ADVICE TO THE MINISTER OF HEALTH

DENTAL HYGIENE REFERRAL

May 1996
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FORWARD

This report was first submitted to the Minister of Health in September 1995. On April 23, 1996 the Minister wrote to HPRAC requesting further clarification of our conclusions and recommendations. The report was revised in order to expand on the rationale for our recommendations. This revised report was submitted to the Minister on May 17, 1996, as requested by the Minister.
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SUMMARY

BACKGROUND

On September 29, 1994 the Minister of Health asked the Health Professions Regulatory Advisory Council (HPRAC) to provide advice on the issue of whether dental hygienists need an order from a dentist to perform the authorized acts of scaling teeth and root planing including curetting of surrounding tissue, or whether dental hygienists should be allowed the option of initiating these procedures without an order, subject to appropriate conditions in regulations as proposed by the College of Dental Hygienists of Ontario (CDHO).

HPRAC conducted a public review with eighteen participants submitting positions and information on the issues related to the referral.

CONCLUSIONS AND RECOMMENDATIONS

The conclusions drawn in this report are summarized in Section 5, on page 25 followed by HPRAC’s recommendations in Section 6, on page 28.
1. INTRODUCTION

1.1 THE REFERRAL

On September 29, 1994 the former Minister of Health, Ruth Grier, asked the Health Professions Regulatory Advisory Council (HPRAC) to provide advice on the issue of whether dental hygienists need an order from a dentist to perform the authorized acts of scaling teeth and root planing including curetting of surrounding tissue, or whether dental hygienists should be allowed the option of initiating these procedures without an order, subject to appropriate conditions in regulations as proposed by the College of Dental Hygienists of Ontario (CDHO).

The Minister asked a series of specific questions related to the general question of whether it is in the public interest to allow self-initiation by dental hygienists. See Appendix A for a copy of the Minister’s referral letter.

In order to facilitate the public review of the referral, HPRAC developed the following two fundamental questions implicit in those posed in the Ministry of Health’s referral:

1. Is it in the public interest to amend the Dental Hygiene Act to allow dental hygienists to initiate their authorized acts of scaling and root planing including curetting of surrounding tissue, subject to appropriate regulations, as proposed by the College of Dental Hygienists?

2. (a) If it is recommended that dental hygienists be allowed to self-initiate the authorized acts of scaling, root planing including curetting of surrounding tissue, but understanding it may not be possible to amend the Act, given the “government’s priorities during its final year of [its] mandate” what other measures may be taken to allow dental hygienists to self-initiate?

(b) If it is not recommended that dental hygienists be allowed to self-initiate the authorized acts of scaling and root planing including curetting of surrounding tissue, what needs to be done, if anything, in the absence of a “protocol,” to ensure that dentists and dental hygienists are acting appropriately within their own scope of practice?

1.2 CDHO PROPOSALS

Section 4 of the Dental Hygiene Act provides that dental hygienists have the following authorized acts:

1. Scaling teeth and root planing, including curetting surrounding tissue
2. Orthodontic and restorative procedures.

The Act further stipulates in section 5(1) that these authorized acts shall not be performed unless ordered by a member of the Royal College of Dental Surgeons of Ontario (RCDSO). Contravention of this requirement constitutes an act of professional misconduct as stipulated in section 5(2).

The College of Dental Hygienists of Ontario are proposing an amendment to the Dental Hygiene Act which would replace section 5(1) requiring an order from a
dentist in order to perform the authorized acts contained in section 4(1). The proposed amendment is:

5(1) a member shall not perform a procedure under the authority of section 4.1 unless:

a) the performance of the procedure by the member is permitted by the regulations and the member performs the procedure in accordance with the regulations; or

b) the procedure is ordered by a person who is authorized by the Dentistry Act, 1991.

(2) A member shall not perform a procedure under the authority of section 4.2 unless the procedure is ordered by a person who is authorized by the Dentistry Act, 1991.

CDHO is proposing to allow the option of self-initiation for scaling and root planing, including curettage surrounding tissue.

The CDHO is also proposing to specify, through regulations and standards of practice, the circumstances in which an order by a dentist would continue to be required and where self-initiation would be allowed. In general, the proposed regulation would permit self-initiation of scaling, root planing, and curettage surrounding tissue only when all of a number of specified conditions have been met. These conditions include that there are no contra-indications to the performance of the procedure and that the member has the knowledge, skill and judgment to perform the procedure safely, effectively, ethically and in accordance with the standards of practice.

The proposed draft standard of practice includes a list of conditions when a member shall not self-initiate scaling, root planing or incidental curettage as well as a prohibition against proceeding if the client has a medical condition or is taking a drug with which the member is unfamiliar. CDHO states in the Note appended to the proposed standard that these headings will be expanded upon along with examples of the various conditions noted.

The proposed regulation and outline of draft standards of practice as proposed by CDHO are found in Appendix B.
2. HPRAC REVIEW PROCESS

During the fall of 1993, the issue of whether dental hygienists need an "order" from a dentist to initiate the controlled acts of scaling teeth and root planing including curetting of surrounding tissue became one of concern to the professions involved and to the Ministry of Health.

By the new year, the former Minister had decided to proceed with an amendment to the Dental Hygiene Act to address the order issue. On April 28, 1994 the Professional Relations Branch (PRB) of the Ministry of Health invited public consultation on the proposal put forward by CDHO to amend the Dental Hygiene Act, 1991. As part of the process, PRB held a consultation session with representatives from groups directly affected by the proposed amendment and requested written submissions. An opportunity for oral presentations was also provided. It was at this point that the issue was referred by the Minister to HPRAC.

The oral and written submissions produced through the PRB process by a range of organizations were taken as the starting point by HPRAC in conducting its review. This allowed HPRAC to focus on what information was still required in order to develop a recommendation for the Minister.

After a thorough examination of the material already on the record, HPRAC requested public participation in the review in November, 1994. On January 4, 1995 HPRAC addressed specific questions to the participants in the review flowing from the two fundamental questions outlined above. Certain questions were designated to particular participants (Appendix C). In this request for information, HPRAC enunciated the principles upon which we would develop a recommendation. These principles are expanded upon in section 3.2 under the heading of Public Interest Principles and Self-Initiation by Dental Hygienists.

The dental profession organizations were asked to consolidate their responses wherever possible. The dental hygienist profession organizations were also asked to consolidate their responses.

HPRAC met individually with the College of Dental Hygienists and with the Royal College of Dental Surgeons and asked both groups to provide a joint response to those specific issues on which both organizations agreed that a joint response was possible.

Eighteen individuals/groups provided written submissions (excerpts of responses to each HPRAC question are provided in Appendix E), with some consolidated responses to specific questions from the four dental hygiene organizations who were participating in the review. All participants received a copy of each of the participants' written submissions and were afforded an opportunity for further comment to HPRAC on these submissions. Participants in the review process are listed in Appendix F.

Given the breadth of information provided by participants and their responsiveness to the issues raised, a further round of submissions or presentations was not necessary. Further information was sought, however, of specific participants with regard to education and standing orders.
3. THE PUBLIC INTEREST

3.1 THE ROLE OF HPRAC

In interpreting its role and responsibilities, HPRAC understands that its duties as outlined in Section 3 of the Regulated Health Professions Act, 1991 (RHPA), are carried out to assist the Minister of Health in ensuring regulation and coordination of the health professions in the public interest (RHPA, Section 3). HPRAC believes that the public interest is promoted by adherence to the principles which underlie the RHPA. These principles provide the foundation for HPRAC in all of its work:

- protection from harm
- accessibility
- quality of care
- equity
- accountability
- equality

3.2 PUBLIC INTEREST PRINCIPLES AND SELF-INITIATION BY DENTAL HYGIENISTS

This referral has been considered against those public interest principles that are raised by and relevant to the issue of self-initiation by dental hygienists of the acts in question. This section represents the starting point for HPRAC’s review and focuses on how the issues had emerged through the PRB consultation in the context of specific public interest principles. The Identification and Analysis of Issues section then discusses and analyses the issues and answers that emerged as a result of HPRAC’s public review.

3.2.1 Public Protection from Harm

One important rationale for regulation of health care professions is the potential risk of harm. It is impossible to completely eliminate the risk of harm and therefore, in the context of the RHPA, harm is necessarily a matter of degree. The goal of RHPA and of the health professions should be to minimize and reduce risk of that harm to the public.

Quality of care and accountability are mechanisms for preventing or mitigating against harm and therefore are subsumed under the principle of protection from harm in the context of this referral.

The RHPA embodies the protection from harm principle through a number of key provisions and mechanisms. The harm clause (section 30), the scope of practice statements for each profession, the controlled acts, the authorized acts, and regulations made under the RHPA provide a College with the authority to govern and hold its members accountable, provide members of the profession with the guidance they need to practice safely and provide the public with assurance that they are protected from harm. Quality of care is established through the formulation and enforcement of regulations and through standards of practice with an aim of minimizing the risk of harm to the public.

HPRAC’s understanding of the premises behind the concept of controlled acts includes:

- that these activities are only authorized to those professions with the necessary knowledge/ skill/ judgment to perform them
- that controlled acts may be performed by more than one profession
that some controlled acts may be performed by health professions only when they have been prescribed or "ordered" by other health professions. Controlled acts by definition present risk of harm regardless of who performs them.

Harm can occur, for example, when a practitioner does not have the technical knowledge and skill to carry out the procedures competently and safely and/or to determine if and when the procedure should be performed.

Submissions received during the Ministry of Health consultation process referred to the harm that can result from improper scaling and root planing, including curetting of surrounding tissue, and to the harm that can result if these procedures are performed when they should not be. There appears to be a consensus that dental hygienists are adequately trained to perform these procedures. The debate generated by this referral centers on whether there are any circumstances where the hygienists’ education or training would allow them to self-initiate these procedures without an order from a dentist, or whether dental hygienists do not have the training to self-initiate these procedures under any circumstances.

HPRAC asked specific questions in the public review to better understand and evaluate the potential degree of harm to the public associated with the authorized acts of scaling, root planing and curetting of surrounding tissue and how this relates to the issue of self-initiation by dental hygienists. In this regard, a number of questions addressed the education and training of dental hygienists, how oral health status is determined and standards of practice.

In general, HPRAC was seeking answers to:

- What is the degree of harm associated with scaling and root planing, including curetting surrounding tissue?
- Is there an increased risk of harm in allowing dental hygienists to self-initiate scaling and root planing, including curetting surrounding tissue?
- What steps is the profession proposing to take to address the potential for harm in self-initiating these acts and are these sufficient?

3.2.2 Access

The public interest principle of access can be understood as the removal of access barriers to safe health care. The access principle is manifested under the RHPA in a number of different ways. The RHPA makes it very clear that access to health services is of prime importance and section 3 of the Act imposes a duty on the Minister of Health to further this goal.

HPRAC believes considerations such as financial means, geography, language, and physical barriers should not preclude access to safe, affordable health care services. The public interest is best protected by the promotion of access to safe, affordable health care.

HPRAC noted in the introduction to access questions in our January 4 letter, that access issues were raised by several participants in the Ministry’s consultation process. HPRAC went on to state that there was agreement among a number of participants in the PRB consultation that there are some Ontarians who, for
reasons of low income and lack of dental insurance coverage, avoid seeking out any form of dental care. There were contested propositions that the availability of dental hygienists in geographically more remote Northern Ontario would permit citizens in these regions to obtain services more easily. There were also contested propositions that dental hygienists working in non-dental office settings will make the services more affordable, ultimately benefiting all Ontarians and making the services more accessible to lower income citizens. There were also contested positions by participants in the PRB consultation that fragmentation of services leads to additional costs and duplication of service, thus reducing access in other ways.

A central access issue that emerged as well was whether the order requirement from a dentist constitutes an undue restriction on direct access to dental hygienists by the public.

HPRAC posed a number of questions designed to evaluate these access issues.

3.2.3 Equality

While there are many equality issues that may arise in the course of a referral, two potential equality issues were identified in the course of the PRB consultation.

One involves whether the professional relations between the historically largely male profession of dentistry and the largely female profession of dental hygiene has led to an inequality between the two professions based on gender. It was alleged that this gender inequality is manifested by the unwarranted restriction of an order requirement with respect to scaling and root planing by a dental hygienist.

The other equality issue relates to the degree of support from the membership of CDHO for self-initiation. Arguments were put forward that many hygienists want to continue with the order requirement and that this raises issues of equality within the profession.

Given our understanding of both these issues, the Council did not seek additional information or elaboration on either in its public review but did clearly state our understanding so that participants could respond if they wished. Both these issues are discussed further in the Identification and Analysis of Issues section.
4. IDENTIFICATION AND ANALYSIS OF ISSUES

Upon reviewing the submissions by participants, a number of key issues emerged relating to self-initiation of scaling and root planing, including curetting of surrounding tissue, by dental hygienists. The following are HPRAC’s analysis and conclusions with respect to each of these issues.

4.1 RELATED BUT NON-ESSENTIAL ISSUES

This first sub-section deals with issues that, while important, were not, in the final analysis, pivotal in developing HPRAC’s recommendations to the Minister on this referral. In large part, these issues involved conflicting positions by various participants that could not be definitively resolved.

4.1.1 Gender Equality

The issue of gender equality raised by some participants relates to the concern that a traditionally male-dominated profession, dentistry, controls the authorized acts of a traditionally female-dominated profession, dental hygiene. Some participants felt that gender equality is a “red herring” with respect to this referral, while others felt that gender has played a role in restricting the ability of hygienists to do what they are capable and trained to do.

HPRAC’S UNDERSTANDING

After reviewing the submissions, HPRAC retains the views expressed on this issue in our letter to participants of January 4, 1995. We stated the following:

*Issues relating to gender and gender equality are of serious concern to HPRAC. Gender can and does affect what appear to be neutral practices, such as perceptions of what a female dominated profession is capable of doing. Practitioners should have the opportunity to practice their profession, without impediment, to the full extent that their training and skill permits. Gender bias must not restrict the scope of practice or self-initiation of controlled acts of any profession. The right to self-initiate must be based solely on the skill, competence and training of a profession.*

HPRAC found it difficult to determine the degree to which gender has affected the ability of dental hygienists to do what they are capable of doing, other than noting the traditional gender composition of both professions. The focus of HPRAC’s analysis, then, has been on determining what it is dental hygienists are capable of doing, that is, on the skill, competence and training of dental hygienists to self-initiate scaling and root planing including curettage of surrounding tissue.

4.1.2 Support from Dental Hygienists

Concern was expressed in some submissions that not all members of the CDHO support the proposed amendment to the *Dental Hygiene Act*. It was the position of these submitters that allowing self-initiation when a significant number of hygienists did not support the change would be unwarranted.
HPRAC’S UNDERSTANDING

Again, after considering the submissions by participants, HPRAC holds the same view as expressed in our January 4 letter to participants. Specifically, the proposed amendment would not force or require any dental hygienist to change from the current relationship between dentists and dental hygienists where an order determines whether a dental hygienist would undertake scaling and root planing, including curetting surrounding tissue. Given this ability on an individual level to maintain the status quo, the level of support for the proposed self-initiation would not be a relevant factor.

It is essential in order to maintain high quality dental care in Ontario that dental hygienists and dentists work together collaboratively, maximizing the expertise and services of each. HPRAC encourages the professions to work together to implement any forthcoming changes. HPRAC encourages the Minister of Health to facilitate this cooperative process as much as possible.

4.1.3 Access

As noted in the public interest principles section, there are conflicting views as to whether self-initiation by dental hygienists of scaling and root planing including curetting surrounding tissue would affect access by the public to oral health services.

The submissions provided a range of useful information as noted in the excerpts of responses to access questions in Appendix E. It is clear, for example, that the vast bulk of dental hygienists work in private practice settings with dentists. It is impossible to assess, at this stage, what affect adoption of the proposed amendment would have on practice settings. While it is clear that dental hygienists get paid less than dentists at present, it is open to speculation what effect self-initiation by dental hygienists would have on dental care costs to the public. As the ODHA noted in their submission, “statistical data is lacking which would support the premise that dental hygienists can provide cost-effective care.” (p. 23) It is evident that, as Royal College of Dental Surgeons (RCDSO) points out, the ratio of dentists to hygienists in heavily populated areas is 2:1 and in more remote areas is closer to 1:1. (p. 43) It is not known how the proposed amendment would affect geographic distribution.

HPRAC’S UNDERSTANDING

These access issues are complex and important and continue to be a source of conflicting positions and opinions. It is impossible at this stage to assess the full cost and access implications of allowing dental hygienists to self-initiate scaling and root planing, including curetting surrounding tissue. The discussion is important and will be ongoing.

However, in the absence of the full picture with respect to access and cost, it is still possible to assess the narrower question of whether the order requirement unduly restricts access by the public to dental hygienists. At present, if a member of the public wishes to see a dental hygienist for such services as having his or her teeth cleaned, including scaling and root planing, the patient must do so through a dentist. If the proposal for limited self-initiation by dental hygienists is adopted, a patient/client might have direct access to a dental hygienist for such services as cleaning of teeth. One can address this access
issue by looking at the risk of harm to the public of self-initiation by dental hygienists of scaling and root planing. Restrictions on access to any health profession should be commensurate with risk.

4.2 DEFINITIONS OF THE AUTHORIZED ACTS

In order to answer the referral questions, it is necessary to understand what the authorized acts in question mean. Many submissions by participants were helpful in defining the acts of scaling, root planing and curettage and in determining the degree of difference in meaning of these terms.

Section 27(2) of the RHPA specifies the following as a controlled act:

2. Performing a procedure on the tissue below the dermis, below the surface of a mucous membrane, in or below the surface of the cornea, or in or below the surfaces of the teeth, including the scaling of teeth.

As noted earlier, the Dental Hygiene Act authorizes a subset of the controlled act to dental hygienists, specifically of scaling and root planing, including curetting surrounding tissue, under the order of a dentist.

i) Scaling

In their joint brief, the four dental hygienist organizations defined scaling as the removal of hardened deposits and resistant stains from the tooth surfaces (the crown and root) in order to remove the major cause of tooth decay and gum disease (inflammatory gingival and periodontal disease) (p. A-1).

RCDSO defined scaling in their submission as removal of deposits, accretions and stains by scaling with hand, ultrasonic, or other devices from all surfaces of the tooth. (p. 2)

The ODA pointed out that scaling refers to the use of specially designed instruments to remove calculus, an abnormal concentration of mineralized dental plaque on the surfaces of the teeth. (p. 5)

ii) Root Planing

Dental hygienists in their joint submission define root planing as removing hardened deposits, diseased or toxic substances from root surfaces in order to remove the major cause of tooth decay and gum disease (p. A-1).

RCDSO defined root planing as the removal of superficial cementum of the root which has been altered following pocket formation and which is usually colonized by bacteria and their by-products. (p. 2)

The Ontario Dental Association (ODA) noted that root planing is an instrumentation technique to remove plaque, calcified deposits and softened or roughened cementum from the root surface. (p. 5)

iii) Curettage

The joint dental hygiene submission noted that the purpose of curetting of surrounding tissue is to remove remnants of diseased or dead soft tissue next to the affected root surface. The submission went on to state: “Purely as a
matter of standards of practice, rather than a result of any legal limitation, the current view of CDHO is that dental hygienists perform curettage as an incidental, but important part of scaling and root planing.” (p. A-1)

The RCDSO submission referred to “Gingival Curettage” which is defined as the removal of granulation and degenerated tissue from the gingival wall of the periodontal pocket. (p. 2)

The ODA noted that inadvertent wounding of the soft tissue may be referred to as curettage, but “this form of curetting of surrounding tissue is only incidental to the controlled act of scaling and root planing and should be differentiated from intentional surgical curettage.” (p. 6)

The Ontario Society of Periodontists (OSP) noted that surgical curettage requires diagnosis, local anesthetic and post-operative instructions, all of which they feel are clearly outside the capacity of dental hygienists to self-initiate (p. 3).

The dispute in the submissions concerning curettage, therefore, centers around whether allowing self-initiation as proposed would permit dental hygienists to independently decide to perform surgical removal of tissue as a specific treatment, or whether the proposal relates exclusively to unavoidable or accidental removal of surrounding soft tissue when doing root planing or scaling, or both.

**HPRAC’S UNDERSTANDING**

HPRAC accepts the view that scaling and root planing inevitably involve some cutting of tissue and that, therefore, in order to allow dental hygienists to perform the procedures of scaling and root planing, it is necessary to allow them to do incidental curettage.

It is important, then, to ensure that the authorizing legislation only allows dental hygienists to perform curettage when it is incidental to the acts of scaling and root planing.

**CONCLUSIONS**

HPRAC has concluded the following:

The authorized act under 4(1) of scaling and root planing, including curetting surrounding tissue authorizes dental hygienists to perform **only** incidental curettage. Dental hygienists are not authorized to perform curettage as an act separate or independent from scaling or root planing. The use of the word “including” in s.4(1) restricts dental hygienists’ authority to do curettage to situations in which it is done as part of or incidental to the acts of scaling and root planing. This is clear from the wording of the authorized act and no additional clarification is needed.

The review issues, therefore, are interpreted to include incidental curettage only. Given this, when the remainder of this report refers to scaling and root planing, this term includes incidental curettage.
4.3 CURRENT PRACTICE

The issues to be addressed in this referral relate to the practical implications of the proposed change: whether it would constitute a significant or relatively minor change in practice and whether the proposed change would result in an increased risk of harm, increased access and/or improved equality. In order to assess these issues, it is important to understand current practice, that is how, and under what conditions, do dental hygienists currently perform the acts of scaling teeth and root planing, including curetting surrounding tissue.

It also is important to understand the steps dental hygienists and dentists take for determining the need to clean our teeth. Who performs these steps and who is deciding when to proceed with the acts in question?

i) Initial Assessment re Oral Health

In determining whether scaling and root planing are necessary, oral health status must be determined. A review of submissions indicates that personal, medical and dental histories taken in part to determine oral health are done in a fairly standardized format, regardless of whether a dentist or dental hygienist takes the history.

While there appears to be general agreement on the kind of information obtained in a history, there are differences of opinion between participants as to what might be involved in interpreting this information. RCDSO noted in its submission that while dentists and dental hygienists may appear to obtain similar clinical histories, the practitioner must have the ability to evaluate the answers to the questions asked in order to decide whether or not to proceed. (p. 7)

Who takes medical histories varies significantly by practice setting. The joint dental hygienists' submission referred to a recent Ontario survey which reported a new client's medical history is taken by the dental hygienist alone in 25.5% of cases, by the dentist in 26.3% of cases and by both in 30.4%. For return clients, the medical history is reviewed by the dental hygienist alone in 74% of the cases. Dental hygienists rarely take medical histories in orthodontic practices (2%) but in public health venues, dental hygienists are more likely than dentists to take the medical history. (p. B-1) The vast majority of dental hygienists work in a dentist’s office at present.

In addition to the information obtained from the client, both professions conduct some kind of physical examination of the mouth. Again, there are apparent disputes as to the differences between these examinations by both professions.

Dental hygienists stated that either a dentist or a dental hygienist may conduct an examination of the teeth, surrounding tissues and oral cavity. A thorough examination, they went on to note, involves more that a visual examination and includes extra-oral and intra-oral palpation and physical examination. (p. B-3)

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RCDSO, on the other hand, argued that dental hygienists perform a preliminary oral assessment, looking for and recording obvious deviations from the normal (p.9). The ODA noted that oral health status is determined by dentists through the integration of factors including, the patient’s health (medical and drug) history and clinical findings drawn from observation and diagnostic testings of the teeth and the oral facial complex. Baseline diagnostics may include medical history, clinical, radiographic, microbiological and immunological information. (p. 10)

HPRAC’S UNDERSTANDING

HPRAC’s analysis of the answers to the questions around determining oral health status leads us to conclude that there is a greater consensus between the participants than there may appear. There seems to be agreement that both professions take similar medical and clinical histories, that only dentists can order and interpret certain tests such as X-rays, that only dentists diagnose and that dental hygienists can at least determine deviations from the normal through their oral health assessment.

Differences focus on: whether dental hygienists are only conducting preliminary examinations or are conducting examinations that include intra- and extra-oral physical examination, and whether dental hygienists can evaluate the information gained in order to decide whether it is safe to proceed.

ii) Orders

An important issue in determining whether it is appropriate for dental hygienists to self-initiate is the degree to which dental hygienists are presently deciding to initiate the procedures in question under standing orders and if they are, the risk of harm this presents.

CDHO stated in its submission that:

“The practice in by far the majority of private practices and in all public health settings, is for the dental hygienists to see the client first, to update the history and to proceed to treat as appropriate. The private practice dentist may examine the client at some point, generally towards the end of the visit.” (p. F-5)

The ODA presented a more restricted picture of the use of standing orders. They submitted that the premise for the ODA standing order protocol is that:

“a standing order could be applied only where the patient was a patient of record for that office and had been examined by the dentist who authorized the use of a standing order to perform certain procedures....In most instances, the standing order would be utilized for “recall” patients and a component of such a visit always includes the dental examination....Other models have been suggested by the profession, including a model that would limit the circumstances to where the patient history was absolutely “clear”. We agree that this is an acceptable approach. “ (p.28)

The Ontario Dental Hygienists’ Association (ODHA) stated in their supplemental submission:
“...it is acknowledged that the dental hygienist must review the medical history of a client and determine if there is any contra-indication before commencing treatment. This is self-initiation. Dentistry seems willing to accept self-initiation, provided it applies to a patient-of-record. However, even with patients-of-record, there may be dramatic change in their health histories from one visit to next with the result that the dental hygienist may have to make a judgment about a significant piece of new information. How does this differ from a circumstance where the dental hygienist is responding to information from a new client?” (p. 3)

The RCDSO in its submission made the following statement:

“After consultation with the professions and other stakeholder groups, the Council conceded somewhat by agreeing that in limited circumstances – when a full and comprehensive medical history (the form of which is approved by the dentist providing the order) is obtained and all of the responses are negative (thereby indicating that there are no contra-indications to treatment), a standing order may be relied upon. The reason why a standing order is acceptable in the above circumstances is because no further determination of the patient’s health status is necessary. Since all of the health history responses are clearly negative, it is unnecessary to require the dentist to “clear” the patient any further.” (p. 26)

This policy has been adopted by the RCDSO on June 1994. The full regulation is found at the end of Appendix C. In particular, section 5 states that a member may provide an order for a patient in his or her care:

(b) where the member has not personally reviewed the current medical history of the patient, such an order shall be subject to the following conditions and no authorized act shall be carried out pursuant to the order unless and until:

1. a current written medical questionnaire, the form of which is approved by the member providing the order, is obtained in respect of the patient and all of the responses to the questions are in the negative, indicating that the patient is not medically compromised and that there are no contra-indications to treatment; or

2. where all of the questions are not answered in the negative, thereby indicating that the patient may be medically compromised or that there may be contra-indications to treatment:

   (i) the confirmation by the member who originally provided the order is obtained, such confirmation being given after the member has considered the patient’s medical history; or

   (ii) a member of the College of Physicians and Surgeons of Ontario has provided medical clearance for the proposed treatment of the patient.

Initial submissions to HPRAC provided helpful information as to the use in the public health setting of standing orders that permit dental hygienists to initiate the acts in question. After a review of this information, HPRAC had further questions and consequently, the Ontario Society of Public Health Dentists was asked to provide more information on how these standing orders operate. The following is taken from their original submission and their responses to our further questions.
“Self-initiation is the provision of services by a professional based on and limited by their education and level of knowledge as well as their scope of practice. It does not involve any reliance on a protocol.” (p.2, Responses to HPRAC Questions)

“Standing orders consist of a protocol, policy, guidelines and outlines of activities which may include self-initiation and how to recognize and deal with exceptions.” (p.2, Responses)

“They become operational after collaborative discussions with staff involved with the program. Quality of care is monitored by planned supervision, by the dental supervisor/co-ordinator (i.e. a senior dental hygienist) a staff dentist and/or the dental director.”(p.7, original submission)

“They also include the access on a 24-hour basis to the supervisor (supervising dentist) or other health unit dentists for immediate consultation, either by direct observation and discussion or discussion alone ... Within the restraints of the guidelines in Standing Orders or protocols there is wide independence to provide services within their scope of practice and to have support for exceptions as above.” (P.2, Responses)

**HPRAC’s Understanding**

Through the submissions and the further clarification by the Ontario Society of Public Health Dentists, HPRAC has determined:

- Self-initiation by a profession of a controlled act is different from initiation of a controlled act under protocol. Self-initiation of a controlled act involves a professional making a decision to proceed based on and restricted by their own scope of practice, training and abilities. No protocols established by another profession are required. The professional making the decision to self-initiate a procedure is solely and fully accountable for that decision. On the other hand, initiation of a controlled act under a standing order or protocol involves another profession setting the terms of when a procedure should be initiated by the profession in question. These orders can vary from being very specific and restrictive to being very general and allowing for a great deal of independence in decision-making for the professional governed by the protocol.

- For non medically-compromised clients, it has been common in many practice settings for dental hygienists under a protocol or standing order to proceed in the absence of contra-indications with scaling and root planing on their own initiative, after taking a medical history. In dental offices, these standing orders are generally used for ongoing patients as opposed to new patients. Standing orders in public health settings seem to have involved a broader base of clients in some cases, and have often allowed for considerable independence in decision making by dental hygienists, with dentists at times off site.

- The RCDSO has passed a regulation establishing a standing order protocol allowing a dentist to provide an order for a patient in his or her care such that a dental hygienist can decide to initiate scaling and root planing of the patient of record where there are no contra-indications, based on an approved medical questionnaire.

- For a number of years, the use of a "standing order" (where a dentist is not always available on site) along with related policy, protocol, policies and
Dental hygiene manuals, has allowed dental hygienists to work in existing public health programs providing dental screening and a variety of preventative programs. These orders include access on a 24 hour basis to the supervisor (supervising dentist) or other health unit dentists for immediate consultation, either by direct observation and discussion or discussion alone.

The CDHO has not taken a position against the existence of “order” in the Dental Hygiene Act. They also agree to the need for a dental hygienist to seek an order for scaling and root planing for the medically compromised client or where the hygienist is uncertain. In addition, the CDHO contemplates situations where dental hygienists are simply more comfortable with an order in place before proceeding with these activities under any circumstances.

4.4 Issues Arising from Self-initiation

Given the above understanding of the authorized acts in question and the current practice, including the protocol and use of standing orders, the proposals to allow self-initiation by dental hygienists raise specific issues. We wish to examine these issues in some detail, analyzing the participants’ positions, followed by HPRAC’s understanding and conclusions.

4.4.1 Practice Issues

Risk of harm to the public by dental hygienists deciding on their own authority to initiate scaling and root planing is addressed in the following sections. The degree to which the proposed amendments and regulations allowing limited self-initiation of these acts by dental hygienists poses an increased risk of harm over the current practice of initiation of these procedures under protocol will be addressed. Specific measures proposed to address potential harm, including in emergencies, are included in this section.

i) Decision to Proceed

Critical questions in this referral relate to the risk of harm to the public of proceeding with scaling or root planing when there is a contra-indication. What steps, protocols, standards, regulations, and training are in place or proposed to mitigate against these risks? Would this entail an increase in risk of harm over current practice?

All dental groups agree in their submissions that harm may occur if invasive procedures are performed when prior evidence indicates they should not have been performed or that the appropriate counter measures have not been taken. All generally agree on the nature and type of risks involved. For example, the ODA noted “that scaling and root planing are invasive procedures, in that they disrupt the gingival tissue. As a result, latent bacteria are disrupted and may enter the bloodstream.” (p. 23) They went on to note that in medically compromised patients, the bacteraemia may present a risk of further, and potentially life threatening, infection. Some patients are particularly susceptible to infection and bleeding, they pointed out. These procedures may cause problems in such patients.

CDHO described two principal types of risk associated with the performance of scaling, root planing and curetting of surrounding tissues. The first is the risk associated with the use of sharp instruments on live tissue. The second is the
risk mentioned above, bacteraemia. They noted that during dental and dental hygiene therapy, including home care (flossing), a transient bacteraemia is produced. They indicated that clients at high risk include those with rheumatic heart diseases, valvular heart defects, prosthetic heart valves, cardiac pacemakers or with previous episodes of bacterial endocarditis. Other contraindications or factors limiting treatment, they went on to note, include the presence of asthma, tuberculosis, rheumatoid arthritis, joint prostheses, anemia, diabetes and cancer. Other risks relate to drug interactions, or allergies. (p. F-1 to F-3)

The key issue tabled by dentists in their submissions is that while Ontario dentists agree that dental hygienists are skilled in the provision of scaling, root planing and incidental curettage, this does not mean that they are necessarily qualified to decide whether or not that procedure should be performed.

According to the ODA, patients often require a combination of treatment services that go beyond scaling and root planing. The ODA’s concern “relates directly to the patient safety factor of when to deliver these procedures and when these procedures can be provided without pre-care or concurrent care, including antibiotic and/or antimicrobial therapy, or post-treatment medication.” (p. 17) The ODA went on to note that since there is not always a single risk indicator, it is virtually impossible to eliminate at-risk patients from hygienists’ practice and where any screening program fails to identify at-risk patients, harm may occur.

Dental hygienists’ organizations jointly submitted that the education and abilities of dental hygienists are adequate to independently decide whether the circumstances permit self-initiation of scaling, root planing and incidental curettage. (p. C-1) They further stated that dental hygienists are trained to take medical and dental histories and to determine whether the client should be seen by a dentist prior to commencing cleaning teeth. CDHO submitted that “the current education in history-taking and contra-indications is unequivocally necessary and appropriate, because graduate dental hygienists have been required to make precisely the distinctions mentioned above in dental offices throughout Ontario for many years.” (p.F-5)

CDHO recognized in their submission that if given the authority to self-initiate, it will be made a ground for professional misconduct to fail to refer a patient to a dentist or doctor where the hygienist believes that there are contra-indications to treatment. They noted that regulations defining self-initiation are to be developed and will clearly indicate that medically compromised clients require an order for these procedures, and where there is any uncertainty as to the advisability of proceeding with scaling and root planing, an order is required. (Annex D-3 footnotes)

As noted earlier, the CDHO further advised that it intends to expand the description of the conditions where a member shall not self-initiate scaling by adding categories and by listing examples of the various conditions noted in their proposed standard of practice The College intends that the standards document will be developed in full consultation with dental/medical groups. (Annex D-3 footnotes)
HPRAC’S UNDERSTANDING

HPRAC found that the current practice of standing orders and the protocol established by RCDSO allow dental hygienists, after taking a medical history based on approved form, to decide independently with a patient of record if there are any contra-indications to proceeding with scaling and root planing including curettage. In other words, it is common practice for a patient of a dental office to have their medical history taken and an assessment made by a dental hygienist as to whether it is safe to proceed with scaling and root planing, without a dentist’s “clearance”, that is without seeing a dentist first. Indeed, there appears to be no requirement that the dentist providing the order need be in the office for a dental hygienist to proceed with these procedures.

HPRAC is presuming that the RCDSO, which is charged with regulating dentists in the public interest, would not have allowed their members to provide a standing order for a patient that would allow a dental hygienist to perform scaling and root planing on their own initiative if the College felt that there was an undue risk of harm to these patients. Furthermore, no evidence was presented during the course of the review that dental hygienists caused harm to any patient when they proceeded on their own initiative to perform these acts under protocol.

The proposed legislative changes, with the anticipated restrictions and clarification through dental hygiene regulations and standards of practice, will extend the present common practice permitted by the RCDSO regulation to any patient where there are no medical reasons not to proceed. In other words, the RCDSO regulation restricts orders allowing dental hygienists to make the decision to proceed where there are no contra-indications to ongoing patients of a dentist. The legislative proposal would allow limited self-initiation of the controlled acts to any patient where there are no contra-indications to proceed.

Furthermore, under the proposed amendments the accountability for a dental hygienist performing these procedures on their own initiative would be moved from the dentist and RCDSO to the dental hygienist and the CDHO. In other words, the public would still be able to hold a professional accountable for initiating these procedures through a regulatory body.

The proposed legislative amendment and related regulations would be applied to dental hygienists in all settings, whether private practice, public health or any other community based setting, thus maintaining equal standards.

CONCLUSIONS

The CDHO proposed amendment and regulations have the same restrictions as those stipulated in the RCDSO regulation as to when a dental hygienist may proceed on his or her own initiative to perform the controlled acts in question. That is to say the type of patient with whom dental hygienists would be allowed to self-initiate these acts under the proposals are the same type of patients that dental hygienists presently proceed with under standing orders. These are patients who do not have health problems that could present possible difficulties or harm from these procedures. The proposed amendments, however, would allow limited self-initiation of these controlled acts by dental hygienists for any patient, including new patients in addition to patients of record, where there are no contra-indications.
HPRAC accepts the argument that patients of record could, and many do, experience a change in health status such that dental hygienists need to determine under protocol if there is a contra-indication to proceeding with these controlled acts. Given this, the same skill and judgment are required of dental hygienists to make the decision to proceed or to refer under self-initiation as under standing order. The dental hygienist in both situations takes a medical history, performs an oral examination, and determines if there are any contra-indications to proceeding with scaling or root planing. The dental hygienist in either case is expected to seek an order from a dentist or doctor if there are any contra-indications or if there is any uncertainty as to the safety of proceeding. Therefore, there is little or no increase in the risk of harm to patients over present practice in allowing dental hygienists to self-initiate scaling and root planing where there are no contra-indications, uncertainty, or other reasons not to proceed.

This determination is premised on HPRAC’s understanding that the restrictions on proceeding in the face of contra-indications or uncertainty can and will be appropriately set out in the statute, regulations and/or standards of practice. These restrictions must include:

- that the professional misconduct regulation provide that it is professional misconduct for a dental hygienist to fail to refer a patient to a dentist or doctor where the hygienist knows, or ought to have known, there are contra-indications to treatment or where the hygienist is uncertain if proceeding is safe;

- that regulations defining self-initiation will clearly indicate that medically compromised clients require an order for these procedures, and that where there is uncertainty as to the advisability of proceeding with scaling and root planing, an order is required;

- that there be specific descriptions of conditions where a member shall not self-initiate scaling and that standards of practice stipulate as specifically as possible when these procedures may and may not be self-initiated. These restrictions should clearly indicate that self-initiation is not to be undertaken for high risk populations.

These standards and regulations ought to be developed in full consultation with dental and medical groups. The CDHO should be required to submit draft regulations and standards of practice for review as part of the amendment package.

The possibility of increased risk of harm was also raised with respect to dental hygienists’ ability to handle emergencies as a result of scaling and root planing. The following section explores and addresses these risks.

ii) Emergencies

The ability of a dental hygienist to handle emergencies is a consideration in determining whether a dental hygienist should self-initiate. Is the dental hygienist less equipped than dentists to handle emergencies and does self-initiation by dental hygienists increase the risk of harm due to emergencies?
RCDSO noted in their submission that, in spite of meticulous precautions designed to prevent these emergencies from arising, some acute medical emergencies occur within a typical dental practice. The majority of emergencies occur during treatment, with a lesser number occurring before or after treatment. Emergencies can include unconsciousness, respiratory difficulty, altered consciousness, seizure disorders, drug related emergency situations, allergy reactions, chest pains and cardiac arrest. (p. 22-23)

RCDSO stated that “dental hygienists, because of their limited training and inability to use prescriptions are not qualified to recognize and manage most emergency situations. Merely being qualified in cardiopulmonary resuscitation (CPR) does not address their lack of training in principles of medicine and pharmacology. Clearly, dental hygienists do not have the same, or even similar, ability to provide the necessary care/treatment if harm should occur as a result of performing scaling, root planing and curettage procedures.” (p. 24)

The joint dental hygiene submission noted that “both dentists and dental hygienists are trained to intervene as necessary with CPR or non-drug related first aid, or to initiate available emergency systems, such as calling 911. Both dentists and dental hygienists are trained to recognize when medical assistance is required from a physician and to react appropriately to such common medical emergencies as when a patient goes into insulin shock. The main difference between dentists and dental hygienists in their response to emergencies is in the dentist’s ability to administer drug therapy.” (p. C-2)

One issue with respect to when drugs are needed relates to allergies. Latex allergies pose a particular risk in the context of dental work because of the latex gloves worn by most dentists and dental hygienists. The ODA reported that patients who have had no prior reactions to latex can experience severe reaction to latex gloves worn by the oral practitioner. Even a first reaction may be extremely strong, i.e. anaphylactic shock. ODA states that while such circumstances would be rare, only the dentist has the necessary counteracting drugs and is prepared to provide needed emergency treatment for such severe reactions. (p.18)

HPRAC sought further information on this potential problem. Andrew Douglas of the Standards Office - Research and Standards Division, Bureau of Radiation and Medical Devices, provided HPRAC with information on latex allergies. Dr. Douglas noted that the use of natural rubber latex gloves in medical and dental practices has become a source of allergic reactions, most often for the health care practitioner. He stated that there is evidence that the more a person is exposed to latex, the more allergic he/she becomes.

According to the ODHA, “access to emergency services must be considered if dental hygienists are to provide services in non-traditional settings. Even now this is an issue in traditional settings. Dental hygienists are being asked to practice when the dentist is not on-site now. The dental hygienist and dentist must discuss and be comfortable with emergency procedures to be followed when the dental hygienist is working on his/her own.” (p. 6 in Supplemental Submission)
CDHO stated in their supplemental submission that dental hygienists will need to seek an order for scaling and root planing for medically compromised clients. (p. 6) Failure to refer such clients would be professional misconduct.

No submissions referred to any evidence of harm occurring due to self-initiation by a dental hygienist, whether in Colorado or California.

CONCLUSIONS

HPRAC has been persuaded that there is little or no increased risk of harm due to emergencies if dental hygienists are allowed to self-initiate scaling and root planing where there are no contra-indications if the following precautions are taken:
- Protocols for emergency referrals/procedures in context of independent practice are in place.
- Supplies are readily available to address emergencies.
- Recognizing that dental hygienists cannot administer drugs and to minimize any potential risk of harm attendant to latex, however remote, dental hygienists should be required to not only have a protocol to deal with emergency situations but should be required to use non-latex substitutes for any client who has any allergies.

iii) Malpractice Insurance

It is important for patients to be able to hold the individual health professional responsible, including through a civil suit, for any harm caused to the patient. Consequently, self-initiation of certain acts by dental hygienists squarely raises the issue of malpractice insurance.

CONCLUSION

CDHO must require malpractice insurance for hygienists who are not otherwise covered under some type of malpractice insurance.

4.4.2 Education and Training

One of the central issues that emerged during the public review has been whether dental hygienists have sufficient and appropriate education and training to determine contra-indications to proceeding with scaling and root planing including incidental curettage.

In order to assess the adequacy of the education programs for dental hygienists, HPRAC:
- reviewed the information provided by participants directly on education and training, including extensive information on George Brown College’s dental hygiene program
- did telephone inquiries of three other programs regarding clinics
- inquired about accreditation of and differences between the thirteen Ontario dental hygiene programs

According to the joint submission, Section E, of CDHO and the Dental Hygiene Educators of Ontario, Ontario dental hygienists are educated by way of a ladder
system in which they take a 34 week long dental assistant training program, followed by 6 to 12 months of work experience as a certified dental assistant, followed by a year’s training in the dental hygienist program. They must possess current first aid and CPR certificates at the commencement of the dental hygiene program.

The joint submission referred at some length to the Dental Hygiene Program at Georgian College, describing the clinical components and courses. These include dental anatomy, oral histology, theory, radiography, dental health education, dental medicine, oral pathology and periodontics. Of the 892 hours involved in the dental hygiene program at Georgian College, 420 hours are for preclinical and clinical training. Students are expected to complete a comprehensive assessment, develop a treatment plan, and provide that treatment for approximately 20-24 clients. (E-3)

The ODA noted in their submission that “dental hygiene education in Ontario is an anomaly in Canada, in that the programme is completed over eight or nine months instead of two years taken in other provinces. Dental Hygienists also gain training in the dental assistant programme, a prerequisite to entering dental hygiene. (p.29) The ODA goes on to note of the seven dental hygiene programs in Ontario surveyed through college calendars and communications, the programs averaged 36 weeks, including both didactic and clinical components. (p. 31)

Dental submissions for the most part indicated that the primary concern has been and remains, that due to a limited educational background, hygienists are not adequately prepared to self-initiate scaling and root planing without unnecessary risk to the public.

For example, RCDSO provided a comparison of the courses at Seneca College, the University of Colorado’s dental hygiene program (where dental hygienists are allowed to work independently) and the University of Toronto Dental School. They argued that dental hygienists in Colorado have approximately twice the number of hours of education in the basic and applied sciences, theoretical basis of dental hygiene and practical experience than do hygienists graduating in Ontario. They went on to note that hygienists in Colorado are currently not permitted to root plane, but can scale and do gingival curettage only. (p. 30-38)

The ODA raised concerns in their submission about the adequacy of the ladder approach, noting that the Commission on Dental Accreditation has expressed concern about this approach in the past, and in particular, concerning the minimal number of hours of clinical education of the Ontario programs. (p. 30)

In its supplemental submission, CDHO contends that “the question is whether dental hygienists can take a medical history and, using this together with their assessment of a client's teeth and surrounding tissue, recognize the existence – or the possibility – of contra-indications to proceeding with scaling and root planing. We have pointed out that where such contra-indications exist, or may exist, the regulations will require a dental hygienist to refer the client to a dentist or physician. The CDHO asserts that dental hygienists in Ontario are educated to this level and have, in fact, been working to this standard of professional judgment in both private and public practice settings for years with no known cases of harm being inflicted on clients.” (p. 4) They further note that dental hygienists trained in
Ontario can practice in other provinces and in the United States, including Colorado.

Accreditation is a process by which the Commission on Dental Accreditation recognizes dental and allied dental education programs and health facility dental services as having met nationally determined requirements or standards respectively as established by the Commission. Dental Hygiene programs are accredited by the Commission on Dental Accreditation of Canada which is composed of members of all dental professions and dental hygienists. The Commission on Dental Accreditation reports that twelve of the thirteen dental hygiene education programs are accredited. Deliberations of the Commission regarding specific programs are strictly confidential and therefore information on specific programs was not available to HPRAC from the accreditation authority.

In 1993, the College of Standards and Accreditation Council (CSAC) was established to define credentials for, set standards for, and accredit publicly-funded programs within Ontario's colleges. Program standards for Dental Assisting and Dental Hygiene are currently being developed by the Program Standards Committee for Dental Assisting/Dental Hygiene. This committee represents a broad range of stakeholders related to Dental Assisting and Dental Hygiene programs, including the CDHO, ODHA, RCDSO, and ODA.

The CDHO and ODHA in concert with the Ministry of Education and Training have begun to evaluate the dental hygiene programs to ensure that they reflect the profession's scope of practice and reflect the future requirements of dental hygienists to provide oral health care to a changing society. The CDHO noted that they are “in discussion with the Ministry of Education and Training with a view to moving from the current two step or ladder program in Ontario to a direct entry program in which dental hygiene would become the focus from the beginning of the program. The immediate objective is to ease what is becoming an unacceptably heavy workload for both faculty and students in the current final dental hygiene academic year. In recent years the dental hygiene teaching programs have moved to an “overall program of care” approach, rather than simply emphasizing a set of technical or manual skills.” (p. 5, CDHO Supplemental Submission)

HPRAC’S UNDERSTANDING

HPRAC found that dental hygiene education is based on a two year ladder system, with one year of training as dental assistants, some clinical experience, followed by another year of training in a program for dental hygienists. This ladder system has led to some differences of opinion on how much training dental hygienists actually have, with some dental organizations alleging that the training is one year unlike the two years required elsewhere. HPRAC found that the ladder system is basically equivalent to the two years training programs elsewhere in Canada and the United States.

Twelve of the thirteen dental hygienist programs are accredited. This accreditation process includes members of all dental professions and dental hygienists. HPRAC noted that no one in the process of the public review questioned the validity or quality of the accreditation system for dental hygiene programs. In the absence of any complaints or concerns of accreditation, we did not embark on a detailed evaluation ourselves of the education programs.
We did, however, review the length of courses, subjects covered, and clinical experience as per the sources listed above.

As noted earlier, the RCDSO regulation allows dentists’ orders so that dental hygienists can make a determination whether it is safe to proceed on their own initiative to scale and root plane, at least with patients of record. Presumably, RCDSO felt the present education program in Ontario to be adequate for dental hygienists to take medical histories, do oral examinations and make a determination on their own initiative whether it is safe to proceed with these controlled acts with patients of record. As also stated in this report, the skill and knowledge required to make the determination as to whether there are any contra-indications to proceeding is the same whether this decision is being made under a protocol with ongoing patients or is being made under legislative authority with any patient. As discussed previously, there is not necessarily any substantive difference between a patient of record and a new patient in this context. Therefore, no changes in the education and training of dental hygienists would be necessary to carry out the same decision making process.

Despite our recognition of and respect for those who are accrediting dental hygiene programs in the province, HPRAC supports the initiatives for revision of the dental hygiene education in that improved quality of care is tied to improved education. HPRAC specifically supports:

- special attention to non-traditional and institutional settings in curriculum and clinical training
- the development of more in-depth clinical programs and attempts to give students as diverse an exposure as possible.
- the broadening of the curriculum to reflect the technical competencies required for employment in alternate practice settings such as public and community health facilities, hospitals, penal institutions and collective living centers.

CONCLUSION

The Commission on Dental Accreditation, which includes dentists, is the body that is expected to determine whether dental hygienists are adequately trained in this province. At present twelve of the thirteen programs are accredited, as noted earlier. HPRAC was not given any indication by any participant that there was any reason to question the expertise and judgment of this body.

Furthermore, RCDSO’s regulation respecting Orders, Delegation and Assigning of Intra-oral Procedures allows dentists to provide an order for patients such that dental hygienists can determine on their own initiative to proceed with scaling and root planing, including curettage, after taking a medical history and conducting an oral examination. HPRAC presumes that this order protocol was based on recognition that the present education of dental hygienists in Ontario provides acceptable training in taking of histories, oral assessments and knowledge of contra-indications to the procedures in question.

Given this, HPRAC accepts that dental hygienists are presently trained to do what they are currently authorized to do under the RHPA, that is scaling and root planing, including curettage surrounding tissue under the order of a dentist. Dental hygienists also are trained to take medical histories, do oral
assessments and initiate the procedures in question under protocols or standing orders where there are no contra-indications. As the skills and judgment are the same to self-initiate these procedures under the same restrictions as they are to initiate under protocols, no further training is necessary.

4.5 CONCLUSIONS RE THE ISSUES

HPRAC has come to the conclusion that the risk of harm to patients/clients will be no greater where a dental hygienist self-initiates under the same or similar restrictions as the protocol established by RCDSO requires.

The RHPA intended to allow access to, and the choice of, safe health care for residents of Ontario. The present practice of allowing initiation of scaling and root planing including incidental curettage only through standing orders is unnecessarily restrictive of dental hygienists and potentially restricts access to their services.

As allowing dental hygienists limited self-initiation of these controlled acts is a change in the scope of practice of dental hygienists, the Dental Hygiene Act should be amended to accomplish this change. It is inappropriate to change one profession’s scope of practice by way of another profession’s protocols, regulations, or even by-laws, should the latter two options be legally permissible. The RHPA’s principled commitment to equality between professions is respected by ensuring that each profession has a self-contained scope of practice that reflects their education, training and abilities. Practice protocol options under the auspices of the regulatory body for dentists would not ensure and clarify what dental hygienists have the training and education to do, would leave access to dental hygienists totally to the discretion of another profession, and would not be consistent with the legislative intention of the RHPA. Furthermore, changing the Dental Hygiene Act to allow limited self-initiation of scaling and root planing will make it clear to the public and the profession who is accountable for these decisions.

HPRAC is of the view that the proposed amendments, with the intended restrictions and safeguards allowing dental hygienists to self-initiate in specific situations, fulfills the public interest principles of access, equality, accountability and quality of care, while not constituting an increased risk of harm to the public.
5. SUMMARY OF CONCLUSIONS

- **Authorized Acts**
  
The authorized act under 4(1) of scaling and root planing, including curetting surrounding tissue authorizes dental hygienists to perform only incidental curettage. Dental hygienists are not authorized to perform curettage as an act separate or independent from scaling or root planing. The use of the word “including” in s.4(1) restricts dental hygienists’ authority to do curettage to situations in which it is done as part of or incidental to the acts of scaling and root planing. This is clear from the wording of the authorized act and no additional clarification is needed.

  The review issues, therefore, are interpreted to include incidental curettage only. Given this, when the remainder of this report refers to scaling and root planing, this term includes incidental curretage.

- **Decision to Proceed**
  
The CDHO proposed amendment and regulations have the same restrictions as those stipulated in the RCDSO regulation as to when a dental hygienist may proceed on his or her own initiative to perform the controlled acts in question. That is to say the type of patient with whom dental hygienists would be allowed to self-initiate these acts under the proposals are the same type of patients that dental hygienists presently proceed with under standing orders. These are patients who do not have health problems that could present possible difficulties or harm from these procedures. The proposed amendments, however, would allow limited self-initiation of these controlled acts by dental hygienists for any patient, including new patients in addition to patients of record, where there are no contra-indications required.

  HPRAC accepts the argument that patients of record could, and many do, experience a change in health status such that dental hygienists need to determine under protocol if there is a contra-indication to proceeding with these controlled acts. Given this, the same skill and judgment are required of dental hygienists to make the decision to proceed or to refer under self-initiation as under standing order. The dental hygienist in both situations takes a medical history, performs an oral examination, and determines if there are any contra-indications to proceeding with scaling or root planing. The dental hygienist in either case is expected to seek an order from a dentist or doctor if there are any contra-indications or if there is any uncertainty as to the safety of proceeding. Therefore, there is little or no increase in the risk of harm to patients over present practice in allowing dental hygienists to self-initiate scaling and root planing where there are no contra-indications, uncertainty, or other reasons not to proceed.

  This determination is premised on HPRAC’s understanding that the restrictions on proceeding in the face of contra-indications or uncertainty can and will be appropriately set out in the statute, regulations and/or standards of practice. These restrictions must include:

  - that the professional misconduct regulation provide that it is professional misconduct for a dental hygienist to fail to refer a patient to a dentist or doctor where the hygienist knows, or ought to have known, there are contra-
indications to treatment or where the hygienist is uncertain if proceeding is safe;

- that regulations defining self-initiation will clearly indicate that medically compromised clients require an order for these procedures, and that where there is uncertainty as to the advisability of proceeding with scaling and root planing, an order is required;
- that there be specific descriptions of conditions where a member shall not self-initiate scaling and that standards of practice stipulate as specifically as possible when these procedures may and may not be self-initiated. These restrictions should clearly indicate that self-initiation is not to be undertaken for high risk populations.

These standards and regulations ought to be developed in full consultation with dental and medical groups. The CDHO should be required to submit draft regulations and standards of practice for review as part of the amendment package.

- **Emergencies**
  
The possibility of increased risk of harm was also raised with respect to dental hygienists’ ability to handle emergencies as a result of scaling and root planing. The following section explores and addresses these risks.
  
  HPRAC has been persuaded that there is little or no increased risk of harm due to emergencies if dental hygienists are allowed to self-initiate scaling and root planing where there are no contra-indications if the following precautions are taken:

- Protocols for emergency referrals/procedures in context of independent practice are in place.
- Supplies are readily available to address emergencies.
- Recognizing that dental hygienists cannot administer drugs and to minimize any potential risk of harm attendant to latex, however remote, dental hygienists should be required to not only have a protocol to deal with emergency situations but should be required to use non-latex substitutes for any client who has any allergies.

- **Malpractice Insurance**
  
  CDHO must require malpractice insurance for hygienists who are not otherwise covered under some type of malpractice insurance.

- **Education and Training**
  
  The Commission on Dental Accreditation, which includes dentists, is the body that is expected to determine whether dental hygienists are adequately trained in this province. At present twelve of the thirteen programs are accredited. HPRAC was not given any indication by any participant that there was any reason to question the expertise and judgment of this body.
  
  Furthermore, RCDSO’s regulation respecting Orders, Delegation and Assigning of Intra-oral Procedures allows dentists to provide an order for patients such that dental hygienists can determine on their own initiative to proceed with scaling and
root planing, including curettage, after taking a medical history and conducting an oral examination. HPRAC presumes that this order protocol was based on recognition that the present education of dental hygienists in Ontario provides acceptable training in taking of histories, oral assessments and knowledge of contra-indications to the procedures in question.

Given this, HPRAC accepts that dental hygienists are presently trained to do what they are currently authorized to do under the RHPA, that is scaling and root planing, including curetting surrounding tissue under the order of a dentist. Dental hygienists also are trained to take medical histories, do oral assessments and initiate the procedures in question under protocols or standing orders where there are no contra-indications. As the skills and judgment are the same to self-initiate these procedures under the same restrictions as they are to initiate under protocols, no further training is necessary.

5.1 CONCLUSIONS RE THE ISSUES

HPRAC has come to the conclusion that the risk of harm to patients/clients will be no greater where a dental hygienist self-initiates under the same or similar restrictions as the protocol established by RCDSO requires.

The RHPA intended to allow access to, and the choice of, safe health care for residents of Ontario. The present practice of allowing initiation of scaling and root planing including incidental curettage only through standing orders is unnecessarily restrictive of dental hygienists and potentially restricts access to their services.

As allowing dental hygienists limited self-initiation of these controlled acts is a change in the scope of practice of dental hygienists, the Dental Hygiene Act should be amended to accomplish this change. It is inappropriate to change one profession’s scope of practice by way of another profession’s protocols, regulations, or even by-laws, should the latter two options be legally permissible. The RHPA’s principled commitment to equality between professions is respected by ensuring that each profession has a self-contained scope of practice that reflects their education, training and abilities. Practice protocol options under the auspices of the regulatory body for dentists would not ensure and clarify what dental hygienists have the training and education to do, would leave access to dental hygienists totally to the discretion of another profession, and would not be consistent with the legislative intention of the RHPA. Furthermore, changing the Dental Hygiene Act to allow limited self-initiation of scaling and root planing will make it clear to the public and the profession who is accountable for these decisions.

HPRAC is of the view that the proposed amendments, with the intended restrictions and safeguards allowing dental hygienists to self-initiate in specific situations, fulfills the public interest principles of access, equality, accountability and quality of care, while not constituting an increased risk of harm to the public.
6. RECOMMENDATIONS

HPRAC recommends that the Dental Hygiene Act be amended to allow dental hygienists to perform their authorized acts of scaling teeth and root planing including (incidental) curetting of surrounding tissue without an order, subject to appropriate restrictions in regulations and standards. The regulations must clearly limit self-initiation to patients where there are no contra-indications or uncertainty as to whether it is safe to proceed. Failure to refer to a dentist or doctor must be grounds of professional misconduct. Regulations and standards of practice setting out the limitations and expectations relating to self-initiation should be established through consultation with other health professionals, particularly dentists and physicians before the Act is amended.

Amendment of legislation should always be considered the best and most appropriate vehicle to change a profession’s scope of practice. However, HPRAC recognizes that in certain limited and extraordinary circumstances where the government is unable to proceed with an amendment directly and expeditiously, an exemption regulation, based upon the intended amendment, may be an acceptable approach in the interim.

It should be noted, however, that in the context of dental hygiene, HPRAC has certain concerns as to whether an exemption regulation is possible. Such a regulation would be expressly amending the Dental Hygiene Act, 1992 by not only expanding the dental hygiene scope of practice, but also by expressly negating the current requirement that the profession’s controlled acts can only be initiated upon the order of a member of the RCDSO, in order to expand the profession’s scope of practice. Generally speaking, the principle of parliamentary supremacy, does not allow a regulation to amend legislation, unless of course the enabling legislation allows for such an eventuality.

Assuming that the exemption regulation power of the RHPA can be interpreted to allow for such amendment, the exact language of the exemption regulation ought to be developed by legislative counsel in consultation with CDHO and RCDSO and incorporate the principles underlying the RHPA, as well as our advice presented in this Report. In HPRAC’s view, an appropriate starting place to develop an exemption regulation would be the CDHO’s proposed amendment to the Dental Hygiene Act, 1992, and the RCDSO protocol. Accordingly, the RHPA exemption regulation might take the following form as an amalgam of the proposed amendment and the protocol regulation:

1. A member of the College of Dental Hygienists of Ontario, is exempt from subsection 27(1) of the Act, for purposes of carrying on self-initiation of scaling teeth, root planing including incidental curretage of surrounding tissues only when the following conditions are met:
   (a) the member has determined that the client’s condition warrants the procedure;
   (b) the member has determined through the use of a written medical questionnaire as approved of by the College of Dental Hygienists of Ontario, obtained from the patient at the time the procedure is performed in respect of the patient’s health and medical conditions, that there are no questions responded to in the negative thus indicating that the patient is not
medically compromised and that there are no contra-indications to the performance of the procedure;

(c) none of the conditions listed in subsection 2 hereof are present in the patient;

(d) the member has the knowledge, skill and judgement to perform the procedure safely, effectively, ethically, and in accordance with the standards of practice of the profession; and

(e) the member accepts sole responsibility for determining that the performance of the procedure is appropriate, having considered:
   i) the known risks and benefits to the client of performing the procedure;
   ii) the predictability of the outcomes of performing the procedure;
   iii) the safeguards and resources available in the situation to safely manage the outcome of performing the procedure; and
   iv) other factors specific to the situation.

2. A member of the College of Dental Hygienists of Ontario shall not self-initiate scaling, root planing or incidental curettage of surrounding tissue when any of the following conditions are reported or known to be present in the patient:

(a) any cardiac condition for which antibiotic prophylaxis is recommended in the guidelines set by the American Heart Association;

(b) any condition for which antibiotic prophylaxis is recommended or required;

(c) any unstable medical condition, where the condition may affect the appropriateness or safety of scaling, root planing or incidental curettage;

(d) active chemotherapy or radiation therapy;

(e) significant immunosuppression caused by disease, medications or treatment modalities;

(f) any blood disorders;

(g) active tuberculosis;

(h) drug or alcohol dependency of a type or extent that it may affect the appropriateness or safety of scaling, root planing, or incidental curettage;

(i) high risk infective endocarditis;

(j) a medical condition with which the member is unfamiliar or which could affect the appropriateness, efficacy, or safety of the procedure; or

(k) a drug or a combination of drugs with which the member is unfamiliar or which could affect the appropriateness, efficacy, or safety of the procedure.