

Christel Koppel Autuori RDH MA

17 March 2013

Regarding:

H.B. No. 6589 (RAISED) PUBLIC HEALTH . 'AN ACT ESTABLISHING A TASK FORCE TO STUDY THE SCOPE OF PRACTICE FOR DENTAL HYGIENISTS'

It is my understanding that the purpose of this bill is to establish a task force to study the scope of practice for dental hygienists with regard to additional procedures performed to increase the access to care by thousands of Connecticut residents who currently are not able to receive dental care.

This issue needs no further study, as it has been studied extensively, and addresses the problem and offers the solution to inadequate access to dental care. This was a problem in 1949, in the mid 1970s, and remains a problem today, in 2013. The solution to this problem—too many people, not enough dentists, inadequate access to care—is to increase the scope of practice for the dental hygienist. We need no further studies—we need action, and we need action NOW.

In the mid 1970s I participated in the Forsyth Experiment in Expanded Duties for Dental Hygienists, the second study of its kind at the Forsyth Dental Center in Boston, Massachusetts. (The first study in expanded duties at Forsyth was in 1949) In October, 2006, I delivered the keynote address at the 75th anniversary celebration of Forsyth School for Dental Hygienists. Excerpts from this address, entitled "From the Forsyth Project to the ADHP", follow:

The old models of dental care are not appropriate for the twenty first century, and new methods of delivering dental care are needed. We dental hygienists have responded with the creation of the ADHP—the Advanced Dental Hygiene Practitioner, a new dental care provider, who will be able to provide restorative dentistry as well as other services. Forsyth recognized this need many years ago, and offered a solution. In 1972 I participated in the Forsyth Project Rotunda, the only project of its kind in this country in which dental hygienists were trained to perform all phases of restorative dentistry,

including the irreversible procedures of removing decayed tooth structure. This was not a new idea at Forsyth.

Access to care, and the problem of too many people, too many cavities, and not enough dentists was a problem before I was born. Forsyth recognized the problem and offered a solution. In 1949 a law was passed enabling dental hygiene students at the Forsyth School for Dental Hygienists to be trained to prepare and restore children's teeth.

Twelve dental hygiene students who entered Forsyth in the fall of 1949 were to receive training in restorative dentistry as well as the basic dental hygiene curriculum. The training period for the restorative dentistry was to be two years, followed by three years of clinical practice under the supervision of a dentist. This project received national publicity, but the House of Delegates of the American Dental Association passed a resolution disapproving this training. There were heated debates between those who believed the project was completely justified by the high rate of untreated caries in the children of Massachusetts, and the dentists who opposed the project as socialistic and dangerous. After only one year, the Board of Trustees of Forsyth was forced to terminate the project, despite the fact that the twelve hygienists had become very proficient in the preparation and restoration of decayed teeth.

By the mid 1960's the decay rate was rising and many people had no access to dental care. Producing more dentists was not a viable answer to the immediate need, for it would strain the existing personnel and facilities beyond their capacity. It takes eight years to produce a dentist—four years of undergraduate education and four years of dental school. The Forsyth Administration and Board of Trustees felt it was time to revisit the possibility of an expanded role for the dental hygienist and proposed that dental hygienists be trained in all phases of restorative dentistry. Dr. John W. Hein, Director of the Forsyth Dental Center, and Dr. Ralph R. Lobene, project director, presented Forsyth's plans to the Massachusetts Dental Society, and the House of Delegates voted 134 in favor, to 5 opposed, to approve and accept this research project. Members of the Massachusetts Dental Society were appointed as a liaison between Forsyth and the Dental Society and the Board of Dental Examiners for the Commonwealth of Massachusetts was continually informed of all of Forsyth's plans.

Funding for the Forsyth Rotunda Project was provided by the Frederick J. Kennedy Memorial Foundation and the Robert Wood Johnson Foundation. Ten registered dental hygienists, (six Forsyth graduates, one Fones graduate, and three graduates of Bristol Community College) were selected to participate in the Forsyth project. We had graduated and practiced clinical dental hygiene for seven months before participating in this project. We were excited and enthusiastic to learn new skills to enable us to better care for our patients, and we were thrilled to have the support of the Massachusetts Dental Society. The project began in March, 1972.

In order to teach restorative dentistry techniques, from cutting tooth structure and removing decay to packing, finishing, and polishing restorations, specific procedures and techniques were developed, with terminal performance objectives and intermediate objectives and goals. Procedures were broken down step by step and explained and taught sequentially. Because the dental hygiene curriculum is rigorous and thorough we

had a solid body of knowledge on which to build and add the new skills of restorative dentistry.

We were taught to administer local anesthesia—infiltrations and mandibular blocks, and we learned to place rubber dams. We prepared and restored Class I through Class V cavity preparations, and even learned to place stainless steel pins in large cavity preparations. Throughout our training all phases of each procedure were completely evaluated by the hygienist who performed the task, by a second hygienist, and by a staff dentist. Our patients were mostly college students and young adults, members of the university community, faculty, and staff. We developed a strong relationship with our patients from the beginning. We performed the initial exam and preventive care, and took an active role in the diagnosis and treatment planning. We were partners with the staff dentists in the treatment and management of our patients. In the majority of cases we performed quadrant restorative dentistry. We saw our cases through, start to finish. We developed a professional relationship of trust and understanding with our patients, and our patients were pleased with the quality of the dental care and the competence and professionalism of the specially trained dental hygienists.

We enjoyed learning these new procedures and it was neither difficult nor intimidating. Learning how to remove tooth decay and prepare a tooth for a permanent restoration was not any more difficult than learning the techniques for scaling and rootplaning, or for the placement of a local antibiotic agent into a periodontal pocket. As you know, the dental hygiene curriculum is intense, and we had learned much more than we were able to use in the daily practice of dental hygiene. We were highly educated and underutilized. By learning additional techniques and skills of restorative dentistry, we were better utilized, and our work was more interesting. It felt good to be able to fully make use of our comprehensive education and it was exciting to learn new techniques and procedures to be able to treat more people who needed restorative dentistry. By our training in restorative dentistry, we were able not only to help prevent dental caries, but to actively treat it as well. We completed the curriculum in restorative dentistry in less time than was originally projected.

Teaching the ten registered dental hygienists new skills in restorative dentistry proved to be economically advantageous. In 1970, the cost of training a dentist was approximately \$50,000 (four years of undergraduate pre-dental education for a total of \$14,000, and four years of dental school for a total of \$36,000) The cost of teaching the dental hygienists new skills in restorative dentistry was approximately \$7,700 (two years of dental hygiene school for a total of \$4,500, and twenty five weeks of training in all phases of restorative dentistry for \$2,300) Not only could the dental hygienists be trained to perform all phases of restorative dentistry in two and one half years as opposed to eight years to train a dentist, but at a cost of approximately 14% the cost of educating a dentist! Training the dental hygienist in all phases of restorative dentistry in less time and at less expense translates into more care for more people at a lower cost!!

Three blind evaluations were conducted to assess the quality of the restorations performed by the advanced skills hygienists. It is important and interesting to note that in previous American studies, the work of expanded duties dental auxiliaries was compared

with that of senior dental students. In the Forsyth Rotunda Project the clinical goal was that the advanced skills hygienists should be able to perform cavity preparations and restorations at least as well as an experienced practicing dentist. In all of the blind evaluations, the work performed by the advanced skills hygienists was determined to be as good, and in some cases, superior, to that of experienced practicing dentists.

After the three blind evaluations indicated that the advanced skills hygienist performed all phases of restorative dentistry at least as well (and in some cases, superior to) experienced practicing dentists, we were ready to begin the third phase of the research in which the advanced skills hygienists would work under the direct supervision of a dentist in a private practice setting. In this third phase of the project, we would determine how many advanced skills hygienists could work under the direct supervision of a dentist, allowing the dentist to perform more advanced procedures while supervising the advanced skills hygienists. This was an important piece of the research, to see how we could provide more care to more people and at a lower cost.

In October, 1973, a group of dentists, never identified, convinced the Board of Dental Examiners to conduct a hearing to justify the Forsyth Rotunda project. At this hearing testimony favorable to the research project was presented by officers of the Massachusetts Dental Society as well as representatives of Forsyth. The only negative testimony challenging the project came from a spokesman from the protesting group of dentists. Initially the Board of Dental Examiners gave Forsyth informal assurances that all was well, but a short time later the Board reversed itself and the members voted unanimously that the drilling of teeth by hygienists was a direct violation of the Dental Practice Act of the Commonwealth of Massachusetts. The Board submitted an opinion and transcript of the testimony from the hearing to the Attorney General for the Commonwealth of Massachusetts for a ruling and action. Despite the fact that three blind evaluations indicated that the restorative dental procedures performed by the advanced skills hygienists were equal to that of practicing dentists, the assistant attorney general ruled that drilling of teeth is deemed in the Practice Act to be undertaking the practice of dentistry and the legislature had not exempted research from this provision.

With this ruling, Forsyth was faced with two choices—to fight the ruling in court and try to keep the research going through legal maneuvers, or to seek a compromise in which Forsyth would agree to suspend its study of expanded duties at the end of the intramural phase in June 1974, and not attempt any further clinical research until the Practice Act was amended. In return, the attorney general would allow the experiment to continue through June without taking any legal action. Forsyth chose this compromise.

It took three years, but in May, 1977, a new Dental Practice Act was passed which authorized the academic freedom to conduct research studies such as the Forsyth Rotunda Project. Of particular interest also is that the new practice act allowed for the inclusion of a licensed dental hygienist on the eight member board of dental examiners.

When the Board of Dental Examiners and the Attorney General terminated the Forsyth Rotunda Project we were frustrated and disappointed that we were not able to practice

these new skills in restorative dentistry and were limited to performing the conventional hygiene procedures as allowed by the dental practice act. We did not feel that this project had been a waste of our time, but rather a terrible waste of our talents and skills in restorative dentistry. It was sad that we were not able to provide restorative dentistry to so many people who needed care. Of the ten advanced skills hygienists, six went back to school for advanced degrees (two went to dental school), one became a research assistant at Forsyth, one returned to the private practice of dental hygiene, and two became instructors in dental hygiene at Forsyth and Fones Schools of Dental Hygiene.

Here we are in the year 2006. Everyday life has changed dramatically. We have gone from using rotary phones to cordless phones to cell phones that will take photos and videos. We have gone from 8 track tapes to cassette tapes to CDs .We have GPS systems in our cars and in our cell phones. We no longer have legible penmanship because we communicate on our computers via instant messenger and e mail. But dental decay remains the number one childhood disease in America and the number of dentists retiring grossly outnumbers the number of dentists graduating. Training the dental hygienist in restorative dentistry techniques and additional procedures is the answer to the problem of access to care. Forsyth recognized this in 1949 and again in 1972. We now have the opportunity to make the ADHP a reality, and bring dental care to so many who have no access to care. This time we will succeed. We are Forsyth graduates. We will make it happen.

IT IS TIME FOR ACTION.

The problem of inadequate access to dental care existed in 1949. The solution to this problem was to expand the scope of practice for the dental hygienist.. This same problem persisted in 1972. The solution to this problem was to expand the scope of practice for the dental hygienist. The same unrelenting problem faced us in 2006. The solution to this problem was to expand the scope of practice for the dental hygienist. It is now 2013, and we are still fighting the same problem of inadequate access to dental care. The solution to this remains to expand the scope of practice for the dental hygienist. We have faced this same problem for the past 64 years. We have the solution—expand the scope of practice for the dental hygienist. It is time for action. People have been waiting for 64 years for increased access to dental care. They must not wait any longer.

Christel Koppel Autuori RDH MA
P.O.Box 269
Ridgefield, CT 06877