Dr. Cindi Sherwood, DDS, Independence
House Committee on Health and Human Services (HB 2079)

My name is Cindi Sherwood and I am speaking in opposition to House Bill 2079. My background is that I was trained as a registered dental hygienist and a general dentist and currently serve as President of the Kansas Dental Association.

The two points that I would like to make today are – first, that there is a huge difference between the education of a dental hygienist and that of a dentist, and second, that the list of allowed procedures in the bill is extremely broad and contains very difficult tasks.

I want to tell you about my experience having had both educations – that of a dental hygienist and a dentist. First, let me say that there is no comparison between the two curriculums. The breadth and depth of the dental curriculum is much more rigorous than the dental hygiene courses. While the titles of the classes are similar – for example, periodontics (the treatment of gum disease) or pharmacology- the basic assumptions are completely different. The dental hygiene classes are based on the concept that the dental hygienist will work as a member of the dental team under the supervision of the dentist. The Commission on Dental Accreditation, which is the recognized group by the United States Department of Education that accredits dental education programs, says, “The dental hygiene process of care is recognized as part of the overall treatment plan developed by THE DENTIST for complete dental care”. This again verifies that the underlying premise of dental hygiene education is that they will be supervised by a dentist.

The dental hygiene curriculum does not teach diagnosis. The diagnosis of dental disease requires knowledge of the underlying science that is not taught to dental hygienists. This includes post graduate classes in cell biology, human anatomy, physiology, histology, biochemistry, microbiology, pathology, pharmacology, oral diagnosis and oral medicine. Dentists must manage patients with complex health situations that take numerous medications. A seemingly simple procedure can

become problematic if there is not understanding of a patient's health history of medications. There could be complications including bleeding, infection, cross reactions of medications with local anesthetic, pain and anxiety control problems.

The prerequisites for dental school are also more advanced than those for dental hygiene school. In order to be accepted into dental school, most students have a bachelor's degree in either chemistry or biology. In Kansas, we have dental hygiene programs that accept students immediately out of high school and therefore can become licensed as a registered dental hygienist with two years of college. With a Bachelor's degree in dental hygiene, I had to take two more successive years of chemistry and physics classes to even apply to go to dental school. They did not accept the General Chemistry (Chem1) class that I took to be accepted into dental hygiene school. I had to take another Chem 1 class that was more complex.

I studied the current curriculum at UMKC for both the doctoral and dental hygiene program to evaluate current information. The classes which teach dental students to diagnose, restore teeth, extract teeth, make orthodontic appliances and crowns – all procedures which the proposed dental practitioner could do – take place all four years of dental school. During the first two years of dental school students take numerous didactic courses and hands on laboratory training to allow them to have the background and practice to work on patients. The last two years of dental school involve mostly direct patient care with close supervision by dental school faculty. A graduating dentist has approximately 360 college hours with 125 hours receiving a Bachelor's degree and another 235 hours as a dental student. The proposed Registered Dental Practitioner would have approximately 170 college hours if they have a Bachelor's degree and another 18 months (45 hours) of education. So the RDP would have less than half the education of a general dentist, yet the list of procedures that the RDP would be allowed to do compose at least 80% of what I do as a general dentist.

My point is that you cannot teach someone oral surgery, restoration of teeth including crowns and implants, pulpotomies, how to treat TMJ, reimplant and stabilize knocked out teeth, numb patients and sedate them with nitrous oxide,

diagnose oral disease and formulate treatment plans, make orthodontic appliances, place crowns – basically do everything a general dentist does except root canals – with 18 months of education on top of a SUPERFICIAL understanding of dentistry which is what you get with an Associates or Bachelor's degree in dental hygiene.

I have one other point that I wanted to briefly discuss. On page 3 of the bill, there is a list of 29 tasks that the RDP can perform. While some of the procedures listed are vague and difficult to know exactly what is meant, I believe that 10 of the listed tasks are currently allowed for dental hygienists (some only allowed by the Extended Care Permit Dental Hygienist that the KDA proposed). I thought it might be helpful to explain what is involved in some of the remaining procedures.

9. tooth reimplantation and stabilization – This refers to when someone gets a permanent tooth knocked out and we try to reimplant the tooth to save it. This is a very complex process that requires a lot of decision making – sometimes the tooth needs a root canal before it is reimplanted, the socket the tooth came out of could be broken, it may need to be stabilized with braces, etc… I have not had to do this procedure very many times in my 30 years of dental practice. I recently had to go through this process with a very scared 11 year old boy who ran into a pole. It was very difficult and took months of follow up treatment. NOT SIMPLE.

10. local anesthetic – That refers to the numbing medications that we use. There are many possible complications with anesthetics – heart attack, reactions with other drugs the patient is taking, some ingredients in certain anesthetics should not be used in medically frail patients, especially the elderly. The most concerning complication would be an overdose, which is possible, especially in children, and they could die. That is why we recommend that when anesthetic is used it either be in the presence of a dentist or in another health care setting such as a nursing home or health clinic where medical attention is available.

11. Nitrous oxide (laughing gas) - This is a potent drug that can be used to put people completely under. It causes respiratory depression and in combination with local anesthetics or other drugs such as tranquilizers, could result in a medical emergency.

12 and 13.Diagnosis of oral disease and the formulation of an individualized treatment plan – As we discussed, diagnosis is the most difficult part of a dentist's job. It takes all the background science and extensive dental classes to establish the exact problem, what caused it, how can we fix it so it doesn't come back again. If a dental practitioner has minimal education in the options available – dental implants, root canals, crown and bridgework, removable partial dentures, temporomandibular joint issues, etc…., how can they put them in a treatment plan?

14 and 15. Extraction of primary teeth and of loose permanent teeth – Dr. Fales will tell you about how difficult it can be to remove children's teeth. There is an old saying in dentistry, "An extraction is never simple until the tooth is laying on the table". I just experienced a very difficult extraction that I thought would be simple last Thursday. A fractured root often cannot be seen on an x-ray. We often have to cut a tooth into pieces with a drill and remove them a small piece at a time due to a person with brittle teeth, or a dense jaw bone or a root that has a small hook on the end of the root that didn't appear to be there on an x-ray. Once you start taking a tooth out, you cannot stop. The long distance oversight that the bill suggests would certainly not work in this situation.

17. Space maintainers – These dental appliances are cemented into a child's mouth usually because they have had to have baby teeth removed early. They can be simple and they can be complex depending on the position of the erupting permanent teeth. An orthodontic complication can occur if they are not placed correctly and removed at the appropriate time.

18. Cavity preparation – Drilling on teeth which is irreversible.

19. Restoration of primary and permanent teeth – By definition to restore means to return to form and function. So it appears that this could mean almost anything that a dentist does. Restoring can be placing filling materials, crowns and doing root canals. Restoring a missing tooth can involve bridges, implants, removable partial dentures and full dentures. This statement literally can mean anything a dentist does.

22. Pulpotomies on primary teeth – A pulpotomy is a root canal on a baby tooth (or the first step of a root canal on a permanent tooth). Again, not a simple procedure, especially on a child.

23. Pulp capping – The need for this procedure can occur when decay is removed from the tooth and we are very close or have even exposed the pulp, or the nerve of the tooth. There is a lot of judgement required at this stage. We ask ourselves, "Is the nerve so exposed that they need a root canal? Was it a pinpoint exposure and is the surrounding dentin hard? Which material should I use for this case? Again, a seemingly simple procedure that requires much background information to make the correct decision.

25. Brush biopsies – This is a relatively simple procedure with complex variables. Does the dental practitioner have the training to counsel the patient on their options concerning oral cancer? If the biopsy comes back inconclusive, what is the next step? Can they evaluate all the patient's risk factors to help them avoid oral cancer?

27. Recementing of permanent crowns – Again, sometimes a simple procedure, sometimes not. There can be decay present that needs to be removed and a judgement made if the crown can be recemented. Frequently if the crown has been off for a while, the teeth shift and extensive drilling of the crown or the adjacent teeth can be required. If the crown is recemented and it doesn't go down all the way, it could need to be removed again (frequently difficult) or have to be adjusted in the patient's mouth.

28. Identifying and referring patients for orthodontic problems – Orthodontic issues are extremely complex and varied. Some kids need referral for speech and breathing issues related to the position of their teeth. This is not something that can be taught in a short class.

I want to make clear that this list of procedures is totally unacceptable based on the amount of education that is suggested for a registered dental practitioner. I am hoping that I helped you understand some of the reasons that we are concerned about a poorly trained person performing these procedures.

Thank you for your attention. This solution to barriers to dental care in Kansas is no solution at all. A dental hygienist is not a dentist in training. There is clear safety concerns based on lack of adequate education for the proposed scope of practice of the dental practitioner. The underserved do not deserve poor quality dental treatment – or a two tiered system of care – we must find answers that protect the public and help them receive safe, quality dental care.