AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 230
(A-24)

Introduced by: American Academy of Dermatology, American Society for Dermatologic Surgery Association, American Contact Dermatitis Society and American College of Mohs Surgery

Subject: Protecting Patients from Inappropriate Dentist and Dental Hygienist Scope of Practice Expansion

Referred to: Reference Committee B

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Whereas, procedures performed by any means, methods, devices, or instruments that can alter or cause biologic change or damage the skin and subcutaneous tissue constitute the practice of medicine and surgery; and

Whereas, there are increased legislative and regulatory efforts to allow dentists and dental hygienists to administer neurotoxins and dermal fillers for therapeutic or cosmetic purposes without physician supervision; and

Whereas, in order to ensure patient safety, administration of neurotoxins and dermal fillers requires supervision by a trained physician, education, training, specific knowledge of facial anatomy (particularly in the periocular region), and the ability to manage complications that may arise; and

Whereas, the focus of dental education is on oral health, rather than the skin and facial tissue; and

Whereas, dentists and dental hygienists are not required to demonstrate competency in procedures that augment skin and soft tissues using products that can alter or damage such living tissue; and

Whereas, the American Dental Association and the American Dental Hygienist Association are silent on the issue of dentists and dental hygienists performing medical procedures related to fillers and neurotoxins; and

Whereas, in 2023 the Food and Drug Administration (FDA) updated consumer guidance to state that anyone considering a neurotoxin or dermal filler should consult with a licensed health care provider who has experience in the fields of dermatology or plastic surgery, who is experienced in injecting dermal fillers, who is knowledgeable about fillers, anatomy and managing complications, and who knows the risks and benefits of treatment[3]; and

Whereas, preventing and treating adverse events of injectable fillers requires the development of evidence-based clinical practice guidelines to support decision-making in daily practice and knowledge of vascular anatomy is *crucial* for all filler injections[4]; and

Whereas, intravascular injection is possible at any location on the face, but certain locations carry a higher risk of filler embolization, necrosis, visual abnormalities, blindness and stroke[5]; and

Whereas, allowing dentists and dental hygienists to administer neurotoxins and dermal fillers for therapeutic or cosmetic purposes jeopardizes patient safety and disregards what is considered adequate and appropriate medical education and training; therefore be it

RESOLVED, that our American Medical Association advocacy efforts recognize the threat posed to patient safety when dentists and dental hygienists are authorized to practice medicine and administer procedures outside their level of education and training (New HOD Policy); and be it further

RESOLVED, that our AMA actively oppose regulatory and legislative efforts authorizing dentists and dental hygienists to practice outside their level of education and training. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 4/24/2024

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REFERENCES

1. General Dentistry. Retrieved from http://www.ada.org/en/education-careers/careers-in-dentistry/general-dentistry
2. Dental Hygienist Education and Training Requirements. Retrieved from http://www.ada.org/en/education-careers/careers-in-dentistry/dental-team-careers/dental-hygienist/education-training-requirements-dental-hygienist
3. Dermal filler Do's and Don'ts For Wrinkles, Lips and More. U.S. Food and Drug Administration. Retrieved from https://www.fda.gov/ForConsumers/ConsumerUpdates/ucm049349.htm
4. Jones D, Fitzgerald R, Cox S, Butterwick K, et al. Preventing and Treating Adverse Events of Injectable Fillers: Evidence-Based Recommendations From the American Society for Dermatologic Surgery Multidisciplinary Task Force. Dermatol Surg 2021;47:214-26.
5. Ibid.
6. Scope of Practice. ADHA. Retrieved from https://www.adha.org/advocacy/scope-of-practice/
7. Advocacy. American Dental Association. Retrieved from https://www.ada.org/advocacy

RELEVANT AMA POLICY

D-35.983 Addressing Safety and Regulation in Medical Spas

Our AMA will: (1) advocate for state regulation to ensure that cosmetic medical procedures, whether performed in medical spas or in more traditional medical settings, have the same safeguards as "medically necessary" procedures, including those which require appropriate training, supervision and oversight; (2) advocate that cosmetic medical procedures, such as botulinum toxin injections, dermal filler injections, and laser and intense pulsed light procedures, be considered the practice of medicine; (3) take steps to increase the public awareness about the dangers of those medical spas which do not adhere to patient safety standards by encouraging the creation of formal complaint procedures and accountability measures in order to increase transparency; and (4) continue to evaluate the evolving issues related to medical spas, in conjunction with interested state and medical specialty societies. (Res. 209, I-11; Reaffirmed: BOT Rep. 7, A-21)

D-160.995 Physician and Nonphysician Licensure and Scope of Practice

1. Our AMA will: (a) continue to support the activities of the Advocacy Resource Center in providing advice and assistance to specialty and state medical societies concerning scope of practice issues to include the collection, summarization and wide dissemination of data on the training and the scope of practice of physicians (MDs and DOs) and nonphysician groups and that our AMA make these issues a legislative/advocacy priority; (b) endorse current and future funding of research to identify the most cost effective, high-quality methods to deliver care to patients, including methods of multidisciplinary care; and (c) review and report to the House of Delegates on a periodic basis on such data that may become available in the future on the quality of care provided by physician and nonphysician groups.
2. Our AMA will: (a) continue to work with relevant stakeholders to recognize physician training and education and patient safety concerns, and produce advocacy tools and materials for state level advocates to use in scope of practice discussions with legislatures, including but not limited to infographics, interactive maps, scientific overviews, geographic comparisons, and educational experience; (b) advocate for the inclusion of non-physician scope of practice characteristics in various

analyses of practice location attributes and desirability; (c) advocate for the inclusion of scope of practice expansion into measurements of physician well-being; and (d) study the impact of scope of practice expansion on medical student choice of specialty.
3. Our AMA will consider all available legal, regulatory, and legislative options to oppose state board decisions that increase non-physician health care provider scope of practice beyond legislative statute or regulation. (CME Rep. 1, I-00; Reaffirmed: CME Rep. 2, A-10; Modified: CCB/CLRPD Rep. 2, A-14; Appended: Res. 251, A-18; Appended: Res. 222, I-19)

H-160.949 Practicing Medicine by Non-Physicians
Our AMA: (1) urges all people, including physicians and patients, to consider the consequences of any health care plan that places any patient care at risk by substitution of a non-physician in the diagnosis, treatment, education, direction and medical procedures where clear-cut documentation of assured quality has not been carried out, and where such alters the traditional pattern of practice in which the physician directs and supervises the care given;
(2) continues to work with constituent societies to educate the public regarding the differences in the scopes of practice and education of physicians and non-physician health care workers;
(3) continues to actively oppose legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision;
(4) continues to encourage state medical societies to oppose state legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision;
(5) through legislative and regulatory efforts, vigorously support and advocate for the requirement of appropriate physician supervision of non-physician clinical staff in all areas of medicine; and
(6) opposes special licensing pathways for “assistant physicians” (i.e., those who are not currently enrolled in an Accreditation Council for Graduate Medical Education training program or have not completed at least one year of accredited graduate medical education in the U.S). (Res. 317, I-94; Modified by Res. 501, A-97; Appended: Res. 321, I-98; Reaffirmation A-99; Appended: Res. 240, Reaffirmed: Res. 708 and Reaffirmation A-00; Reaffirmed: CME Rep. 1, I-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: Res. 208, I-10; Reaffirmed: Res. 224, A-11; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Res. 107, A-14; Appended: Res. 324, A-14; Modified: CME Rep. 2, A-21)

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