HANDBOOK OF CLINICAL DENTAL AUXILIARY PRACTICE

Francis A. Castano & Betsey A. Alden | Second Edition

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To Today's Dental Auxiliaries
in recognition and appreciation of
their vital role as members of
the dental health team

Preface

When the first edition of this text was published in 1973, under the title *Handbook of Expanded Dental Auxiliary Practice*, the role of the auxiliary and her responsibilities to the dental practitioner and to the public were evolving. No one could foretell the eventual outcome of the various issues involved as they related to dental auxiliary practice. Though change continues, the picture today is far clearer than it was seven years ago. Thus, when setting out to prepare the second edition of the text, the editors first carefully reviewed the state of the art, to ensure that the revised edition would accurately reflect every significant advance in research and clinical practice.

The American Dental Association Surveys of Dental Practice have demonstrated a consistent increase in the number of independent dentists who employ one or more auxiliaries. Between 1955 and 1977 the increase in this number was 77 percent. The number of patients has increased, too. The figures speak for themselves: where no auxiliary was employed, an independent dentist handled on an average 45 patient visits per week; the dentist who employed one auxiliary averaged 60 visits per week; where three auxiliaries were employed, patient visits averaged 83 per week; and where four or more auxiliaries were employed, as many as 95 per week. It has thus been established beyond any doubt that auxiliaries play a vital role in the practitioner's office by increasing his productivity as well as his ability to satisfy the public's need for good dental care.

Changes in dental practice acts have mandated upgrading in both knowledge and clinical skills

on the part of the auxiliary. Hence, in addition to revision of all chapters carried over from the first edition, the second edition includes three entirely new chapters.

Chapter 2, Clinical Record-Keeping, delineates the reasons for establishing and maintaining accurate and complete dental records. Not only is this good business practice; it is an important element in protecting both auxiliary and dentist against charges of malpractice.

Increasing interest and concern about the relationship of nutrition to dental health is recognized in the new Chapter 6, Role of the Auxiliary in Nutrition Counseling. With such information at her fingertips, the auxiliary is well prepared to help guide the patient into dietary practices that will contribute to his overall health as well as to improved dental health.

Chapter 14, new to this edition, is titled Medical Emergencies in the Dental Office. It provides the auxiliary with all the essential information she needs to enable her to handle most of the medical emergencies that can arise in the dental office. Reliable instruction in basic first-aid practices is included as well.

The basics of dental anatomy and physiology, dental materials, dental pharmacology, and dental x-ray technology have been purposely omitted from this text; the reader is assumed to possess such knowledge and information. Further, though it is still true that the largest part of dental care is provided by the general practitioner, dentistry's increasing complexity has given rise to many types of specialization. For this reason the editors selected contributing authors for their expertise in each of the major areas of specialization.

The reader will find that some techniques and procedures are described in more than one chapter. This, too, is deliberate. The same technique may have quite different applications based on the requirements of the specialty. To take one example, the health history is relevant to oral medicine, preventive dentistry, operative dentistry, endodontics, and orthodontics—yet subtle distinctions mark its use in each of those specialties.

Readers will search out content dealing with the specific aspects of auxiliary practice that are of greatest interest and usefulness to them. Preventive dentistry, operative dentistry, and periodontics may be the subjects of primary concern and interest to the dental hygienist, whereas an auxiliary functioning in a specialty practice may have a greater interest in endodontics, pedodontics, and orthodontics. The goal of the second edition remains the same as that of the first—to provide a book that has something for everybody rather than everything for somebody. It should serve as a useful supplement to the basic texts as well as a stimulus to further reading and learning.

A final word. Though we have consistently used "he" when discussing the dentist or the patient, and "she" when discussing the auxiliary, the use of these pronouns should not be regarded as sexist. Until our language invents a single word that is equally applicable to both sexes, we need to continue using those old-fashioned pronouns for the sake of clarity. It is our hope that both "he's" and "she's" will profit equally from reading this book.

Francis A. Castano
Betsey A. Alden

Introduction

In the years since the first edition of this excellent text was published, there have been countless hours of discussion, numerous conferences, and scores of studies and papers devoted to auxiliary utilization in the dental practice.

Originally intended to increase dentist productivity during the days of a presumed shortage of dentists, auxiliary practice has so effectively proved its value that it is now firmly anchored in modern dental practice. Third party payment, better public education, and a higher standard of living have all contributed to the demand for improved dental care. At this writing, some 60 million Americans are the beneficiaries of third party plans. As the wisdom of including dental care among employee fringe benefits is increasingly appreciated, more Americans will be enrolled in one or another dental care plan.

The dental profession has gone on record as being "committed to improving the health of the American public by providing the best quality of dental care to all the people of the nation. The commitment dictates that dentistry assume responsibility for assuring that there will be adequate manpower and appropriate standards of education and training for all personnel who participate in the provision of dental care. In addition, this responsibility extends to identification of the need for specific types of auxiliaries and establishment of appropriate controls on the delivery of services provided by those auxiliaries."

The profession is responding in a positive fashion to societal and political pressures to deliver better care to more people at reasonable cost. Programs to implement the profession's

commitment necessitate inclusion of auxiliaries as essential members of the dental health team. The mission of the dental health team is the attainment of a high standard of dental health for all Americans through a comprehensive program of prevention, education, treatment, and maintenance. The auxiliary plays a critical role in the attainment of these goals.

I congratulate Dr. Castano, Ms. Alden, and the individual contributors to *Handbook of Clinical Dental Auxiliary Practice* on their achievement. Texts such as this one will serve the important function of equipping auxiliaries to effectively fulfill their roles.

I. Lawrence Kerr, D.D.S.
President
American Dental Association

Contents

1

THE TRAINED DENTAL AUXILIARY—KEY TO INCREASED DENTAL PRODUCTIVITY, BETTER PATIENT CARE

Francis A. Castano
Betsey A. Alden

When the first edition of this text was published in 1973, it had the title *Handbook of Expanded Dental Auxiliary Practice.* The problem facing the dental health care delivery system in the United States appeared to be a clear-cut one: how could dental manpower meet the ever-increasing demands of the public for competent and thorough dental care? This requirement by the public can be appreciated by noting that total expenditures for all health care in the United States have increased from $12.0 billion in 1950 to $162.6 billion in 1977. Stated another way, health care services accounted for 4.5 percent of the Gross National Product in 1950, increasing to 8.8 percent in 1977. Of these amounts, dental services accounted for $0.9 billion in 1950, and $10.0 billion in 1977.[1]

In 1970, the Carnegie Commission on Higher Education made the following statement: "The most serious shortages of professional personnel in any major occupational group in the United States are in health services. Thus, one of the greatest challenges to higher education in the 1970s is to mobilize its resources to meet the need for expanding the education of professional health manpower."[2]

The dental profession attempted to respond to that finding. At first, the emphasis was on reversible expanded duties for the dental auxiliary. This was followed by reversible expanded duties for the dental hygienist, and finally irreversible duties for the dental hygienist. In light of projections of need for all members of the dental team—dentist, assistant, auxiliary, and laboratory technician—which indicated a severe de-

ficiency for the late 1970s, it was reasonable to stress, in the first edition of this text, the need for and desirability of expanded duties. There was a growing impression at that time that a dentist who did not utilize expanded duty auxiliary practice was unresponsive to national need and was out-of-date in his thinking. Subsequent reports confirmed the view that dental auxiliaries could deliver many of the duties traditionally reserved to the dentist as well as, and in some cases better than, the practicing dentist or the dental student. It became obvious to the unbiased observer that many traditional "dentist" duties could be delegated to auxiliaries without a decrease in the quality of patient care.

Why then has the concept of expanded duties not gained a firmer foothold within the profession? Many answers to this question have been proposed and, as is often the case, there is a bit of truth in each of them.

Perhaps the first response that comes to mind is that the predicted pressure for changes either did not develop or was not sensed within the profession. Though there are shortages of dentists in certain regions in the United States, there appears to be a surplus of dentists in other areas of the country. As a whole, the profession has not been overwhelmed by a demand it cannot satisfy.

For one thing, there has been a marked increase in the number of dental school graduates within the last decade—an increase directly attributable to the federal government's capitation grants which financially rewarded dental schools that increased class size. Along with this, the number of dental schools has grown from 49 in 1964 to 60 in 1978, and enrollments have risen more than 60 percent during those years.[3]

A second factor is the growing percentage of practicing dentists who have been educated and trained in dental auxiliary utilization (DAU), based on four-handed dentistry. Dental auxiliary utilization has had the desirable outcome of significantly increased dentist productivity. Ninety-five percent of dentists in private practice now employ at least one full-time auxiliary. It has been demonstrated in many studies that a dentist with one full-time auxiliary and two chairs is approximately 30 percent more productive than the practitioner with one chair and no chairside auxiliary.[3]

At the same time, auxiliaries thoroughly trained in expanded duties are in short supply. By and large, the training of chairside auxiliaries is still being done by the dentist in private practice in the office setting—in other words, on-the-job training. Contributing to this situation is the reality that many schools that purport to educate and train dental auxiliaries lack proper facilities, qualified faculty, and soundly structured preclinical and clinical curriculum. It would seem that if only for this reason the profession should provide increased support to auxiliary training. We go so far as to state that until the profession displays the same degree of interest, support, and responsibility toward dental auxiliary training and education that it does toward those of the dentist there is little hope that significant numbers of well-trained and highly motivated auxiliaries will enter the field.

Does all of the foregoing mean that today's auxiliaries are of only marginal competence and capability? Indeed not. In fact, the dentist's increased productivity and the better quality of dental care available today attest to the dedication, intelligence, and drive of today's auxiliaries. What it does mean is that under the present office-based training system, no important expansion in auxiliary duties can be expected. Dental auxiliary educators have made great strides, working with limited resources and guidance; what is needed now is to give them the tools to finish the job.

It is not surprising to note that little change in state dental practice acts has been seen in recent years regarding expanded duties. Some states are adopting a more conservative interpretation of regulations with wording open to more than one view.

Perhaps it is useful to remind ourselves of the far-reaching influence and effect of the Flexner report on the practice of medicine and the training and education of physicians. Abraham Flexner and his colleagues undertook a five-year investigation of medical schools, reporting their findings in 1910.[4] They found that medical education ran the gamut from diploma mills to glorified apprenticeships to schools providing rigorous training and education. No or few standards existed, and where they did exist they were rarely enforced. One effect of the Flexner report was the establishment of a set of minimum standards for all schools of medicine. Subsequently, dental schools and schools of dental hygiene established corresponding standards, with the result that

there was reasonable assurance to the public that a graduate of such schools would be qualified to serve the dental needs of the public.

Insofar as dental auxiliary schools are concerned, standards do exist; however, compliance with them is voluntary, as is application for certification. As matters stand, a dental auxiliary need not be certified, and the consequences of lack of certification in the present job market are minimal.

Though we can do little more than decry the present situation and attempt to offer some insight as to why dental auxiliary education in general and expanded duty training in particular are in their present state, there is much that an individual dentist, dental auxiliary, or student can do. The credo for auxiliaries committed to both individual improvement and quality standards for all auxiliaries must be "dedication to excellence." Discipline toward the work and striving for excellence will do more than any other single factor to raise the level of the dental auxiliary and prepare the way for the eventual acceptance of expanded duties.

SUMMARY

1. Shortage of dental manpower not apparent on countrywide scale
2. Federal capitation grants to dental schools have resulted in increased class size and larger numbers of graduates
3. Dentist productivity increases as result of DAU
4. Reasons for de-emphasis on expanded duty functions:
   a. Chairside auxiliaries often trained on-the-job
   b. Minimal adherence to established standards for dental auxiliaries
   c. Certification not required
5. Continuing commitment to high standards of patient care gives best assurance of eventual acceptance of expanded duty concept

NOTES

1. U.S. Bureau of the Census, Statistical Abstract of the United States: 1978 (99th ed.). Washington, D.C., 1978.
2. The Carnegie Commission on Higher Education: Higher Education and the Nation's Health. New York, McGraw-Hill, 1970, p. 13.
3. Getting Through Public Education Program. Chicago, American Dental Association, January, 1979.
4. Flexner, A.: Medical Education in the United States and Canada. Carnegie Foundation for the Advancement of Teaching, 1910. Reproduced by Science and Health Publications, Washington, D.C., 1960.

2
CLINICAL RECORD-KEEPING

Sherri Young Dunbar

Is this patient allergic to anesthetic?

What antibiotic did I prescribe last time?

How did my patient react to the treatment last time?

Did I mention the plaque control program?

How much gingival recession did this patient have six months ago?

What did I tell the parents about orthodontic treatment?

How are these questions answered in your office? Often the answers are hidden in the memories of the dentist and the auxiliaries or they are recorded in abstract hieroglyphics on the service or treatment chart. A casual approach to record-keeping does not supply the dentist with sufficient information to protect the patient from injury, does not ensure that the patient is given all the information about his oral condition, and consequently would not protect the dentist and his employees from malpractice suits.

What needs to be recorded? Who records it? How is it recorded? Where is the information stored? Who has access to it? Although both clinical and business records are needed in a dental practice, this chapter will focus on clinical records. For each patient these would include (1) diagnosis of all oral-related problems; (2) the plan for treatment or nontreatment; (3) the treatment completed at each visit; (4) the treatment to be scheduled for the next visit; and (5) notes relating to behavior, treatment problems, patient reactions, etc.