and simple fixed or removable orthodontic appliances.

It is reasonable that with appropriate postgraduate continuing education, a dentist is able to treat orthodontic cases appropriate to their level of training and experience, ensuring they are comfortable in providing treatment to the complexity level of the cases accepted to be treated.

A reasonable and recommended guide to the amount of continuing education acceptable may be the percentage of the dentist's practice that is limited to orthodontics versus the dentist's general practice, or to a recommended minimum of at least 10 hours per continuing education cycle in comprehensive orthodontics to allow providing patients with fixed, removable, and clear aligner orthodontics.

2. BEST PRACTICE

It is understood that education and experience will address the level of care that should be met with the complexity of the orthodontic treatment attempted and may be encompassed by a recommendation to follow these outlined parameters.

A) CASE SELECTION

With education and training, the dentist can decide on the proper diagnostic information that should be obtained prior to initiating orthodontic therapy (i.e., complete orthodontic records allowing for a proper diagnosis and treatment plan).

Recommended complete orthodontic records can include but are not limited to:

1) Comprehensive clinical exam (also recommended a general dental exam, with completion of basic restorative and hygiene needs prior to or concurrent with orthodontic treatment, with ongoing annual recall exams and hygiene as deemed appropriate);

2) Appropriate radiography as deemed necessary (pantomograph recommended as a minimum, lateral cephalogram and CBCT if deemed necessary);

3) Full extraoral dental photographs, as well as intraoral dental photographs or digital scan imaging;

4) Physical impressions or digital scans of maxillary and mandibular arches along with bite registration.

With education, and subsequent experience, the dentist can determine their comfort zone of providing a diagnosis for treatment which should include at a minimum:

i) Assess and diagnose skeletal and dental malocclusions;

ii) Assess degree of crowding of spacing;

iii) Assess esthetic requirements and/or challenges;

iv) Assess localized mutations and/or complications.

These initial starting parameters can be used in determining the level of complexity and give the dentist a comfort level that one should possess in treating any orthodontic case. As well, knowledge of the diagnostic criteria, can be used to help determine the appropriateness of a general dentist versus a dental specialist (orthodontist) in providing treatment.

Every effort should be made to demonstrate competency in completing a variety of less complex cases before treating more complex cases. Once comfortable with less complex cases, followed by demonstrated education and clinical experience, the general dentist may choose to treat more complex cases at their discretion.

It is beneficial to recognize the gradient of difficulty of the case to be treated (ie. simple, moderate, or complex nature of the orthodontic problem to be corrected). Parameters that can be assessed to grade complexity can include, but are not limited to:

1) Class I malocclusion with adequate spacing vs Class II or Class III skeletal and/or concurrent dental malocclusion;

2) Assessed dental crowding from minimal to severe, determining the necessity and thus the complexity of permanent tooth extraction;

3) Previous orthodontic relapse cases;

4) Number of clear aligners required to correct a malocclusion.

B) PROPER CASE PRESENTATION AND AN INFORMED CONSENT

An adequate representation of the pre orthodontics situation and the projected post orthodontics situation is recommended to be presented to the patient. It is recommended to obtain written informed consent.

The informed consent at a minimum should:

1) Outline expectations, risks, and benefits of the proposed treatment;

2) Outline expectations, risks, and benefits of the proposed treatment;

a. Recommend to include, if interproximal reduction (IPR) or orthodontic extraction is applicable, a detailed and comprehensive explanation, easily understood in layman's terms, and consented to, by the patient with subsequent notation in patient chart notes;

3) Framework of expected treatment time;

4) Cost of treatment;

5) Treatment considerations, decisions, and limitations;

6) Patient responsibilities during treatment

a. Should include that regular check-ups and cleanings are recommended, and adequate oral hygiene is a necessity, and orthodontics may be stopped mid treatment if lack of oral hygiene has the potential to cause detrimental and irreversible oral health effects;

7) Summary of continuation of care outlining patient responsibilities.

It is recommended that the patient have a good understanding of what to expect and what not to expect from the orthodontic treatment plan.

Limited and/or comprehensive fixed orthodontics face similar guideline recommendations.

C) ONGOING PATIENT COMMUNICATION DURING ACTIVE TREATMENT

Highly recommended with both clear aligner and fixed orthodontic cases.

Documented verbal informed consent as per the CDSS guidelines.

D) TREATMENT CONCLUSION

Should conclude based on the details encompassed within the informed consent treatment plan and protocol.

If for a stated reason, either the dentist or the patient elect to conclude treatment prior to achieving the treatment outcome outlined, every effort should be made to come to a mutually acceptable decision, and that this decision be outlined in a subsequent consent.

E) ORTHODONTIC RETENTION AND CONTINUUM OF CARE

Recommended to be outlined within the initial informed consent outlining cost, patient responsibility, and/or potential complications arising from inadequate patient compliance.

Retention appliances details should be outlined within the initial informed consent.

Follow up by the dentist, in addition, should be outlined.

F) RETENTION OF RECORDS

All retention records deemed necessary by the dentist should be maintained for medico-legal purposes, as per the complexity of the orthodontics performed.

All records to be maintained as per CDSS guidelines.