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The collaborative practice of dental hygiene

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Dates:
Accepted 12 November 2003

To cite this article:
Int J Dent Hygiene **2**, 2004; 36–39
Reitz M, Jadeja R:
The collaborative practice of dental hygiene

Abstract: This paper discusses the collaborative practice of dental hygiene, primarily using examples from California and New Mexico. Several advantages are discussed, including an increased access to all populations and more respect for the field. The earliest roles of a dental hygienist reflect common components of a collaborative practice. Responsibilities of dental hygienists today as educators and preventive dental providers are also tied to this type of practice. Currently, few states in the USA allow such practices; however, benefits are discussed and the positive effects noted. Opposition to these practices exists, although the concerns have not been proven accurate. Collaborative dental hygiene practices are shown to be a positive avenue through which the population can gain access to noted provider shortages, as well as a rewarding option for the field of dental hygiene.

Key words: collaborative practice; unsupervised practice; dental hygienist

Introduction

The profession of dental hygiene has faced much opposition as a discipline since its origin in the early 1900s (1). The idea of allowing hygienists to work independently in order to further provide preventive services for the public has kindled much controversy. It has only recently been fully developed in some areas of the world, and examples in this paper are primarily from the states of California and New Mexico, within the USA. This concept of collaborative practice is the practice of dental hygiene working in a collaborative manner with a dentist. By definition, collaborative practice is the science of the prevention and treatment of oral disease through the provision of educational, assessment, preventive, clinical and the other therapeutic services in a collaborative working relationship with a consulting dentist but without general supervision. This term can be synonymously interchanged with both independent and unsupervised practices; and the term used

depends upon the legislative wording. It was developed to reach a greater number of the under-served population, and to provide a better forum to promote prevention in oral public health. The primary roles and responsibilities of a dental hygienist as a preventive health care provider and educator are directly tied to this type of practice as well.

The process of initiating a collaborative practice can be a costly and time-consuming endeavour. Most importantly is the effect these practices can have on the future of the profession, by paving the way for more change, respect and improvement of the nation's public health. Many articles and studies have shown the benefits of such practices; however, dentists in these studies continue to show opposition. The intent of this paper is to broaden awareness of what collaborative practice means to the public and to the profession of dental hygiene.

Significance of the issue

Collaborative practice is the key to enabling dental hygienists to provide oral public health and dental services to more of the population. One reason this topic has such significance is that indigent populations are believed to have a great need for facilities that accept all insurance, including Medicaid. Another reason is to reach more rural communities. These populations have little to no access to dental care, and independent hygiene practices can greatly relieve this deficit. In addition, collaborative practice is a worthwhile endeavour that has the capability to improve the profession and to broaden knowledge by allowing hygienists to utilise all of their skills.

Supporting evidence has shown that collaborative practice has had great magnitude and has been implemented internationally, and within the last 15 years here in the USA (2). Independent practices improve the professional status of hygienists by allowing them to work with greater independence than in the traditional setting in a private dental office. Dental hygienists are licensed professionals, and are capable of working in a collaborative setting with a consulting dentist. The population could be positively impacted by these offices. Documentation also shows that the population directly benefits from hygiene practices by allowing both privately insured and Medicaid insured patients to receive prevention-based care, thus improving the overall health of the whole community.

Opposition to collaborative practice comes primarily from dental organisations (3). One argument posed is that hygienists are not qualified to operate such a practice, and that dental hygiene is merely a field of study. Dentists also argue that hygienists who own their own practices are somewhat threatening because of the monetary impact of in-office dental cleanings, which make it profitable for dentists to employ hygienists (3). The related controversy creates a need for new studies regarding collaborative practice. In addition, studies must be performed to prove that independently practising hygienists do not infringe upon the income of dentists, but rather will enhance the lucrative business of dentistry by dental hygienists, referring patients for needed restorative work of patients. There is a noticeable lack of research that has been performed regarding the overall benefits of independent practices for dental hygienists, dentists, and most importantly, the public.

History of dental hygiene

To understand the evolution of the role of the dental hygienist and the collaborative practice movement requires a perspective on the history of dental hygiene.

While the title 'Dental Hygienist' was not officially termed until 1913, the roots of dental hygiene trace back through the early 1800s (1). Nevertheless, it was the efforts of Dr Alfred C. Fones who brought the dental position to the forefront of the medical practice and holds the title of the Founder of Dental Hygiene (1). His efforts emphasised the necessity of preventative oral health care and the role of the dental hygienist in educating, assessment and treatment. Fones perceived the position to be distinctly unique: one that did not need to be confined to the walls of traditional private practice. He believed that hygienists could provide education, dental treatment and preventive care to individuals outside of the private practice setting, such as in public schools. In particular, he stressed the potential opportunity to use hygienists as dental 'outreach workers' who could actually bring patients into the private practice if necessary. It is important to note that Fones actually taught the first dental hygienist, Irene Newman, and founded the first dental hygiene programme, the Fones School of Dental Hygiene.

As Fones continued his efforts to establish the dental hygiene profession, animosity and opposition from state dental organisations and dentists towards the movement became more prevalent across all of the USA. The fear was tied to the belief that dental hygienists would detrimentally affect or even destroy the dentistry profession (3). This, of course, was tied to the fear that the practice of this profession would ultimately reduce control and future earnings of dentists. As a result, many laws were developed to prevent the hygienist from practising outside of the dental office or outside of the supervision of a dentist. It is important to highlight the opposition amongst dentists as many of the fears prevalent during this period of history can be associated with concerns regarding the development of collaborative/unsupervised practices today.

The role and responsibilities of the dental hygienist

The role and responsibilities of the dental hygienist has evolved over the years. While the original emphasis of the dental hygienist was tied to preventative care and education, today, there is much more that a dental hygienist must be trained and capable of completing. Today, dental hygienists' responsibilities in terms of procedures within the process of care include (4):

- Conduct preliminary dental examination, including extra/intraoral structures of the head and neck.
- Examines gum tissues, including measurement of periodontal pockets, recession and other signs of gum disease
- Obtains health history and measures vital signs.
- Charts conditions of decay and disease for diagnosis and treatment by dentist.
- Exposes, develops and interprets dental X-rays.
- Consults with dentist regarding patient history and treatment.
- Formulates a dental hygiene treatment plan.
- Performs dental prophylaxis, which involves scaling and root planing.
- Applies carries-preventive agents such as fluorides and pit and fissure sealants.
- Helps patients develop and maintain good oral health by educating them about plaque control, diet, tobacco use cessation and other habits affecting oral health.
- Applies desensitising agents and topical anaesthesia, and local anaesthesia.
- Takes impressions for study models, custom fluoride trays or athletic mouthguards.
- Places and removes periodontal dressings. Removes sutures.
- Maintains up-to-date records on patients.

The type of clinical services provided by hygienists typically can be broken down into preventive, educational and therapeutic (5). Preventive services refer to the methods/actions employed by the clinician and or patient to promote and maintain oral health care. Educational services are those methods used to generate awareness and practice of oral health care requirements. Finally, therapeutic refers to all of the clinical treatments designed to address and control disease and maintain oral tissues in health. The latter includes scaling and root planing, as well as placing of sealants. The increasing emphasis on the skills of the dental hygienist has placed a greater emphasis on the education system to ensure that students of this profession are receiving adequate levels of training (4). As a result, dental hygiene graduates are more capable of carrying out their roles as clinicians, educators and promoters or oral health. This plays an important part in the discussion of the collaborative practice as we will see later.

Responsibilities to the public

The dental hygienist has many responsibilities to the public. The goal of the dental hygienist, in general, should be 'maintenance of oral health and the prevention of oral diseases' (5).

Dental hygienists are ethically and morally obligated to provide oral health care to all individuals and groups without discrimination. In addition to obligations to professional peers and dentists, hygienists must commit to the highest level of standards in health care provision. These include (1):

- recognising and upholding all laws and regulations;
- consistently undergoing reviews to ensure health care standards are being met and to adjust/improve any subpar standards;
- respect the confidentiality and privacy of data and patient care; and
- be knowledgeable concerning currently accepted preventative and therapeutic methods, products, technology, and their application within the practice.

These are only a few of the many responsibilities that hygienists must uphold within their profession. And it is this commitment to such high standards of responsibility that has allowed the dental hygiene profession to develop respect, trust and autonomy within the dental profession.

The establishment of the unsupervised practice

In the USA, the majority of dental hygienists work in private practices today (6). These practices provide care for approximately 50% of the population. The need for dental hygiene services within society, however, is much more prevalent across all demographics and socioeconomic groups. As a result, a movement to establish dental hygiene practices that do not require the supervision of dentists has gained momentum. The collaborative practice of dental hygiene is defined as 'the science of prevention and treatment of oral disease through the provision of educational, assessment, preventive, clinical and other therapeutic services in a collaborative working relationship with a consulting dentist, but without general supervision' (5).

As the responsibilities of the dental hygienists have grown in comprehensiveness, their ability to deliver patient care through this collaborative manner has strengthened. The establishment of the collaborative practice, in essence, means that dental hygienists may work in a variety of settings, including nursing homes, schools or even private dental hygiene practices without a dentist present. In providing hygienists with greater 'freedom', the population that does not seek or desire regular dental care can be targeted more effectively.

The establishment of such autonomy gained publicity in California and in New Mexico. In New Mexico, for example, a

study of human resources highlighted a shortage of dentists as a probable link to the numerous problems with the delivery of dental care in the state (7). While other potential solutions were considered, allowing the unsupervised practice of dental hygienists quickly became a viable solution.

Unfortunately, such practices are not allowed in all states as will be described later.

Benefits and opposition

The benefits of working in a collaborative setting have been documented. One of the most important being the increased access to care. Many dental organisations have argued that there are shortages of dental hygienists, and therefore, more hygiene institutions are needed to increase the workforce (3, 8). In New Mexico, it was determined that there was actually an existing shortage of dentists (currently, 1 dentist to every 2636 people) (9), and it was then decided that dental hygienists could help in increasing dental care, unsupervised practice being the solution. By initiating unsupervised practice in New Mexico, the access to care should continue to increase, thus providing the various populations that previously had little to no access to dental care (10).

Another benefit is the ability of such practices to contain fees. One study found that independent practices observed charged lower fees than the dentists would charge for similar services (11). This is directly tied to the issue of access to care and delivery. While these practices allow hygienists to practice in more settings in more places, they also allow hygienists to serve a more indigent population, often suffering from preventable dental disease, and could not previously afford dental care (12–15).

Collaborative practices are also an excellent avenue through which patients can be referred to various dentists. It has been found that these hygiene practices can have an influence on the demand for services of dentists, similar to the influence general dentists have on demand for services of speciality dentists. A minimum of one-third of patients in the studied practices were referred to collaborating dentists, thus helping to direct the flow of patients. Dental associations have opposed this issue directly, suggesting that dental hygienists may take a share of a shrinking dental market. Studies performed on this issue however have proven that this is not the case (11, 14).

Another opposing issue is the level of training. It has been argued that dental hygienists do not have the sufficient training to be practising on their own and that dental hygiene is merely a field of study (16–18). However, the scope of education has been documented as more than comparable to the training that dental students receive in periodontics (hygiene schools provide about 540 h versus 138 h in dental schools) (19). As the profession grows, the idea of dental hygiene being a discipline may become more widely accepted (16–18).

Conclusion

In conclusion, the collaborative/unsupervised practice of dental hygiene in the USA has many benefits. These include increased access to care for all populations, increased preventive measures in various settings, an increase in acceptance of government insurance programmes, lower costs, increased referrals to dental offices, autonomy for the hygienist and an increase in respect and establishment for the profession. If other states continue to see this as an option, and work towards this goal of working in a collaborative manner, the rewards will be great for both the population and the profession.

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