MINUTES OF THE MEETING
SENATE PUBLIC HEALTH, WELFARE AND SAFETY
MONTANA STATE SENATE

FEBRUARY 1, 1985

The meeting of the Public Health, Welfare and Safety Committee was called to order by Chairman, Judy Jacobson, on Friday, February 1, 1985 in Room 410 of the State Capitol at 1:00 p.m.

ROLL CALL: All members were present for the meeting. Karen Renne, staff researcher, was also present.

There were many, many visitors in attendance. See attachments.

ACTION ON SENATE BILL 121: This bill is an act to authroize the Department of Social and Rehabilitation Services to administer all funds allocated to the Department for residential alcohol and drug treatment for indigent youths in need of care, youth in need of supervision and delinquent youths and providing an effective date.

Senator Towe question whether or not the bill should perhaps be amended.

A motion was made by Senator Towe that the bill be amended on page 3, line 5; following: "associations"; insert: "or private organizations". Motion carried, with all senators voting "yes" with the exception of Senator Lynch who voted "no".

Senator Lynch expalined that he liked the bill as is in the present form.

A motion was made by Senator Norman that SB 121 receive a DO PASS AS AMENDED recommendation from the Comittee. Motion carried.

A motion was made by Senator Norman that the Statement of Intent be adopted for Senate Bill 121. Motion carried.

CONSIDERATION OF SENATE BILL 214: Senator Joe Mazurek of Senate District 23, the chief sponsor of SB 214, gave a brief resume of the bill. This bill is an act permitting certain dental hygienists to administer local anesthetic agents;

removing the requirement that an applicant for a license to practice Dental Hygiene submit to an oral interview and providing an effective date.

Senator Mazurek stated that this bill does what most other western states are already doing. Anesthetic is to make a patient more comfortable. This would utilize what they have learned in dental hygiene school.

The oral interview does not serve any useful purpose. This entire bill is permissive legislation.

Don Allen, representing the Montana Denal Hygienist, stood in support of the bill.

Peggy Newman, representing the Montana Dental Hygienists' Association, stood in support of the bill. She stated the Association feels that the changes in the Dental Practice Act, as addressed in the bill, would be beneficial to the dental consumer of Montana, as well as the dental hygiene professional. The dental hygienists is the preventive professional in the dental delivery system. Mrs. Newman handed in a package of facts and testimony to the Committee for their consideration. See attachments.

Patti Conroy, Legislative Chairman and past president of the Montana Dental Hygienists' Association, stood in support of the bill. Local anesthesia is frequent necessary as an adjunct to the oral prophylaxia and periodontal treatment currently provided by dental hygienists. Research continues to demonstrate the importance of establishing a clean, smoothly planed root surface in order to create an environment for optimal oral health. Local anesthesia is often essential to the comfort and well-being of the patient in order to complete these delicate and occasionally uncomfortable procedures. There are benefits to the consumer, to the dentists and to the dental hygienist. See written testimony with the attachments.

Valerie Olson, vice president of the Montana Dental Hygienist Association, stood in support of the bill. She received her school at the University of Oregon Dental School. In Oregon dental hygients are allowed to administer anesthesia which she was allowed to do. However, when she moved back to Montana she was no longer permitted to do that in which she was trained. See attachments for written testimony.

Douglas C. Smith, a dentist, stood in support of the bill. He stated that he practiced general dentistry and had for eleven years in Bigfork, Montana utilizing dental hygienists within his office. He left the practice of general dentistry and completed a medical residency in Boston in anesthesiology. He presently practices anesthesiology in North Western Montana providing sedation and general anesthesia for dentists and oral surgeons in northwest Montana. He stated that he is a strong supportor of allowing dental hygienist to provide local anesthesia for dental procedures providing the hygienists fulfulls the education requirements provided by training in situations and approved by the Board of Dentistry. The Board of Dentistry will provide requirements in rules and requlations to handle any complications resulting from the administration of local anesthesia under the supervision of the dentist.

David Tawney, a members of the Montana Board of Dentisry, stood in support of the bill. He stated that he was not speaking for the board but rather expressing his personal views on registered dental hygiensts administering local anesthetics. In his office they feel that the best service they can render to their patients is education. They teach people how to care for themselves and prevent dental disease. Prevention is the general theme of a good dental practice. Allowing dental hygienist to administer local anesthesia will improve the dentists ability to do a better job of prevention and provide a better service to the public. Dr. Tawney handed in written testimony for the Committee to review. See attachments.

Tom Christensen, a member of the Montana Dental Hygienist Association, stood in support of the bill. He stated that he agrees with allowing dental hygienist the right to administer anesthestic and also favors the removal of the oral interview from licensing requirements. It is expensive to wait for this interview and the questions are irrelevent. Hygienists have the training to administer anesthetic. Most important it gives the dentist a choice in the manner. It would increase patient comfort and increase quality care.

Roger Tippy representing the Montana Dental Association stood in support of the bill. There are 400 dentists which are members of the Montana Dental Association. The Asssociation takes no position on Section I, however they do support Section 2.

With no further proponents, the chairman called on the opponents.

Dr. Jim Olson, President of the Board of Dentistry stood in opposition to the bill. He stated that the Board was split in their decision on their stand on this bill. The Board's job is to protect the public. He assured the Committee the oral interviews would be more meaningful in the future. He handed in a letter of Jeannette Buchanan, a registered dental hygienist on the Board of Dentistry. See attachments.

Sharon Diezinger, represent the Montana Nurses Association, stood in opposition to the bill. She stated her group has some question regarding the language in the bill and also the question of passing a law that is in conflict with the Montana Nurse Practice Act which places the act of administering medications under the license of the Registered Nurse or Licensed Practical Nurse under supervision of a RN. However, under their own Practice Act neither RN's nor LPN's administer local anesthesia unless they are a Certified Registered Nurse Anesthetist. Mrs. Diezinger handed in written testimony. See attachments.

With no further opponents,the meeting was opened to a question and answer period from the Committee.

Senator Towe asked Mrs. Diezinger why the Nurses Association took the stand they did. She stated that it is in the law. Senator Towe then asked where in the law. She could not answer his question.

Senator Stephens asked Dr. Olson about the oral interview. He was told that the Board of Dentistry is just caring out a legislative mandate by doing the interview.

Senator Hager asked Dr. Olson if the oral interview could be done over the phone. No answer was given.

Senator Newman asked if all dental hygienists are trained to give anesthestia. Yes, they have been receiving training in this field since 1970 aproximately.

Senator Newman asked how much more training would be required for those not trained in pain control. It would take one semester or 2 quarters of training.

Senator Mazurek closed. He stated that he feels that this is a very worthwhile bill and asked the Committee to give it favorable consideration.

CONSIDERATION OF SENATE BILL 226: Senator Judy Jacobson of Senate District 36, the chief sponsor of SB 226, gave a brief resume of the bill. This bill is an act to generally revise the law relating to the Board of Hearing Aid Dispensers; providing a continuing education requirement; revising the trainee license law; and giving the Board authority to fine licensees.

Darrel Micken, representing the Montana Hearing Aid Society, stood in support of the bill. He stated that this bill will strengthen the consumer's protection. It will improve the training. Six months training is not enough. Mr. Micken favored the fact that under this provision everyone, excluding medical doctors, would be required to take a test. He handed in a letter from Dr. Charles Parker which he read to the Committee. See attachments.

Betty Hilner, a licensed audiologist, stood in support of the bill and the proposed amendments.

Dudley Anderson, representing himself and the Montana Hearing Aid Dispensers Board, stated that the consumer, often elderly and sometimes vulnerable as individuals, deserve competant service. Hearing problems are medically related, complicated problems and ofter cause a breakdown in social involvement. Relations and contact with the world, neighbors, relatives, and loved ones are often impaired. Mr. Anderson handed in written testimony for the record. See attachments.

Christian Grover, an audiologist, stood in support of the bill. Mr. Grover stated that for consumer protection he supports minimal competency and enforecement of disciplinary actions.

Dr. William Simic stood in support of the bill.He is a member of the Montana Board of Hearing Aid Dispensers. The Board members have a duty to the public of the State of Montana. A high percentage of the people taking the exam do not pass.

Enforcement of complaints concerning violations come from 2% of the people. The provision regarding the fine will help with the enforcement.

William Fowler, representing the Montana Hearing Aid Society, stood in support of the bill. He stated that there were aproximately 1,000 hearing aids in Montana last year. He stated that this bill will upgrade the quality of care for the people of Montana.

With no further proponents, the chairman called on the opponents. Hearing none, the meeting was opened to a question and answer peiod from the Committee.

Senator Towe asked how many opthamologists there are in the State of Montana at the present time. There are about 25-30 opthamologists.

Senator Hager asked about the provision regarding ethical conduct. This will deal not with their private lives but the dispensers public life in dealing with the people of our state.

Senator Jacobson closed.

ANNOUNCEMENTS: The next meeting of the Public Health, Welfare and Safety Committee will be held on Monday, February 4, 1984 in Room 410 of the State Capitol.

ADJOURN: With no further business the meeting was adjourned.

Judy Jacobson

SENATOR JUDY JACOBSON, CHAIRMA

eg

ROLL CALL

PUBLIC HEALTH, WELFARE & SAFETY COMMITTEE

49th LEGISLATIVE SESSION -- 1985 Date 2-1-85

SENATE SEAT #	NAME	PRESENT	ABSENT	EXCUSED
6	SENATOR JUDY JACOBSON, CHAIRMAN	✓		
5	SENATOR J. D. LYNCH, V.CHAIRMAN	✓		
42	SENATOR TOM HAGER	✓		
30	SENATOR MATT HIMSL	✓		
17	SENATOR TED NEWMAN	✓		
45	SENATOR BILL NORMAN	✓		
14	SENATOR STAN STEPHENS	✓		
26	SENATOR TOM TOWE	✓		

Each day attach to minutes.

STANDING COMMITTEE REPORT

FEBRUARY 1, 19 85

MR. PRESIDENT

We, your committee on PUBLIC HEALTH, WELFARE AND SAFETY

having had under consideration SENATE BILL No. 121

FIRST reading copy (WHITE color)

SRS TO ADMINISTER YOUTH ALCOHOL AND DRUG ABUSE TREATMENT FUNDS

Respectfully report as follows: That SENATE BILL No. 121

be amended as follows:

1. Page 3, line 5.
Following: "associations"
Insert: " or private organizations"

AND AS AMENDED

DO PASS

~~DO NOT PASS~~

STATEMENT OF INTENT ADOPTED AND ATTACHED

SENATOR JUDY JACOBSON
Chairman.

FEBRUARY 1, 1985

MR. PRESIDENT:

WE, YOUR COMMITTEE ON PUBLIC HEALTH, WELFARE AND SAFETY HAVING HAD UNDER CONSIDERATION SENATE BILL NO. 121, ATTACH THE FOLLOWING STATEMENT OF INTENT:

STATEMENT OF INTENT

SENATE BILL 121

A statement of intent is desirable for this bill to clarify the existing rulemaking authority granted to the department of social and rehabilitation services under section 41-3-1103(2)(c), MCA, as it applies to the proposed amendment to section 41-3-1103(1), MCA.

The department of social and rehabilitation services may adopt rules to carry out the administration of all funds appropriated and allocated to the department to pay for residential alcohol and drug treatment for indigent youths in need of care, youths in need of supervision, and delinquent youths who require such treatment.

It is contemplated that the rules shall address the following:

(1) criteria for determining whether residential treatment for alcohol and drug abuse is necessary and appropriate in each case;

(2) criteria for determining whether the youth's family is indigent; and

(3) procedures for administering the funds.

SENATOR JUDY JACOBSON, CHAIRMAN

DATE ____________

COMMITTEE ON ____________

VISITORS' REGISTER

NAME	REPRESENTING	BILL #	Check One: Support	Oppose
Dr. Douglas Smith	Montana Dental Hyg.	214	yes	
Toni Christensen RDH	~~MDHA~~ Dental Hygiene Ass.	214	yes	
Rhonda Owen-Zook R.D.H.	Montana Dental Hygiene Ass.	214	yes	
Kelly Kemmer		214	yes	
Alyson Tawney		214	yes	
[illegible]	Helena Easter Seal Soc.	226	yes	
Peggy Newman	Montana Dental Hygienists Assoc.	214	yes	
Valerie B Olson	Montana Dental Hygienists	214	yes	
Ruth J Conroy	Montana Dental Hygienists	214	yes	
Jo Anne Fair	Mt. Dental Hygienists Ass	214	yes	
[illegible] Seyer	MT. Dental Hygienists Assoc	214	yes	
Roger Tippy	Mont-Dental Assn.	214	yes (S2)	
[illegible]	MT Medical assn	214		
Don Allen	Mt. Dental Hygienist Assn	214	yes	
Christian Driver	Mt HAG AID Society	226	yes	
Ruth Meyer	MNA	214		✓
Gretchen Fitzgerald	MNA	214		
Marty Rhea	MNA	214		
Deb Rainey	Mont Dent Hyg	214	yes	
Marjorie Foran	Mont Dent Hyg	214	yes	
Michele Olson	MDHA	214	yes	
Julie Jedeloo	MDHA	214	yes	
Odette Peterson	MDHA	214	yes	
Rebecca Lochbyer	~~MDHA~~ RDH in MT.	214	yes	
Wm. Hand	M.H.A.S.	226	yes	
J W Olsen DDS	Mont State Dental Bd	214		✓

(Please leave prepared statement with Secretary)

DATE _____

COMMITTEE ON _____

VISITORS' REGISTER

NAME	REPRESENTING	BILL #	Check One	
			Support	Oppose
Jim Cook	Tom Asay Rep.	Z14		
Darrell Micken	Self HI Hwy Aid Soc	226		
Dudley Anderson	Self & hearing aid dispensers Board	226		
~~Donna Wade~~	~~M~~			

(Please leave prepared statement with Secretary)

(This sheet to be used by those testifying on a bill.)

NAME: Don Allen DATE: 2/1/85

ADDRESS: Helena

PHONE: 449-4795

REPRESENTING WHOM? MT. Dental Hygienists' Assn.

APPEARING ON WHICH PROPOSAL: SB 214

DO YOU: SUPPORT? ✓ AMEND? _____ OPPOSE? _____

COMMENT:

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

(This sheet to be used by those testifying on a bill.)

NAME: Peggy Newman DATE: 2/2/85

ADDRESS: Box 1155 Columbia Falls MT 59912

PHONE: 892-3113

REPRESENTING WHOM? Montana Dental Hygienists' Association

APPEARING ON WHICH PROPOSAL: SB 214

DO YOU: SUPPORT? ✓ AMEND? _____ OPPOSE? _____

COMMENT: Testimony as prepared.

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

SB 214

DENTAL HYGIENISTS
PRACTICING FOR THE PATIENTS' PROFIT

What is a Dental Hygienist? Dental Hygienists are a group of concerned professionals dedicated to providing educational, clinical, and therapeutic oral health services to the public.

What qualifications do Hygienists possess? Dental Hygienists graduate with an Associate degree or a Bachelor degree from accredited colleges and universities. After graduation hygienists must take and pass the National Dental Hygiene Board Examination, a regional clinical examination and a Montana written examination. They have been thoroughly educated and tested and have been found qualified to practice dental hygiene.

What does a Dental Hygienist actually do? Montana Dental Hygienists provide treatment and education to prevent oral diseases such as cavities and periodontal disease (gum disease). A few of their routinely performed functions are:

*Removal of plaque, stain, and calculus both above and below the gum line.
*Application of cavity-preventive agents such as fluorides and dental sealants.
*Plaque control instruction and development of personal oral hygiene programs for home care.
*Exposure and processing of dental x-rays.
*Placement of temporary fillings, periodontal dressings, removal of sutures, and polishing of silver fillings.
*Provide nutritional information.
*Oral cancer and blood pressure screening.
*Root planing and gum curettage.

Why do Montana's Hygienists feel this bill is important? Their primary concern is to give the public the finest dental care possible. Pain control in the dental office is of the utmost importance and is beneficial to the patient.

Montana Dental Hygienists' Association

FACT SHEET

SB214

A bill for an act entitled: An act permitting certain dental hygienists to administer local anesthetic agents; removing the requirement that an applicant for a license to practice dental hygiene submit to an oral interview.

Reasons for Deletion of Oral Interview:

1. Delays employment
2. Financial hardship for applicants
3. Not used for pass/fail in licensure procedures
4. Complaints of irrelevant, discriminatory questions

Administration of Local Anesthesia by Dental Hygienists:

1. Thorough cleaning of tooth root surfaces is the best method of treating and preventing periodontal (gum) disease. Ninety percent of the adult population in the United States suffer from periodontal disease. It is the primary reason for tooth loss after age 35. It is essential for hygienists to have the ability to use all procedures necessary to carry out their role in preventing and controlling the disease. The administration of local anesthesia is one of these procedures.
2. Benefits
   A. Consumer
      1. Pain control during uncomfortable periodontal procedures
      2. Uninterrupted treatment
      3. Cost efficiency
   B. Dentist
      1. Decreases interruptions
      2. Option of delegation of this duty
      3. Direct supervision requirement
   C. Dental Hygienist
      1. Utilization of learned skills
      2. Better utilization of time
      3. Ease of patient management
3. Educationally qualified to administer local anesthetics. Continuing education programs available in local anesthesia administration. Most dental hygiene schools offer training in local anesthesia.
4. Montana is the only western state which does not allow this function.
5. This issue is under consideration in 13 other state legislatures.
6. No legal actions or complaints in any of the states which allow this function.
7. The majority of Montana dental hygienists are in favor of this proposal. This information taken from several surveys over the last few years.
8. This proposal is supported by many Montana dentists.
9. The administration of local anesthesia by dental hygienists is supported by The American Dental Hygienists' Association, and the Council on Dental Education of the American Dental Association.
10. Education standards and examination requirements for certification in this area would be established by the Board of Dentistry.

"DENTAL HYGIENISTS --- PRACTICING FOR THE PATIENTS' PROFIT"

Montana Dental Hygienists' Association

To: Legislative Committee Members
From: The Montana Dental Hygienists' Association
Re: Testimony in Support of Senate Bill 214

Chairman, Committee Members, and Guests,

The Montana Dental Hygienists' Association supports Senate Bill 214. The Association feels that the changes in the Dental Practice Act, as addressed in the bill, would be beneficial to the dental consumer of Montana, as well as to the dental hygiene professional.

Direct benefits for the dental consumer would be the cost containment of dental health care services.

1. Less visits required to complete dental health services.
2. Less overtime for dental hygienists, thus reducing overhead costs which are covered by patient fees.
3. Increased patient comfort.

The dental hygienists is the preventive professional in the dental delivery system. In Montana, the majority of dental hygienists are employed in a private practice setting. We work directly with the public to prevent tooth and gum disease. Gum disease (periodontal disease) is fast replacing tooth decay as the major dental problem facing most Americans. Treatment of this condition involves a thorough cleaning of the teeth (oral prophylaxis). It becomes necessary to slip an instrument deep beneath inflammed gum tissues, remove the debris that has collected on the root of the tooth, (root planing) and remove diseased gum tissues that is next to the root of the tooth. (curettage)

This type of treatment is painful. Dental hygienists can administer local anesthetic agents which would eliminate this this discomfort. It is within our scope of practice. We have the education and the skills necessary to perform this function.

Senate Bill 214 -- Local Anesthesia, Section 1.

1. "Certain dental hygienists" defined
2. "Direct supervision" defined
3. Options to patients, dentists and dental hygienists

Senate Bill 214 -- Elimination of the Oral Interview, Section 2.

1. Interview Situation
2. Objectivity
3. Types of Questions
4. Cost and Inconvenience to Candidate
5. Delay in Employment

The Montana Dental Hygienists' Association supports Senate Bill #214. This support is based on Association policy adopted by the members of the Montana Dental Hygienists' Association.

MDHA supports the administration of local anesthesia as an expanded duty for dental hygienists. (adopted May 1982)

MDHA supports the concept of a Board of Dentistry local anesthesia endorsement. (Adopted May 1982)

MDHA supports the concept of a licensing process which does not unduly restrict the dental hygiene candidate from future employment possibilities. (Adopted May 1981)

We urge the members of the Committee to review carefully the data and the testimony that is being presented and support Senate Bill 214.

Thank you.

Peggy Newman, R.D.H.
President

THE OREGON HEALTH SCIENCES UNIVERSITY

School of Dentistry
Department of Dental Hygiene

611 S.W. Campus Drive Portland, Oregon 97201 (503) 225-8895

December 18, 1984

State of Montana Legislature

Dear Legislator:

The purpose of this letter is to offer information on administration of local anesthetic agents by dental hygienists, for your consideration in acting on legislation proposed by the Montana Dental Hygienists' Association. I am the Director of the Dental Hygiene Program and Chairman of the Dental Hygiene Department at the Oregon Health Sciences University. I have held the position since January, 1977. Prior to that time, I was Assistant Secretary of the American Dental Association's Council on Dental Education and Commission on Dental Accreditation. The assistant secretary has administrative responsibility for development and implementation of Association policy related to education, utilization and practice of dental assistants, dental hygienists, and dental laboratory technicians. I was employed by the American Dental Association for seven years and during that time drafted educational standards for basic dental hygiene education and expanded function dental hygiene education as well as standards for education in the other dental auxiliary fields. It was my responsibility to oversee the evaluation and accreditation of dental hygiene education programs which required that I visit programs on a routine basis and that I be familiar with the curricula of all programs across the country. It also was my responsibility to maintain information on legal provisions for performance of "expanded or new functions" by dental assistants and dental hygienists in all states and U. S. territories.

Dental hygiene education provides the science background required for teaching administration of local anesthetic agents. When the Oregon Dental Practice Act was amended in 1972 to allow dental hygienists to administer local anesthetic, instruction in the procedure was incorporated into the dental hygiene curriculum. That instruction includes review of the anatomy of the head and neck, pharmacology of anesthetic agents and their interaction with other drugs, management of adverse effects and emergencies; and techniques of administering anesthetics. In the fourteen years that the Oregon Health Sciences University Dental Hygiene Program has been teaching local anesthetic administration, there has never been an adverse reaction. In fact, there has never been a reported life-threatening reaction to administration of local anesthetic by a dental hygienist in Oregon or any of the other states in which hygienists are performing this function.

Certainly, the benefits to the public and their well-being are the most important concerns in considering the question of whether the dental hygienist should administer local anesthetic agents. It is well documented that thorough root instrumentation in the form of "root planing" is the best method of preventing advancement of, and treating periodontal disease. Ninety percent of the adult population in the United States suffer from periodontal disease. It is the primary reason for tooth lose after age thirty-five. Hygienists play a key role in preventing lose of teeth from periodontal disease and it is essential that hygienists have the ability to utilize the adjunct procedures that are necessary to carry out their role in preventing and controlling the disease. There is considerable evidence to support the fact that hygienists can administer local anesthetics without harm. To deny hygienists the opportunity to

administer local anesthetics is not in the best interest of the public. In many instances, hygienists are not able to perform the extensive root instrumentation they are legally and ethically responsible for without the use of local anesthetic. Without legal authority to administer local anesthetics, dental hygienists are "by law limited to patient neglect".

The provision in Oregon law for dental hygienists to administer local anesthetic agents has improved the quality of dental hygiene care provided to the citizens of Oregon, as well as their access to care. In Oregon, dental hygienists practice with general supervision. Thus, the dentist is not always on the premises when the hygienist is providing treatment for patients. The hygienist's ability to administer the anesthetic when it is indicated has extended availability of services to meet patients' needs, and allowed dental hygienists to practice in accord with their ethical and professional responsibility.

Respectfully submitted,

Margaret Ryan

Margaret M. Ryan
Chairman
Dental Hygiene Department
Oregon Health Sciences University

FAMILY DENTAL GROUP
10 THREE MILE DRIVE
KALISPELL, MONTANA 59901
PHONE 755-7890

January 29, 1985

Senate Public Health Committee
Capital Station
Helena, Montana

Dear Senators,

I am writing in support of Senate Bill 214; a bill for an act entitled: "An Act Permitting Certain Dental Hygienists to Administer Local Anesthetic Agents; Removing the Requirement that an Applicant for a License to Practice Dental Hygiene Submit to an Oral Interview; Amending Sections 37-4-401 and 37-4-402, MCA; and Providing Effective Dates."

I have a long history of actively seeking a rules change by the Board of Dentistry which would allow dental hygienists to administer local anesthesia in the practice of dentistry. Hygienists do perform procedures now which in many cases utilize local anesthetic, such as root curettage (root planing). A large number of periodontal patients receive these services in my practice from a well trained, competent dental hygienist and many times there are significant delays in beginning treatment until I am able to administer the local anesthetic.

Most schools of dental hygiene including Carroll College Department of Dental Hygiene train hygienists in administration of local anesthetics. That training is comparable in scope to that which is received by dental students. In addition in recent years that same training has been available through university programs for dental hygienists who were graduates prior to widespread local anesthesia training within their hygine programs. It only makes sense that hygienists should be equipped in their training to provide their patients with adequate pain control in conjunction with routine treatment.

The second issue, that of deleting the oral interview, also meets with my approval. The way the interviews have been conducted has led to little or no useful information relative to licensure of applicants, contributes to inefficiency in the licensing procedure, and has the potential of introducing unjustified bias into the licensing process.

Thank you for your consideration.

Sincerely yours,

Robert W. Bowman, D.D.S.

RWB/cbm

KEVIN P. CONROY, D.M.D.
935 LAKE ELMO DRIVE
BILLINGS, MONTANA 59101
TELEPHONE 252-4200

January 28,1985

To: Legislative Committee Members
Re: SB214

To Whom It May Concern,

I would like to express my support for SB214. In regard to the deletion of the oral interview requirement for dental hygiene licensure:

1. This has proven to be an inconvenience for dentists who wish to employ a hygienist immediately following regional board exams.
2. Hygienists often are required to forego employment for several months, causing considerable financial hardship.
3. Quite frequently the expense of making an additional trip for the interview adds to the financial hardship.

In regard to the certification of certain qualified dental hygienists administering local anesthesia:

1. A need exists for dental hygienists to administer local anesthesia to patients receiving painful periodontal procedures. Interrupting a dentist for the administration of a local anesthetic is at the least an inconvenience and at times is not possible (ie when performing surgical procedures).
2. Most dental hygiene programs now teach local anesthesia administration and excellent continuing education programs are available for those who need this type of program.
3. Dental hygienists are trained in medical emergency treatment. Under the direct supervision requirement, the dentist is also available to respond to an emergency. The administration of local anesthesia is a relatively safe procedure and should not be confused with the risks associated with administering general anesthesia.
4. Many other states now permit hygienists to administer local anesthesia, and the acceptance level is high both among the dental community and the general public.
5. The delegation of this duty is optional. Those who do not wish to utilize a hygienists' skills in this manner, have that option.

Sincerely,

Kevin P. Conroy D.M.D.

STEPHEN L. BLACK, D.D.S., P.C.
Diplomat of the American Board of
Oral and Maxillofacial Surgery
115 West Kagy Boulevard
Bozeman, Montana 59715
(406) 587-0767

1/16/85

To whom it may concern.

I wish to support legislation proposed by the Montana Dental Hygienist association which would allow appropriately trained hygienists to administer local anesthesia, under the direct supervision of their employer dentist.

Stephen L Black DDS

The Office of
Sid H. Hall, d.d.s.

Specialist in Periodontics

108 North Eleventh
Bozeman,
Montana
59715
(406) 587-2222

January 14, 1985

To Whom It May Concern,

I am personally in support of the bill in the legislature to allow dental hygienists to use local anesthetics under the supervision of their employing dentists. I feel that this bill is most reasonable and will allow hygienists to provide better care to the people that they serve. I can see nothing in the bill that is detrimental to the interests of either the public or the dentists of Montana.

I think it is important to note that under this law no dentist would be forced to allow this in his office. It only gives the individual dentist the choice to allow his hygienist to use local anesthetic if he/she so desires (and, of course, if the hygienist is properly trained and certified by the Board of Dentistry).

Thank you for your consideration of this.

Sincerely,

Sid Hall, DDS

Sid Hall, D.D.S.

DAVID L. MOVIUS, D.D.S.,M.S.D., P.C.

Practice Limited To Periodontics

January 15, 1985

To: Legislative Committee Members

Re: Local Anesthesia for Dental Hygienists

I support legislation allowing administration of local anesthesia for Registered Dental Hygienists under the following conditions:

1. Successful completion of accredited didactic course (sponsored by a university dental school) in all aspects relating to local anesthesia (e.g., pharmacology, anatomy, physiology, medical history evaluation, emergency procedures, etc.)

2. Certification of clinical competency in technique of administration of local anesthesia.

3. Board of Dentistry certificate of competency.

4. Continuing education standards.

5. Practice under direct supervision of licensed dentist.

6. Responsible dentist may elect not to allow dental hygienist to administer local anesthesia even though certified.

Sincerely yours,

David L. Movius, DDS, MSD

sb

2370 Avenue C • Billings, MT 59102 • [406] 656-2461
Rose Park Professional Building

January 24, 1985

Mr. Chairman, Members of the Committee, and Guests,

I would like to take this opportunity to voice my support of the MDHA in their campaign to amend the Dental Practice Act to allow them to administer local anesthetic under the direct supervision of a person holding a D.D.S. or D.M.D. degree.

All hygienists have at least two years of training in their profession. Many of them have spent additional years in college. This is similar to the amount of time many Registered Nurses in the state of Montana spend on their education and, as we all know, nurses are allowed to administer a wide range of injectable medications. During the two years, in most schools, the hygiene students are introduced to the various aspects involved in the administration of local anesthetic. In addition to this introduction in school each candidate will be required to complete additional training dealing only with local anesthesia, will complete and pass an examination by the Board of Dentistry, and then will be allowed to administer local only if the dentist who employs the hygienist is present and agrees. If the dentist feels that even with certification the hygienist is not qualified to administer local or if the hygienist were to use local without permission or even against the wishes of her/his employer, the employing dentist has the right not to allow that hygienist to administer the anesthetic. By setting such strict rules, I feel that the Hygiene Association has demonstrated their concern for continuing the high standard of dental care exhibited by Montana dentists. I also feel that it demonstrates great concern for that portion of the public who seek our services.

Along more practical lines, I feel that allowing this procedure would enable those practitioners who work extensively with a hygienist to have more flexibility in their practice. It would prevent their having to leave the patient with whom they are working in order to anesthetize the hygienist's patient. This allows both patients to receive more continuous care without the dentist's patient feeling "abandoned" and the hygienist's patient feeling that the hygienist "was so rough that the dentist had to numb me".

I think that we should all keep in mind that this is not designed to become a "routine" procedure. The vast majority of patients do not need anesthetic but those patients who require extensive scaling and root planing, duties usually delegated to the hygienist, could benefit immensely. These patients would be able to receive their care under optimum conditions and comfort without waiting for the dentist to have time to anesthetize. It would serve to improve the relationship between the primary care giver at that time, the hygienist, and his/her patient. No relationship can be good and no patient can be treated well or humanely when they are hurting. Also, no hygienist can be expected to do a good job under the stress of dealing with a patient who cannot tolerate the procedure.

In closing, I feel it is important, regardless of the decision of the legislature, that at this time when we have people in Montana practicing aspects

of dentistry without any formal education that we recognize the efforts of the hygienists who are not interested in "short cuts", but seek to improve themselves and their profession through proper channels and under strict control.

Respectfully submitted,

Mary R. Youngbauer, DDS

Mary R. Youngbauer, D.D.S.
Forsyth, MT

DOUGLAS S. HADNOT, D.D.S.

JACKIE S. JONES, D.M.D.

FAMILY DENTAL GROUP

SOUTHGATE MALL
MISSOULA, MT 59801

PHONE:
721-3608

January 17, 1985

To whom it may concern:

I am writing this letter in reference to the issue of Dental Hygienists Administrating local Anesthesia to their patients. As a former dental hygienist I feel very strongly about this issue. As a practicing dentist I am very much in favor of allowing dental hygienists to administer local anesthetics under the guidelines proposed by the Montana Dental Hygienists' Association. Under these guidelines the dentist and hygienist each may choose in this matter. Since not all hygienists must take the local anesthesia certification and not all dentists must allow their Hygienists to perform this duty it leaves the final decision up to the individuals involved.

Having been trained in local anesthesia as a hygienist and subsequently as a Dentist I have no doubt that the training requirements in this bill will adequately train the hygienist and protect the public.

I strongly **recommend** passage of this bill.

Sincerely,

Jackie S. Jones DMD

Jackie S. Jones, D.M.D.

ROBERT W. BERGESON, D.D.S.
ROSE PARK PROFESSIONAL BUILDING
2370 AVENUE C
BILLINGS, MONTANA 59102
(406) 652-2130

January 21,1985

To Whom It May Concern;

I am writing to state my support for the proposed legislation to allow dental hygienists in the state of Montana to administer local anesthesia.

As long as the law would provide for the necessity of meeting very stringent requirements for certification including didactic and clinical education, then I feel the hygienist is qualified for this expanded duty.

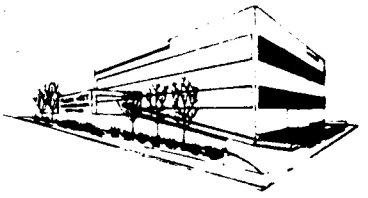
I think it is important to stress that the dentist always has the option of using this expanded duty or not. For example, I see no place for this service in my own practice now or in the future.

Sincerely,

Robert W. Bergeson D.D.S.

Robert W. Bergeson
D.D.S.

PLAZA WEST DENTAL GROUP
1537 AVENUE D
BILLINGS, MONTANA 59102
PHONE 248-7171



S D Erickson D M D
C V Gorder D D S
D G Hanson D D S
D F Mawyer D D S
M J McCarthy D D S
R S McDonald D D S
R A Miller D D S
D E Peterson D D S
M L Slade D M D

January 17, 1984

Dear Committee Members:

I would like to take this opportunity to express my support for the new legislation that would allow a Registered Dental Hygienist to administer local anesthetic under the supervision of a licensed dentist.

Dentistry faces a tremendous challenge from the voting and paying public. Specifically, "We want the best dentistry for the most people at an affordable rate!"

I feel that the only way dentistry can meet this need is to step into the more progressive era of auxiliary utilization. This will permit well trained and certified staff personnel to perform supervised duties that will free the dentist to use his training in a more efficient manner.

The foundation for the academic and technical expertise needed to administer local anesthetic has already been provided for in the curriculum of most accredited dental hygiene schools.

The bill itself provides for a Board of Dentistry approved program of certification insuring that those who need additional training or continuing education must reach that level of expertise before being certified.

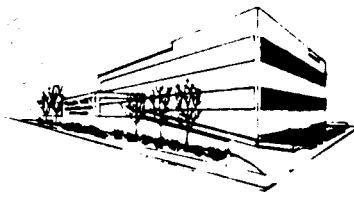
I urge you to seriously support this progressive type of legislation for passage and provide Montana with the ability to meet the new demands in dentistry.

Sincerely,

Dr. Michael J. McCarthy DDS.

Dr. Michael J. McCarthy

PLAZA WEST DENTAL GROUP
1537 AVENUE D
BILLINGS, MONTANA 59102
PHONE 248-7171



S D Erickson D M D
C V Gorder D D S
D G Hanson D D S
D F Mawyer D D S
M J McCarthy D D S
R S McDonald D D S
R A Miller D D S
D E Peterson D D S
M L Slade D M D

January 17, 1985

To whom it may concern:

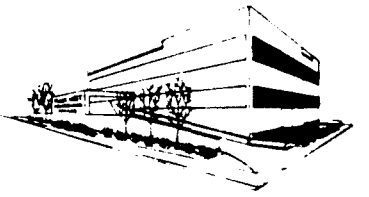
As a Montana Licensed dental professional, I urge your committee to recommend a "do-pass" on the proposed changes for the Dental Practice Act as it pertains to Dental Hygiene.

Thank you for your considerations.

D.E. Peterson, D.D.S

1537 Avenue D
Billings, Montana

PLAZA WEST DENTAL GROUP
1537 AVENUE D
BILLINGS, MONTANA 59102
PHONE 248-7171



S D Erickson D M D
C V Gorder D D S
D G Hanson D D S
D F Mawyer D D S
M J McCarthy D D S
R S McDonald D D S
R A Miller D D S
D E Peterson D D S
M L Slade D M D

January 17, 1985

To whom it may concern:

I endorse the concept of Dental Hygienists administering local anesthetic with proper training.

Cordially;

Mac L. Slade, D.M.D.
1537 Avenue D
Billings, Montana

KEVIN M. BREWER, D.D.S.
GENERAL & PREVENTIVE DENTISTRY

BILLINGS WEST PROFESSIONAL BUILDING
1650 AVENUE D • SUITE B
BILLINGS, MONTANA 59102
406-259-1509

January 15, 1985

Dear Legislative Committee Members,

I'm writing this letter in support of the Dental Hygienist's Anesthesia Bill. The hygienists are a valuable ally in the dental profession. In many instances a hygienist's work can be made easier, for the hygienist as well as the patients, with the use of a local anesthetic.

I feel the key issue here is whether or not the hygienist is trained and qualified, I see no problems - after all, she is still working under the authority of the dentist, and if the dentist does not feel comfortable with hygienist local anesthesia, then the dentist can reject this procedure from office policy.

Sincerely,

Kevin M. Brewer, DDS

Kevin M. Brewer, D.D.S.

KMB/cmb

LAWRENCE P. PENDLETON, D.M.D.
108 NORTH 11TH AVENUE
BOZEMAN, MONTANA 59715
TELEPHONE 586-5949

January 28, 1985

To Whom It May Concern:

RE: SB 214

I support the administration of local anesthesia by properly trained and qualified registered dental hygienists. The ability to administer local anesthetics would enable dental hygienists to perform their functions more effectively.

Sincerely,

Lawrence P. Pendleton, D.M.D.

Lawrence P. Pendleton, D.M.D.

GREGORY W. OLSON, D.M.D., P.C.
P.O. BOX 938
COLSTRIP, MONTANA 59323
TELEPHONE 748-2022

TO: Legislative Committee Members

FROM: Gregory W. Olson, D.M.D.

RE: Testimony for Senate Bill 214

I would like to state my full support of the Montana Dental Hygienist Bill proposing the use of local anesthesia.

These people are highly trained individuals whose profession of oral hygiene requires great skill. The skills required to do a proper scaling and or curretage are consistent with those required for proper injection technique.

Many of these individuals have already been trained and certified to give injections by accredited dental schools.

The tax payer of Montana is not getting his or her dollars' worth when a student is trained in a particualr skill and is not allowed to use this skill.

I urge you to support Senate Bill 214.

Gregory W. Olson D.M.D.

GREGORY W. OLSON, D.M.D.

American Dental Hygienists' Association
444 North Michigan Avenue, Suite 3400
Chicago, Illinois 60611 (312)440-8900

DATE: January 15, 1984

TO: Legislative Committee Members

FROM: Judy Harbrecht, RDH
ADHA District X Trustee

RE: Local Anesthesia for the Dental Hygienist

The American Dental Hygienists' Association (ADHA) is the organized National voice of the dental hygienist. As a member of the Board of Trustees of ADHA, I speak in favor of this bill.

Existing ADHA policy statements, support the efforts of the Montana Dental Hygienists' Association to seek legislative change in the Montana Dental Practice Act to allow the administration of local anesthesia by the dental hygienist.

"The ADHA believes that expansion of functions of a dental hygienist must be predicated on formal educational preparation. The licensure renewal process must represent assurance to the public that the dental hygienist has the qualifications necessary to function in an expanded role." (R-40- Am-82-H)

"The ADHA advocates that licensed dental hygienists successfully complete clinical and didactic education before performance of additional functions permitted through a change of state law." (R-9A-Am-78-H)

"The ADHA believes that in order to be most effective in the delivery of primary preventive dental care to all people, services of the dental hygienist should be fully utilized in all public and private practice settings." (R-55-Am-82-H)

"The ADHA supports the broadening of the scope of dental hygiene practice to meet the health care needs of the public in accordance with state dental and/or dental hygiene practice acts, and the ADHA encourages the implementation of the scope of dental hygiene practice through alternative methods of practice in a variety of settings which would enable the dental hygienist to become a primary care provider of preventive services, thereby delivering increased health care to a greater percentage of the population." (SR-45-77-H)

"The ADHA supports current Cardio-Pulmonary Resuscitation certification for all dental hygienists." (R-19-82-H)

"The ADHA believes that the practice of dental hygiene is an integral part of the dental health care delivery system and that services provided by the dental hygienist must be performed in cooperation with the dental profession and within the context of the overall dental health needs of the patient." (SR-42-Am-81-H)

Local anesthesia for the dental hygienist is not a new idea. Many states have allowed this expanded function for many years. In California, a dental hygienist is not eligible for licensure without being qualified to administer local anesthesia. The need has been identified, the demand by the public and the dental community has been recognized and the safety precautions for the public have been addressed.

ADHA endorses the expanded function of local anestesia for the dental hygienist under the guidelines as outlined by the Montana Dental Hygienists' Association.

2303 South Third
Bozeman, Montana
January 27, 1985

To Whom It May Concern:

This letter is to urge your support of SB 214 which would allow qualified dental hygienists to administer local anesthesia in Montana.

As a practicing dental hygienist for over twelve years, seven of those years in Montana, I have seen the need for hygienists to administer local anesthesia to relieve the extreme pain some patients experience during a thorough dental cleaning. A thorough dental cleaning known as a prophylaxis has become the treatment of choice in most cases of periodontal disease which is fast replacing dental decay as the major dental problem facing most Americans. A prophylaxis usually includes deep scaling of teeth, root planing and curettage of the gum tissues. Needless to say, these procedures commonly performeded by the dental hygienist may cause great discomfort to the patient. Presently, the dentist must interrupt treatment of his patient to anesthetize the dental hygienist's patient. This approach is disruptive to both practioners, to the patient and to the smooth and efficient operation of the dental practice.

If dental hygienists in Montana were allowed to administer local anesthesia, both the education and licensing to enable the dental hygienist to practice this function would be carefully defined and controlled by the Board of Dentistry and the schools of Dental Hygiene to insure the safety of the patient. The dental hygienists' educational background provides them with the scientific knowledge necessary to support the learning of this expanded function. The administration of local anesthesia is presently taught in most schools of Dental Hygiene including Carroll College in Helena. The practice of dental hygienists administering anesthesia in other states has proven safe, effecient and most dentists report that their patients prefer the hygienist to administer local anesthesia because of reduced discomfort during the injections.

If a dentist objects to a dental hygienist administering local anesthesia, he is free to make that a policy in his practice. But those dentists seeing the benefits of such an expanded function for dental hygienists may take advantage of the legislative enactment of SB 214. I strongly urge your support of this bill.

Thank you for your time and consideration.

Sincerely,

Sandra McAdam Morasky

Sandra McAdam Morasky, BS, R.D.H.

165 Wedgewood Lane
Kalispell, Montana 5990
January 30, 1985

Senate Public Health and Welfare Committee
Capital Station
Helena, Montana 59601

Dear Senators,

I wish to voice my support for Senate Bill 214; "An Act Permitting Certain Dental Hygienists to Administer Local Anesthetic Agents; Removing the Requirement That an Applicant For A License to Practice Dental Hygiene Submit to An Oral Interview; Amending Sections 37-4-401 and 37-4-402, MCA; and Providing Effective Dates."

I have practiced dental hygiene in the state of Montana for the past fourteen years, thirteen of which I have worked primarily with adults seeking treatment for periodontal disease. Local anesthesia is essential for patient comfort when deep root scaling and curettage are performed. In the past it has been necessary to wait to proceed (wasting my time as well as the patient's time) until my employer dentist is able to leave his patient to perform this service. With advances in education, administration of local anesthetics is now taught throughout the country in dental hygiene schools at a level equal to dental students' training and is allowed by practice acts in most Western states with no complications.

Regarding the requirement that an applicant submit to an oral interview, this has been used by the Board of Dentistry in the past for no useful purpose, and has only been an inconvenience to applicants who may need to make a special trip to Helena to "meet" the Board members. This also has a potential for creating a bias which the Board of Dentistry has worked with Western Regional Examiners to eliminate by having ananimity of all applicants during an exam.

Thank you for your consideration.

Sincerely yours,

Carol M. McGuire

Carol M. McGuire, R.D.H.

January 30, 1985

Dear Senators,

I wish to voice my support for SB 214. I am very much in favor of allowing a licensed dental hygienist, with the proper training, to administer local anesthetic agents in conjunction with dental hygiene services.

I am a dental hygienist, licensed to practice in the states of Montana and California. I am certified by the state of California to administer local anesthetic.

There are certain dental hygiene procedures that, if done correctly, can be somewhat uncomfortable for the patient. I found that the administration of a local anesthetic allowed me to deliver the highest quality of care to my patients, while they experienced the minimum amount of discomfort. It was a mutually beneficial situation, and one that would be welcome in Montana.

Sincerely,

Michele G. Kiesling, RDH

Michele G. Kiesling, RDH

January 30, 1985

RE: SB 214

Dear Senators of the Public Health Committee,

The dental hygienists of Montana would like to be allowed to administer local oral anesthetic. You may know that several other western states are presently permitting this practice.

As a registered dental hygienist in Oregon, I was certified to give anesthetic infiltrations, and I found them to be very beneficial. Some calculus (tarter) removal becomes extensive, involving scaling several millimeters below the gumline. In such cases, the gums of the patient are usually inflamed and can be painfully tender. Because gum curettage (scraping) is often performed in conjunction with calculus removal in these cases, the cleaning can be distressing. I have seen patients perspire and grip the chair until their hands turned white. The administration of a local oral anesthetic made a remarkable difference in their comfort and my ability to perform a thorough cleaning.

Timing becomes an ackward problem when the hygienist must rely on the dentist to anesthetize her patient for her. Often much of the scheduled cleaning time is lost waiting for the dentist's schedule to permit him to leave his patient.

With proper training and certification, dental hygienists could utilize a technique that would greatly help the patients of Montana.

Sincerely,

Carla Gillie, R.D.H., B.S.

Helena, Montana

February 1, 1985

PROPONENT SB-214

TO: SENATORS, PUBLIC HEALTH COMMITTEE

I urge you to vote FOR SB-214.

Passage of this bill will allow the qualified dental hygienist to administer local anesthetics as a means of pain control for the patient being treated in the dental office under the supervision of the dentist.

A well trained dental hygienist can safely provide a painless dental hygiene experience to the patient if allowed to administer local anesthetics. A painless experience will give better service to the patient.

I have been teaching local anesthesia and local anesthetic techniques at Carroll College since Fall 1979, as part of the dental hygiene educational curriculum. As graduates, these students can administer local anesthetics in California, Idaho, Colorado, Nevada and Arizona, but not in their home State of Montana.

It is my firm belief that in order to give the most complete care and treatment to a dental patient, that the dental hygienist should be allowed to eliminate any pain connected with the procedures necessary to restore a person to optimal oral health.

Vote YES for SB-214.

JO ANNE KARR, Registered Dental Hygienist

February 1, 1985

IN SUPPORT OF SB-214

To: SENATORS, PUBLIC HEALTH COMMITTEE

I urge you to vote YES for SB-214 which will eliminate the Board of Dentistry Oral Interview presently required of the dental hygienist prior to licensure. The Oral interview is a waste of the taxpayers' money. Elimination of the oral interview would eliminate the time required by the members of the Board of Dentistry to conduct these interviews, thus reducing the per diem payed to each member.

The oral interview serves no purpose toward determining the qualifications of a dental hygienist. There is no mechanism to deny licensure based on results of the oral interview.

The oral interview of a dental hygienist by the Board of Dentistry will not protect the consumer.

The oral interview of a dental hygienist by the Board of Dentistry is an illegal discriminatory practice. It should be eliminated from the statutes.

I urge you to vote Yes on SB-214.

Proponent,

Jo Anne Karr

JO ANNE KARR, Associate Professor
Chairperson, Dental Hygiene Department
Carroll College, Helena, Montana

January 29, 1985

Sandra K. Portouw R.D.H.
309 Harrison Blvd.
Kalispell, MT 59901

Senate Committe for Health and Human Services
Helena, MT 59620

Dear Committe Members

I would like to state my support for senate bill 214, which will allow licensed Dental Hygienists to administer local anesthesia. I am licensed in Oregon to perform this function, and I feel it enriches the performance of the Dental Hygienist. The People of Montana should be given the opportunity to obtain the latest skills and technology available to them.

I am opposed to the oral exam given by the board, because it did not seem pertinent to the licensing process. I was asked by the board how I liked the exam, where I would be working, and if I had any suggestions or questions for the examinators.

I hope that you will join with me in supporting bill 214 and allow it to pass through the legislature in 1985.

Sincerely,

Sandra Portouw, R.D.H.

January 16, 1985

To the Members of the Legislative Committee:

I am writing in regard to the legislation concerning administration of local anesthesia by dental hygienists. I am a graduate of a four year dental hygiene program with a Bachelor of Science degree and also have several years of experience in dental hygiene. Because of her background and training, a hygienist has the qualifications to become certified to perform this function.

There are benefits to be gained from such legislation. I consider this additional responsibilty advantageous to the profession of dental hygiene. A more important benefit would be for the dental consumer. This function could enable hygienists to provide uninterupted and more efficient care, possibly lowering costs for the consumer.

Respectfully,

Julie Ledeboer RDH

Julie Ledeboer, RDH

January 17, 1985

To whom it may concern:

I strongly urge your support of dental hygienists administering local anesthetics in the practice of dental hygiene.

The use of local anesthesia would in my opinion allow the dental hygienist to more effectively and efficiently treat patients needing subgingival scaling. The benefit would be for the patient in two areas: comfort and effectiveness of treatment. The dental hygiene operator could provide a much greater service for the patient.

Mary Lynn Eiseman, RDH

Mary Lynn Eiseman RDH
3555 Pattee Canyon Rd.
Missoula, Mt. 59803

JANUARY 17 1985

TO WHOM IT MAY CONCERN:
I am a practicing dental hygienist and would like the option of using a local anesthetic. This would enhance the comfort to the patient and it would enable me to perform a more thorough prophylaxis.
I would appreciate your positive support in passing this bill.

THANK YOU
Kim Mayes-Smith R.D.H
Kim Mayes-Smith R.D.H.

27 January 1985

TO WHOM IT MAY CONCERN:

With all the educational and licensure requirements necessary for a hygienist to become registered, it seems appropriate for her to perform the administration of local anesthetic. The hygienist is required to complete more courses in Anatomy than their sister professionals, the nurses.

Sincerely.

Carol Simensen

Carol Simensen R.D.H.

27 January 1985

TO WHOM IT MAY CONCERN:

It is my firm belief that a Registered Dental hygienist should be legally allowed to administer local anesthetic.

Nurses have been giving shots for many years. The hygienist is required to take three more courses in Anatomy than a nurse.

If one considers the educational requirements of a hygienist, there should be no doubt in anyones mind as to their ability to administer a local anesthetic.

Sincerely,

Alice K. Wynne

Alice K. Wynne R.D.H.

27 JANUARY 1985

TO WHOM IT MAY CONCERN:

If Hygienist's were able to administer local anesthetic to thier periodontal patients when they are performing periodontal scalings, they would be able to render a service to the patient under much less painful circumstances. They have been educated to perform more difficult procedures than this. They are licensed professionals capable of performing this task.

Sincerely,

Debi Nansel

Debi Nansel

To whom it may concern:

I am writing in regards to SB214 which would allow Dental Hygienists in the ~~state~~ of Montana to administer local anesthetic. I am a Dental Hygienist employed by a periodontist. We treat these patients with more severe gum disease. Due to the severity of the disease in most of our patients; we use local anesthetic on the average of two to three of my patients per day. Every time I need anesthetic for a patient I must wait till the dentist is available to give the injection. This detains my patient longer and takes the dentist away from his patient. I do not hesitate to ask for anesthetic for my patients though because most of them are older and I feel it is safer for them to have the anesthetic than deal with a traumatic dental experience. If this bill passes I feel it would benefit Dental Hygients, Dentists, and most of all the consumer; as every one likes their dental appointments to be as painless and expedient as possible.

Thank you very much for your time.

Sincerely,
Donna L. Durham,
Registered Dental Hygienist

600½ Toole Avenue
Missoula, Mt 59802
January 18, 1984

To whom it may concern:

I am writting to urge your support for the bill permitting dental hygienists to administer local anesthetic. I have been practicing in Montana for three and a half years and have worked for the Missoula City-County Health Department, the University of Montana and in private practice. Frequently I have had patients who needed anesthetic during dental hygiene procedures such as scaling and root planing. Although this is a skill I was taught in dental hygiene school, Montana is the only Western state which requires anethetic to be administered by a dentist. This results in an increase in chair time and anxiety for my patients.

The passage of this bill would be extremely helpful to hygienists and health care consumers. Your support will be appreciated and remembered.

Sincerely,

Erica Brown R.D.H.

410 Whitaker Dr.
Missoula, Mt.
5980

1-17-85

To whom it may concern:

I have worked as a registered dental hygienist in the same established dental practice for 13 yrs this June.

My most important function is as an educator in the prevention of dental & periodontal (gum & bone) disease. However as many patients do suffer with periodontal disease, there are treatment procedures that the doctor and hygienist perform. I face my limitations ~~in helping~~ the patient because of existing Montana law. If the hygienist were able to administer local anesthesia, the patient could be treated more effectively as the procedures of deep scaling and root planing are painful. The patient could be treated more completely and comfortably. The dentists time would be uninterrupted

in working with another patient.

Legalizing local anesthesia would be to the patient's benefit, take some pressure off the dentist timewise and give the hygienist greater confidence and satisfaction about the completeness of her treatment procedure.

Thank you for your time.

Sincerely

Judy Guthrie R.D.H.

Montana Dental Hygienists' Association

To: Legislative Committee Members
From: The Montana Dental Hygienists' Association
Re: Testimony in Support of SB214

Mr. Chairman, Committee Members, and Guests,

My name is Patti Conroy. As Legislative Chairman and a past president of the Montana Dental Hygienists' Association, I represent that organization in addressing the change in Section 37-4-401 of the Montana Dental Practice Act.

Local anesthesia is frequently necessary as an adjunct to the oral prophylaxis and periodontal treatment currently provided by dental hygienists. Research continues to demonstrate the importance of establishing a clean, smoothly planed root surface in order to create an environment for optimal oral health. Local anesthesia is often essential to the comfort and well-being of the patient in order to complete these delicate and occasionally uncomfortable procedures.

BENEFITS

Benefits to the Consumer

1. Patient comfort increases during root planing and curettage procedures when the tissue is anesthetized.
2. Patient apprehension, fear, anxiety, and stress levels decrease with pain control
3. Patients can receive uninterupted treatment.
4. The dental hygienist is able to do more thorough scaling when tissue is anesthetized.
5. The cost of preventive services is kept to a minimum when fewer appointments are necessary, due to better utilization of the hygienist's time.

Benefits to the Dentist

1. The dentist's time with his own patients would be uninterupted by the hygienist, enabling the dentist to provide continuous care to his patients.
2. The dentist would have the option of allowing a hygienist to perform this function, or to administer the local anesthetic himself.

Benefits to the Dental Hygienist

1. Learned skills could be utilized.
2. Better utilization of time. Time now spent waiting for the dentist to inject a patient could be used for actual instrumentation and direct patient care.
3. No compromise is made because of patient discomfort, reluctancy to ask the dentist for anesthesia, or shortened amount of productive work time.
4. Patient management is much easier. Patients are more cooperative and appreciative of the care they are receiving if they are not in pain.

REPRESENTATION

Montana hygienists have been surveyed on several occasions in the past few years regarding the local anesthesia issue. A 1978 legislative survey revealed that 96% of the respondents felt hygienists should have the opportunity to become certified

(This sheet to be used by those testifying on a bill.)

NAME: Paul Carey DATE: 2-1-85

ADDRESS: 1328 Valley Forge Billings

PHONE: 252-2336

REPRESENTING WHOM? Montana Dental Hygienists' Association

APPEARING ON WHICH PROPOSAL: SB 214

DO YOU: SUPPORT? ✓ AMEND? _____ OPPOSE? _____

COMMENT: Testimony prepared

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

(This sheet to be used by those testifying on a bill.)

NAME: Valerie B. Olson DATE: 2-1-85

ADDRESS: P.O. Box 128 Colstrip, Mt. 59323

PHONE: 748-2022 (work) 748-3245 (home)

REPRESENTING WHOM? Montana Dental Hygienists Assoc.

APPEARING ON WHICH PROPOSAL: SB 214

DO YOU: SUPPORT? X AMEND? _____ OPPOSE? _____

COMMENT:

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

Montana Dental Hygienists' Association

TO: Legislative Committee Members

FROM Valerie B. Olson, RDH, MDHA Vice-President

RE: Testimony Supporting Senate Bill 214

Mr. Chairman, Members of the Committee and Guests:

I am a practicing dental hygienist from Colstrip. I was born in Billings, went to college at the University of Montana for two years, then completed my Bachelor Degree at the University of Oregon Dental School. The state of Montana helped my education by paying the out of state portion of my tuition through a WICHE scholarship. Many of my classes at the University of Oregon Dental School were taken with the dental students who were working toward their doctorates. Together we took two quarters of Pain and Anxiety Control where we learned initially about local anesthetics, then moved on to a clinical class where we learned to give anesthesia to each other, and finally to volunteer patients.

After graduation I practiced in a private office in Portland. In addition to my routine duties of taking and developing x-rays, cleaning teeth, and patient education, I was frequently called upon to root plane and curettage teeth with gum disease. This deep scaling is very uncomfortable and is not a procedure I feel at ease doing when my patient is not numb. Because of the training at the dental school, I felt qualified to administer local anesthesia and was required to do so by the dentist I worked with. I never had a patient complaint regarding my injections and I feel my treatment was faster, more efficient, and less painful because of my ability to do the proper anesthesia.

Four years ago I returned to Montana and am the only hygienist in Rosebud County. Because of the current law, I am not able to administer local anesthesia and must rely on the dentist I work with to postpone treatment of his patient, come to my operatory and administer the numbing agent. Several times the doctor has

been in surgery and has not been able to leave his patient. These delays are inconvenient to our patients. It would be a great service if I were able to proceed with treatment free of interruption.

There have been numerous studies committed to discovering whether or not a dental hygienist is capable of administering local anesthesia with proper training. In 1973 a pilot project at Loma Linda University School of Dentistry in California selected five hygienists to receive training and then use dental anesthetic in a private setting. Dr. Richard C. Oliver was the principle investigator on the project and said the following:

> "...each of the five hygienists administered local anesthetics hundreds of times in practice over a three year period to facilitate scaling and root planing in subgingival areas. Patient acceptance was excellent, the quality of dental services improved without the pain barrier to thorough calculus removal and there was not a single untoward incident (even fainting) during the period of time. In addition, this service saved from 1/2 to 1 hour of the dentists' time each day."

Another study, The Forsyth Experiment from 1971, had similar results.

I have been trained, tested, and licensed in Oregon to administer local anesthesia and I would like the chance to do the same here in Montana. Thank you for the opportunity to present my opinion and the facts supporting the state's hygienists.

Valerie B. Olson, RDH

VALERIE B. OLSON, R.D.H.

(This sheet to be used by those testifying on a bill.)

NAME: Douglas C Smith DMD DATE: 2-1-85

ADDRESS: P.O. Box 266 Bigfork, MT. 59911

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REPRESENTING WHOM? Montana Dental Hygienists'

APPEARING ON WHICH PROPOSAL: SB 214

DO YOU: SUPPORT? Yes. AMEND? _____ OPPOSE? _____

COMMENT: I practiced general dentistry for eleven years (1970-1981) in Bigfork, Mt. utilizing dental hygienists within my office. I left the practice of general dentistry and completed a medical residency in Boston, Mass. (1981-1983) in anesthesiology. I presently practice anesthesiology in N.W. Montana providing sedation and/or general anesthesia for dentists and oral surgeons in N.W. Montana. I am a strong proponent of allowing dental hygienists to provide local anesthesia for dental procedures providing the hygienist fulfills the education requirements provided by training institutions and approved by the Board of Dentistry. I certainly feel that the Board of Dentistry will provide requirements in rules and regulations to handle any complications resulting from the administration of local anesthesia under the supervision of the dentist.

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

Douglas C Smith DMD
2/1/85

(This sheet to be used by those testifying on a bill.)

NAME: David B Tawney DATE: 1 Feb 95

ADDRESS: 3667 Fox Canyon Missoula Mont

PHONE: 549685

REPRESENTING WHOM? Self

APPEARING ON WHICH PROPOSAL: 214

DO YOU: SUPPORT? I AMEND? _____ OPPOSE? _____

COMMENT: Att.

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

February 1, 1985

Judy Jacobson, Chairman
Senate Public Health, Welfare and Safety
State Capitol Building
Helena, Montana 59620

Senate Committee Chairman and Members:

My name is David Tawney. I am a member of the Montana Board of Dentistry. Today I am not speaking for the Board, but rather am expressing my personal views on registered dental hygienists administering local anesthetics. I have practiced dentistry in Missoula for 36 years.

In our office, we feel that the best service we render to our patients is education. We teach people how to care for themselves and prevent dental disease. Prevention is the central theme of a good dental practice. Allowing dental hygienists to administer local anesthesia will improve the dentists ability to do a better job of prevention and provide a better service to the public.

I speak in support of the first part of SB 214 permitting certain qualified dental hygienists to administer local anesthetic agents.

In our general dental practice we have many patients with periodontal or gum disease. Periodontal disease is a condition which involves the destruction of bone and tissue around teeth. Most often this condition is controllable if properly diagnosed and managed. The dental hygienist plays an integral part in the management of periodontal disease. Patients with perio problems require treatment that involves more than a routine prophylaxis or cleaning. This treatment involves root planing which is a thorough scaling of root surfaces. Root planing can be a painful procedure. If a dental hygienist were allowed to administer local anesthesia, the patient would be comfortable during the procedure and the hygienist could do a more thorough job. In other words, allowing qualified hygienists to administer local anesthetic will make periodontal treatment available in the least expensive and most efficient manner.

Recent graduates of dental hygiene schools have been thoroughly trained in the use of local anesthetics. By recent, I mean within the last 10-12 years. My youngest daughter graduated in dental hygiene from Shorline Community College in Seattle last June. I have a copy of her local anesthesia text book. It is very comprehensive, including pharmacology.

The Board of Dentistry earlier discussed that stringent testing procedures be completed before a dental hygienist would be allowed to administer local anesthesia. We discussed using an exam similar to the one used in the State of Utah. I would venture to say that most practicing dentists would have difficulty passing the exam without considerable study, if they'd been out of school very long.

The inability of dental hygienists to use skills they're trained for in Montana, has kept two hygienists that I know, from practicing in this state.

The privilege to use local anesthetics will be strictly regulated and it will be voluntary. Hygienists must be certified and it will be up to each employer dentist and his or her hygienist to decide if they want to use the privilege in their practice. The dental hygienist will be under the direct supervision of the dentist. The dentist is ultimately responsible for the dental hygienist he employs.

By denying this service to Montana citizens, I feel that it is more difficult for them to obtain proper periodontal treatment in the dental office. Effective use of properly trained registered dental hygienists would also help hold down costs to patients.

The majority of Western States allows properly trained dental hygienists to administer local anesthetics. They include Colorado, Utah, California, Oregon, Arizona and Washington. Mr Chris Rose, Executive Secretary for the Washington State Dental Examiners, indicates that the Board has received no complaints concerning dental hygienists administering local anesthetics.

I feel that it is very much in the public's best interest to allow registered dental hygienists to administer local anesthetics.

I speak in opposition to the second part of SB 214 removing the requirement for an oral interview in that the Board is in the process of developing a formalized format for the interview process with the assistance of the University of Montana.

Thank you for your consideration.

Dr. David B. Tawney, P.C.
Missoula, Mt.

Changing concepts in periodontics

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Performance in clinical dentistry is based on concepts that represent understanding of current knowledge. When the basic knowledge changes, concepts should change. Change in concepts is often a delayed and painful process because concepts have a strong component of subjective rationalization. The knowledge base in any field will always be time related. There is no absolute truth in science; truth is a state of mind dependent on the scientific information available at that time, which, colored by interpretations, forms concepts. Interpretation of dental phenomena tends to rely heavily on past observations and acquired concepts, and often results of scientific trials are evaluated in light of dubious, unsubstantiated concepts that are used as yardsticks for validity. For instance, a commonly accepted concept in periodontics is that periodontal health can be maintained and loss of teeth from periodontal disease can be predictably prevented only with a gingival sulcus depth of 3 mm or less. This concept was not based on scientific research but on theoretic, deducted rationalization of observations related to the shallow sulci commonly found in healthy gingival and the likely inability of the person's plaque control to extend deeper than 2 to 3 mm subgingivally. This false concept of a magic 3 mm sulcus depth has been the cornerstone for assessment of success or failure in periodontal therapy for generations, and treatment techniques have been developed to reach this fictive goal of a 3 mm crevice regardless of cost in terms of pain, esthetics, loss of teeth, and the patient's money.

Prior to the last two decades, periodontology had a weak scientific basis. Clinical periodontics was an empirical art that retrospectively, included good and bad features, as did all practice of medicine and dentistry until the last three or four decades.

The knowledge of periodontal biology, as well as etiology and pathogenesis of periodontal disease, has advanced through concentrated research efforts, but this increase in knowledge has not been translated into appreciable betterment of periodontal health in average populations or to introduction of any revolutionary new methods for treatment and prevention. However, great progress has been made in evaluating the success or failure of various treatment and preventive procedures that have been tested in controlled experimental settings.

Old deductive concepts and beliefs have been subjected to prospective clinical trials with resultant rejection or partial acceptance. The results of increased knowledge of basic science related to periodontal biology and the clinical trials on prevention and treatment of periodontal disease demand a broad review of the concepts and scope of periodontal practice. This article focuses on common aspects of periodontal therapy that, on the basis of published research findings, should be reviewed and revised immediately. It is well understood that the old concepts have been repeated so often and with so much conviction that they have become dogmas in the minds of most people. The concepts have taken on a life of their own, and they can only be changed first in the mind of the dentist and then in practice gradually by sincere truth searching, more research, and more education.

Ten concepts that were accepted as dogmas[1] with little question until 10 years ago will be discussed. Unfortunately, they are still accepted and used as guidelines in the daily practice of most dentists, although all have been proven to be partially or completely wrong.

Dogma No. 1: Periodontal crevices that can be probed clinically beyond 3 mm are progressive lesions previously untreated or treated.

No single concept has had a more profound impact on periodontal treatment that the alleged need for a posttreatment gingival crevice no deeper than 3 mm to stop progressive loss of periodontal support. The main test for success or failure of periodontal treatment was, and still is for some, the posttreatment crevice depth, which should not exceed 3 mm. It was assumed that beyond this depth, in spite of good oral hygiene, bacteria would collect and lead to destructive periodontitis.

Longitudinal studies have shown that a posttreatment healed periodontal pocket may exist as a residual anatomic defect manifested as a crevice that can be penetrated by a thin probe for more than 3 mm without pain or bleeding and be stable over 8 years, which was the length of the trial.[2] However, this will in most instances require periodic maintenance care, as will treated pock-

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ets with less than 3 mm depth. Furthermore, some crevices will become deeper with time regardless of whether they were originally more or less than 3 mm. The critical consideration is not the crevice depth. The concept of a long epithelial attachment or epithelial adaptation in a healed periodontal pocket has evolved as a viable solution to periodontal treatment when combined with proper maintenance care.[3] This means that resective, disfiguring surgical techniques have no acceptable place in treatment of periodontal pockets. There is no experimental evidence to indicate that a treatment method aimed at surgical elimination of pocket depth is more successful for maintenance of periodontal support than a method that does not apply surgical pocket elimination. This is true regardless of good or poor postoperative care.[4,5] Arguments are often heard that the dentist wants to be sure of the best result, which includes pocket elimination, or that periodontal treatment ideally should include surgical pocket elimination. Such statements are indefensible from available scientific data.

Even more important is that the new concept of a long junctional epithelium allows treatment with good prognosis of pockets that for anatomic reasons, cannot be surgically reduced to the 3 mm limit.

The key to understanding successful maintenance of healed pockets with probable depth beyond 3 mm is to be found in the altered bacterial flora in successfully treated pockets.[6] This concept will be reviewed during a discussion of drug therapy later in this article.

Dogma No. 2: A surgical sculpturing of gingiva and bone resembling horizontal atrophy to the level of the deepest defect is needed to stop further loss of support.

This dogma is closely related to the alleged need for a 3 mm crevice depth, combined with a contour concept that has been fictively related to maintenance of periodontal health. Reduction of bone and gingival tissues to the most apical level of pockets in the involved regions of the dentition in practice meant that really deep pockets could not be treated satisfactorily except by extraction of the most involved teeth. Often pocket elimination leads to postsurgical pain, ugly root exposure, root sensitivity, and eventually root caries.

Studies in Michigan[2,7] and Goethenburg, Sweden,[8] have documented that surgical pocket elimination including bone surgery offers no advantage to maintenance of the teeth and their support compared with more conservative modalities of treatment. If patients are given the preoperative information to which they are legally entitled regarding choice of modalities of periodontal pocket treatment, it is surprising that so many give their informed consent to pocket elimination by surgery. Quality of life (esthetics and lack of pain) should be an important consideration in selection of therapy, especially if life expectancy of the teeth is not enhanced by the more complicated method. It is hard to justify disfigurement and unnecessarily painful pocket elimination with bone surgery when the results of long-term clinical trials are considered.

Dogma No. 3: Complete plaque control by the patient is needed to stop the progress of periodontitis.

Unquestionably, there is a current consensus among investigators that a cause and effect relationship exists between bacterial plaque and periodontal disease. However, not all organisms in plaque are equally pathogenic, and plaque may vary considerably in composition, not only between individuals and for different teeth in the same individual, but as related to supra- or subgingival location and how long it has been present. In addition, the effect of bacterial plaque is influenced by host responses from the patient.

A stunning effect on the rate of caries and gingivitis after repeated professional cleaning of teeth was reported a decade ago by Axelsson and Lindhe[9] and confirmed by numerous subsequent studies. The repopulation time in subgingival plaque after removal seems to be much longer for certain organisms than in supragingival plaque.[10] Although reports on repopulation of infection in pockets have not established any specific time interval for repopulation of specific organisms, it appears that a significant amount of some of the alleged pathogenic organisms, such as *B. gingivalis* and spirochetes, can be restricted by periodic professional tooth cleaning at intervals up to 3 months.[6] It also may be that the long junctional epithelium that is established after successful treatment of periodontal pockets will act as a barrier against bacterial penetration at the bottom of the treated pockets.[11] These findings coincide with our observations in longitudinal clinical trials that loss of clinical periodontal attachment in most instances can be prevented with professional tooth cleaning and topical fluoride application every 3 months without regard to the effectiveness of the patient's home care.[12] Professional cleaning should remove subgingival as well as supragingival plaque on all tooth surfaces and include subgingival polishing interproximally.[13] It should be understood that no maintenance care is 100% effective in prevention of loss of periodontal support over time for every tooth surface, with or without perfect plaque control, and bacterial repopulation rates for certain organisms are not always related directly to clinical loss or gain of attachment.

We know what can happen to the dentition of the average patient with certain degrees of periodontal loss in response to various types of treatment and well controlled maintenance care. However, for reasons yet unknown there are teeth and/or patients that do not behave as the average, regardless of good or bad oral hygiene. Loss of teeth in clinical trials has been clearly

related to residual calculus, mainly in furcations, rather than to poor oral hygiene by the patient. The immediate posttreatment results are in most instances better for patients with good oral hygiene than with poor oral hygiene,[12] but with periodic recall every 3 months, the degree of effectiveness of oral hygiene after the first year was not significantly related to maintenance of attachment levels for the teeth. Thus we now have a compensatory alternative to offer patients with less than perfect oral hygiene, which includes most patients whom we have treated for moderate to advanced periodontitis. The old concept of recall for prophylaxis every 6 months has been found to be totally inadequate for maintenance of periodontal support for such patients.[5] There is even presumptive evidence that they are better off periodontally without surgical therapy (including pocket elimination) if they are to be recalled only every 6 months for maintenance care.

Obviously some patients get along fine on 6-month recalls, and some do well without recall for years. However, reliable criteria have not yet been established for selection of such patients in populations with moderate to advanced loss of periodontal support. With a 3-month recall schedule, maintenance of posttreatment results can be assured for most treated teeth if the recall visits include complete removal of sub- and supragingival plaque and other acretions.

Dogma No. 4: Furcation involvement signifies such poor prognosis for the tooth and the adjacent teeth that extraction is preferable unless the furcation involvement can be eliminated by odontoplasty, hemisections, or amputations.

This dogma has been only partially refuted. The long-term prognosis for teeth with various degrees of furcation involvement, with or without treatment, has not been well established. However, from both retrospective and prospective studies, it appears that the prognosis is more favorable than had been assumed. In 118 first patients treated and regularly recalled over an average of 7.2 years in longitudinal studies, 17.2% of molars with various degrees of furcation involvement were lost, while only 5.7% of molars without furcation involvement were lost. None of these teeth was treated with odontoplasty or any form of sectioning. Longer term studies give different figures for survival rate. However, even with more than 20 years of observation, two thirds of such molars were still present,[14] which for most patients probably would be worth treatment, especially since root sectioning apparently has a discouragingly poor prognosis. Thirty eight teeth of 100 were lost over 10 years in one study.[15] The value of odontoplasty has not been documented. From examination of teeth lost in our studies, it is clear that all deposits in the furcation areas could not be removed, and the challenging problem is one of difficult access for instrumentation. This is one aspect of periodontal therapy where improved techniques, and possibly judicious drug therapy, may improve the prognosis for such molars.

Dogma No. 5: The deeper the pockets, the poorer the prognosis.

This concept was based on the alleged need for pocket elimination and without consideration of the benefit of the frequent recall principle. Obviously, pockets that extend almost to the apex provide poor access for root planing and cleaning, and conflict with accessory pulp canals may have a negative influence on the results. However, for single-rooted teeth, the average response to treatment of deep pockets is as good or better than that of shallower pockets.[2] The deciding factor is accessibility to the exposed root surface rather than actual pocket depth.

Dogma No. 6: The progress of advanced periodontal disease cannot be stopped by current treatment modalities.

There is convincing evidence in the literature that for most patients with advanced periodontitis and a functional dentition, the progress of loss of attachment can be stopped with a variety of treatment methods, and the average attachment levels can be maintained with regular recall care.[2] However, the progress of periodontitis cannot be stopped for every tooth for every dentition, and assurance cannot be given that no attachment loss will occur over time in every tooth without pockets.

The slight risk for loss of teeth after treatment of advanced periodontitis is mainly confined to maxillary molars and first premolars with extensive furcation involvement.

Dogma No. 7: Healing after scaling and root planing is enhanced by soft tissue curettage.

Recent studies[16,17] have clearly established that results after scaling and root planing are not significantly influenced by soft tissue curettage, either when performed as part of the scaling and root planing[18] or as a separate surgical procedure.[19] This means that time and effort spent on soft tissue curettage is wasted.

The old concept was that curettage for removal of pocket epithelium would induce connective tissue reattachment. However, it appears that the chances for connective tissue reattachment are remote, and results from recent longitudinal studies for up to 6½ years[20] indicate that even in deep pockets scaling and root planing alone will have as favorable response as surgical methods including removal of crevicular epithelium and chronically inflamed connective tissues.

Dogma No. 8: Teeth with less than 1 mm of attached gingiva will continue to lose attachment if not treated surgically.

A number of well controlled longitudinal studies

clearly demonstrate that gingival health and periodontal attachment levels can be maintained by good plaque control even in the absence of attached gingiva.[21] If all attached gingiva has been removed,[22,23] the attachment level can still be maintained, and increasing the width of the attached gingiva does not make it more "resistant" to irritation from plaque on the teeth.

Dogma No. 9: Gingival blanching as a result of lip pull indicates need for mucogingival surgery.

This faulty concept has given license to much unnecessary surgery, especially in children and prior to making complete crowns. Most patients will get along well without attached gingiva with suitable plaque control. Furthermore the zone of attached gingiva has a tendency to increase in width with increasing age.[24]

There are valid reasons for mucogingival surgery for esthetic and functional reasons in prosthetic patients, but not as a routine procedure after failing a lip-pull test.

Dogma No. 10: Teeth with increased mobility after periodontal therapy that includes occlusal adjustment should be splinted.

This concept, which is deep rooted in the mind of many dentists, has been refuted convincingly by investigators[25] and by common clinical observations. However, there is still controversy related to the significance of increasing tooth mobility and the effect of increased mobility on the immediate results of treatment of periodontal pockets.[26] The current prevailing concept, which is still open to challenge, is that increased tooth mobility with or without concomitant trauma from occlusion has little to do with the etiology and results of treatment of gingivitis and periodontitis.

In addition to the 10 listed dogmas, there are a number of controversial periodontal concepts undergoing reevaluation at the present time, and new concepts are being born as new knowledge and theories emerge.

The use of drugs in prevention and treatment of periodontal disease is the subject of extensive studies, often related to bacteriologic investigations. No generally acceptable conclusions have been reached in this complex field, and only preliminary evaluations can be offered. A number of chemicals, such as antiseptics applied supra- and subgingivally,[27] enzyme inhibitors,[28] and change of surface tension to discourage plaque adhesion,[29] may enhance local plaque control. Long-term efficacy and safety has not been established for these drugs. An exception is chlorhexidine gluconate to a certain degree, but objectionable taste, discoloring of teeth and restorations, and nonacceptance by the U.S. Food and Drug Administration rule out use of this drug in the United States.

The use of antiseptics as an adjunct to mechanical scaling and root planing has not proved to be of significant benefit. Even if chemical mouthwashes could reduce plaque accumulation to the same extent as mechanical means, it has less beneficial effect on gingival response because of subgingival reaction to mechanical approaches.[30]

Interest is currently focused on antibiotic therapy in periodontics.[31] However, the results from bacteriologic and clinical studies are bewildering, and these methods are not ready for routine clinical application. It appears that antibiotic therapy alone for periodontal disease will not give satisfactory long-term results. Antibiotics in addition to mechanical therapy may enhance the short-term response to the treatment, but a combination of mechanical and drug therapy has no long-term advantage over periodic mechanical recall therapy alone. A few patients who are recalcitrant to mechanical therapy may get some benefit from the addition of antibiotic therapy.[32] It also appears likely that tetracycline in combination with mechanical therapy for patients with juvenile periodontitis will augment the results.[33]

Problems concerning the development of resistant bacterial strains after long-term use of antibiotics are often mentioned in the literature without any established significance.[34] At the present time, tetracycline seems to be the drug of choice because of its broad spectrum of efficacy and infrequent severe side effects. However, there is a definite consensus that drug therapy, especially over prolonged time, should be avoided if satisfactory results can be obtained by mechanical therapy notwithstanding the fact that in recent years bacteria have been found to invade pocket walls.[35] The long-term clinical evidence indicates that excellent results generally can be obtained and maintained without drug therapy. Of grave concern is an unfortunate trend to compensate for inadequate scaling and root planing with the use of antibiotics.

Another controversy in periodontics concerns regenerative procedures applied to periodontal pockets. From the standpoint of scientific documentation, the value is not clear. Spectacular results of "bone fill" in intrabony pockets have been reported with or without bone implantation. The studies, however, have not been designed in such a way that specific evaluation of the results is merited.

The recently promoted allograft materials seem to be completely without scientific merit.[36]

Various acid and other "root conditioners" work well in animals but the benefit in humans has not been demonstrated in a convincing manner.[37]

SUMMARY

This article has concentrated on aspects of periodontics where research over the last decade has demonstrated that old concepts are outmoded and for the patient's benefit should be changed in clinical practice. The following statements were made.

1. Periodontal pockets do not need to be reduced surgically to a 3 mm limit to save teeth.
2. Bone and soft tissues do not need to be sculptured

to uniform horizontal atrophy at the level of the deepest pocket.

3. Treated teeth can be maintained without loss of periodontal support with less than perfect plaque control if professional tooth cleaning every 3 months is practiced.

4. Furcation involvement complicates the treatment of periodontitis, but such teeth have a better prognosis than has been commonly thought.

5. Deep pockets have a relatively good prognosis after treatment. The problem is access for efficient root planing.

6. Advanced periodontitis can be stopped in most patients.

7. Gingival curettage does not improve the results of scaling and root planing.

8. Support for teeth can be maintained without attached gingiva.

9. Gingival blanching in response to lip pull is meaningless.

10. Splinting is not needed for most teeth with increased mobility after periodontal therapy.

It was acknowledged that in other controversial aspects of periodontics scientific information still is not available to support firm concepts that may guide clinical practice. One problem in dentistry is the lag that often exists between the publication of research findings and their application in clinical practice if there is no inherent economic reward in the new procedure. Crown margins are still routinely placed subgingivally by dentists although it has been known for more than 20 years that this is a periodontal hazard.

Patients are legally and morally entitled to give consent to the proposed treatment after they have been informed of what can be expected in terms of length of life for their teeth and quality of life for themselves.

Allow patients to benefit from what has been learned in modern periodontics, and there will be fewer extractions, less surgery, and happier patients.

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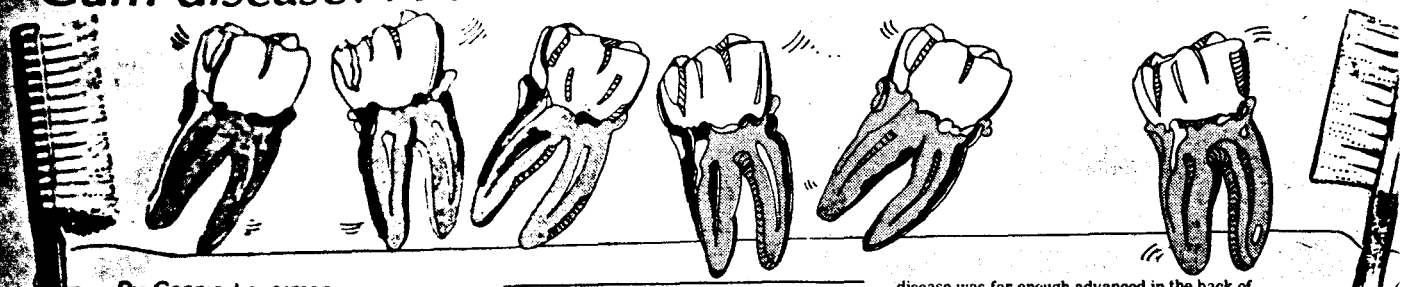
28. Wieder, S. G., Newman, H. N., and Strahan, J. D.: Stannous fluoride and subgingival chlorhexidine irrigation in the control of

Gum disease: A dental threat that can't be brushed asid



By Connie Lauerman

First of three parts

LIKE THOUSANDS of Americans, the 29-year old Chicago attorney faithfully brushed his teeth morning and night—though he admittedly was lax about visiting a dentist for regular check-ups. "I thought I was taking reasonable care of my teeth," he said. "I assumed that if I had a major problem I'd know it because it would hurt."

Several months ago, he had a dental checkup for the first time in four or five years only to discover he had been living with a false sense of security: He had gum disease. "I certainly didn't know I had it, and I didn't even know anything about gum disease and what the consequences are," he lamented.

At worst, the consequences of gum disease are tooth loss. At best, the alternative is time-consuming, expensive, sometimes painful treatments and surgery as dental specialists battle to save the teeth—if it is not already too late. Once dentures were viewed as an inevitable part of growing old. Today, false teeth can be avoided. "Dentistry is at a stage where we know how to save teeth for the lifetime of a patient," says Dr. Clifford H. Miller, associate dean of Northwestern University's School of Dentistry. "But it can't be done without the cooperation and motivation of the patient."

The invisible disease

"The possibility of losing my teeth disturbed me quite a bit," said the young lawyer. "I was also feeling prematurely senile. I take some degree of responsibility for not seeing a dentist more often. But had a dentist ever told me about gum disease and why you should floss your teeth every day, I think I would have been motivated to take better care of my teeth. The disease was far enough advanced in the back of my mouth to warrant surgery. I've had two operations on my gums so far and I'm scheduled for two more. Then I'll have maintenance therapy, which means having my teeth professionally cleaned every three months. I brush my teeth twice a day and floss them once a day."

More than 95 percent of Americans have or will suffer from some form of gum disease during their lives. Gum disease—not cavities—is the major cause of tooth loss among adults over age 35.

Even though Americans put a high premium on straight, white teeth, 50 percent of us do not visit a dentist in a given year, according to a survey by the Academy for General Dentistry.

Fear of pain and ignorance—the attitude that they are not susceptible to dental disease—are the main reasons people avoid dentists. Of those who skip regular dental check-ups, 39 per cent believe they are immune to cavities, gum disease and other dental ailments. A majority of those surveyed who were over 45—an age bracket when the incidence of dental disease increases—did not visit dentists at all.

Gum disease, technically called periodontitis, begins its destruction silently. There may be no signs, or a prime symptom—bleeding gums during tooth-brushing—may be perceived as normal.

"I thought everyone's gums bled," said a Chicago woman who has a severe case of gum disease. Such bleeding should always sound an alarm that something is wrong, but there are many cases of periodontal disease where the bleeding is not obvious and must be revealed by other symptoms or discovered by a dentist.

"That's the rub," says Dr. John Crawford, head of periodontics at the University of Illinois College of Dentistry. "It's extremely difficult to tell the very early stages of periodontal disease and impossible for the patient himself to tell. It's a very sneaky disease. The teeth can be wobbly and almost beyond recall before you start to realize it."

The first stage of gum disease is gingivitis, a superficial inflammation of the gum tissue from bacterial plaque. Gingivitis is common even in school-age children. It doesn't hurt and develops slowly.

THESE BACTERIA invade the sulcus, the space between the gum lining and the tooth. If they are not removed through brushing and flossing, the sulcus will become diseased and then it is called a pocket. At this point, the process is reversible by properly removing the plaque.

But if the disease goes deeper, it begins to destroy the bone that surrounds and supports the tooth. When the bone starts to melt away, the disease is called periodontitis. The pockets are deeper and contain more bacterial plaque. Though it doesn't cause pain, bone loss is irreversible.

Shiny, swollen or puffy gums may indicate bone breakdown. Other signs include teeth that feel loose or start to protrude or spread apart. Gums may recede from the crowns of the teeth and a painful abscess can develop when the pus that is always being formed in the periodontal pocket cannot drain out. Persistent bad breath may be another symptom at this stage.

"One of the signs is loose teeth, but by the time a patient is able to notice a loose tooth, it's too loose," says Dr. Erwin Barrington, a periodontist on the faculty of the University of Illinois' dental college who also has a private practice.

Periodontists are dentists who specialize in treating diseased gums and bone, and helping to rebuild the neglected mouth along with other dental specialists.

GUM DISEASE is nothing new. It's as old as man. The Egyptians, Greeks and Phoenicians, wired loose teeth together for support in their treatment of gum disease. But modern dental science knows enough about gum disease to take extraordinary efforts to save teeth and to try to prevent it by educating and encouraging patients to remove dental plaque by brushing their teeth properly and flossing them daily.

Dentists have gone beyond their old image as "drillers and fillers." Dental science has progressed to the point that specialists are able to transplant teeth, re-implant teeth that have been knocked out, repair fractured teeth, restore decayed or stained teeth with new, less painful methods and even straighten adult teeth.

Fluoridated water, fluoride treatments and improved nutrition have reduced the incidence of cavities dramatically. A recent survey by the American Academy of Pedodontics showed that 37 per cent of children between the ages of 5 and 12 have no cavities at all.

"Caries [tooth decay] was the principal concern of dentists 20 years ago," said Northwestern's Miller. "Periodontal disease has almost replaced caries as the principal concern. People paid lip service to it for ages, but now dentists are much more attentive to the removal of dental plaque, the cause of gum disease."

So the impetus of the dental profession now has shifted from crisis intervention to prevention. "If people take care of things, they shouldn't have any problems," said one dentist. "Prevention is cheaper than any treatment that can be done."

YEARS OF NEGLECT eventually take their toll.

"I'm furious," said a 47-year-old woman who moved to Chicago from Kentucky and found out a year ago that her mouth was such a disaster she needed two root canals and six operations; otherwise she would be wearing dentures within five years. "It could have been avoided if some dentist—like the one I was seeing every six months in Kentucky—had ever brought up the subject of flossing. I wasn't even taught how to brush properly until I came to the dental clinic at Northwestern.

"By the time I'm through I will have 19 units including bridges and crowns in my mouth and I will probably lose four teeth, maybe five. My student dentist will get 19 credits from my bridgework alone—she needs 35 [bridgework credits] to graduate. It's a long, agonizing, expensive process. It will cost me $4,970. And I'm told it would be at least twice that at a private dentist."

Dentists often blame mouth problems on patient negligence, and, of course, they are right about the patient's responsibility. But recently some patients, who are becoming increasingly sophisticated and demanding as medical consumers, have begun fighting back, challenging the competence of dentists by filing malpractice suits.

"There have been a few malpractice cases [involving undiagnosed gum disease] in the last few years but not that many," says Dr. Robert H. Griffiths, president of the American Dental Association [ADA]. " A dentist may do everything he can do, but if the patient doesn't follow through it doesn't help."

A 1975 ADA SURVEY found 23 million edentulous [toothless] people living in the United States with most of them wearing some form of dentures. But even dentures do not end periodontal problems. Wearing them eventually will result in loss of the bone that supports them and a patient needs a dentist who understands the process of bone resorption [breakdown], how to curb it and how to correct it. Each case is different, but ill-fitting dentures can contribute to bone loss in some patients.

"There are probably a lot of possibilities for saving teeth—many have been available for quite some time," said Dr Allen Anderson, associate dean for clinical affairs at the University of Illinois College of Dentistry. "Now more specialists are available and dental insurance has made these kinds of treatment available to those who could not afford it otherwise."

Much of the recent publicity about gum disease has been sparked by a debate within the dental profession about the nonsurgical gum treatment technique of Dr. Paul Keyes, a general dentist and former researcher at the National Institute of Dental Research.

Modulated and Monitored Therapy [MMT], popularly called the Keyes technique, involves phase contrast microscopy as a diagnostic tool, monitoring device and patient motivator. Via a television screen hooked up to a microscope, patients view the bacterial activity in their mouths and can monitor changes in it as their treatment progresses.

THE DISEASE itself is treated with a combination of traditional methods of scaling, root planning and curettage—procedures periodontists generally refer to as surgical even though there's no real cutting—and rigorous personal hygiene. Patients must brush and floss daily with a mixture of baking soda, salt, and hydrogen peroxide, then irrigate the gum spaces with salt solution. Keyes views traditional surgery, which involves laying back a flap of gum tissue to clean out the infection, as a last resort.

Most dentists regard the Keyes technique as experimental, noting that there is no scientific data yet to prove its effectiveness. Others discount it as just another "laetrile hoax." But most agree that anything that focuses public attention on the importance of good oral hygiene may prove helpful in the end, no matter how the Keyes technique stacks up scientifically.

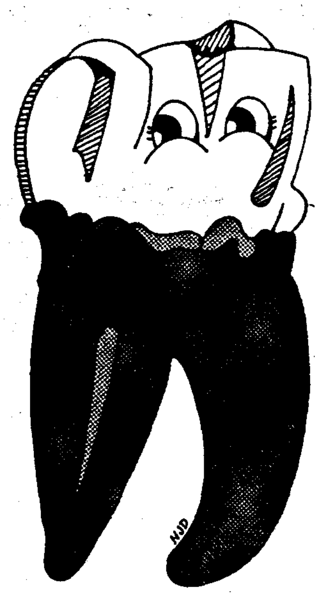
But they are dubious that the Keyes technique will work on the many unmotivated patients whose poor oral hygiene led to their gum problems in the first place.

"I've got a couple patients who come in every month to have me clean their teeth because they just can't seem to do it themselves," says one periodontist.

"It all comes down to discipline," says Dr. Kirk Hoerman, professor and chairman of preventive dentistry and community health at Loyola University School of Dentistry. "I don't care if you use tiger urine. If you get in there and disrupt things [colonies of bacteria] you can prevent gum disease. Compliance is always a problem. Flossing is a nuisance. Let's say you've got a family of six and one bathroom. Dad goes in and starts to floss and the kids start pounding on the door. He ends up not doing it."

Monday in Tempo: The Keyes controversy.

Before you go—a checkup for the dentist



CONSUMERS OF DENTAL care may have a hard time evaluating the competence of a dentist. A person who doesn't get well or has frequent relapses may quickly become suspicious about a doctor.

But careless dentistry may leave patients with a false sense of security until dental problems escalate. Even then, they may not relate their problems to the quality of previous care.

One way to evaluate a dentist is to determine if he or she is performing a thorough examination. An examination should include a visual examination of the soft tissues of the mouth [tongue, throat, cheeks as well as gums], teeth and bite; a periodontal examination in which a probe is used to measure the depth of pockets that may have formed between gums and teeth [an indication of periodontal disease]; and a full set of X-rays if you haven't had a recent set taken by a previous dentist. A medical and dental history also should be taken.

IF TREATMENT is indicated the dentist should discuss the problem, the treatment options and how much each will cost. A treatment plan should emphasize trying to save teeth rather than extraction. The best dentists are skilled in the latest techniques and, most of all, they are prevention-oriented. Be wary of dentists who send you on your way with "everything's all right; don't worry" and do not discuss your diet and oral hygiene.

"Even among dentists graduated from recognized dental schools, some are better than others," says Dr. Allen Anderson, associate dean for clinical affairs at the University of Illinois College of Dentistry. "They tend to be people able to inspire their patients. Call it chairside manner, if you will. It is a gut reaction. Of course, there are some very good dentists who don't communicate too well. If a patient doesn't feel confident, he shouldn't feel obligated to continue with that dentist."

"Patients should expect someone who is concerned about them as a whole person, not just their teeth, and who will be attuned to their problems and responsive to them," says Dr. Clifford Miller, associate dean of Northwestern University School of Dentistry.

Dentists are trained to refer patients with problems they cannot handle to specialists who can, but some of them might not for fear of losing patients. This is often true with patients who discover late that they have gum disease.

"I had been seeing a dentist four or five times a year, but still I started having severe gum problems and ended up at the periodontist's office," said a 45-year-old Chicago man who works for a sausage manufacturing company. "It was a result of either laxity or ignorance on the part of the previous guy."

PATIENTS WHO feel unsure should not hesitate to get a second opinion. "A patient may not be able to pinpoint the problem—whether it's approach or cost—but a second opinion certainly is appropriate," Anderson says. "It may end up making the patient more confident about his original dentist."

Those seeking a dentist for regular care may ask for referrals from universities with dental schools, hospitals with accredited dental services, the local dental society, family physicians or friends whose judgment is reliable.

Dentists recommend that children be brought in for a first dental exam around the age of 2½, when there is no crisis and therefore no pain involved. This can be done by a family dentist who is comfortable treating children or a pedodontist [children's dentist].

A recent trend in the delivery of dental care has been the growth of franchise dental centers, sometimes placed in department stores or shopping centers. Such centers may advertise lower fees and faster care than is usually available from private practitioners.

BULK EQUIPMENT purchases and shared overhead costs help to keep the prices down. The big question is whether dentistry practiced in such a setting will be good as well as cheap.

"There is not necessarily a relationship between cost and quality of care unfortunately," says Dr. Charles Mitchell, a Downers Grove dentist. "Some are good; some are terrible. I know some dentists in the high-rent districts of the Loop and the North Shore and the quality of care they give is not as good as in some clinics. You cannot relate fee and quality."

For those who can't afford private dental care or who do not have dental insurance, good dental care can often be obtained in hospital-based dental clinics or the student clinics at dental schools, where faculty members supervise the students' work. One patient who had extensive dental work done at a student clinic says she thinks she got better care there because a full complement of dental specialists were consultants on her case.

Connie Lauerman

'Sneaky' periodontitis starts early and takes its heavy toll late

More than 95 percent of Americans have or will suffer from some form of gum disease, called periodontitis, during their lives. Gum disease—not cavities—is the major cause of tooth loss among adults over age 35. The second of a three-part series examines what causes the disease.

By Connie Lauerman

I KNEW THERE was something wrong when at age 29 and after having four kids my teeth started to separate," explained Kathleen Wallis, 45, of Chicago. "There were big separations between my teeth. My dentist sent me to a periodontist [gum specialist] and I had some treatments.

"But in a few more years when I was 34—the year my husband died— I started having abscesses and infections. I went to see a new periodontist who said, 'Oh, you need a lot of work.'"

Wallis, who is going back to school this fall for a master's degree in industrial relations, was lucky. Dentists managed to save most of her teeth though she already had irreversible bone loss.

Arresting Kathleen Wallis' gum disease and putting her neglected mouth back together required two years of root canals, painful surgery and restorative work. Dentists had to make an appliance to pull her bottom teeth into line ["It drove me bananas; I gagged incessantly"] and eventually anchor them by using gold pin splints with crowns.

"My teeth on the bottom have almost no bone, but I still have my teeth," says Wallis. "My mother lost her teeth to periodontal disease. I used to just brush my teeth, and I had no cavities

The invisible disease

for ten years. Nobody told me about flossing. I don't fault the dentists really. I just don't think the importance of flossing was common knowledge.

"They told me they had never seen such a bad mouth without tooth loss. The thought of losing my teeth was just devastating to me. You don't grow new bone in your 30s and 40s. I used to tell my dentist, 'Who would marry a widow with four kids and no teeth?' The thought of dentures was my big motivation. I lost a couple of teeth but I could have lost them all before I was 35. I have learned not to goof off. I floss my teeth thoroughly once a day and I brush more often than they say I have to. I don't snack if I can't brush my teeth afterwards. I see either my periodontist or my dentist every three months."

Gum disease can start early in life. There is a loose collar of gum around the tooth with a small space between the gum tissue and the tooth, the sulcus, where colonies of bacteria live. If these bacteria are not removed by proper brushing and flossing, they irritate the gum lining, cau[sing] the cells to swell and separate. The gum ti[ssue] [gingiva] may look red, shiny, puffy and bleed easily, especially during toothbrushing. Th[is] early stage of destruction is gingivitis.

Gingivitis is caused by bacterial plaque, nearly invisible, slimy mesh of bacteria, [mucin], tran [a sticky material that allows bac[teria to] adhere to the tooth surface], saliva a[nd] breakdown products. When plaque har[dens] and calcifies into calculus it serves as a breeding ground for more bacteria and le[ads] to bone breakdown. Once the bone surrou[nd]ing and supporting the tooth begins to be destroyed by the disease, it is called periodon[ti]tis.

AS THE BACTERIAL colonies release [tox]ins, the gums pull away from the teeth. F[ood] debris and pus collect in the pocket betw[een] tooth and gum, allowing toxins to reach t[he] roots and destroy the periodontal ligamen[t] [which attaches tooth to bone] and the suppor[t]ting bone itself. At this point, the disease process is not reversible though it still ma[y be] treatable.

"If my gums had bled, I would have kn[own] something was wrong and I would have g[one] to a dentist sooner," said one 36-year-old Chicago man who recently discovered he has a case of gum disease that will require surgical treatment. "But there weren't any signs[,] all that I could see. I wasn't taking very g[ood] care of my teeth, but nothing hurt."

"That's the rub," says Dr. John Crawford, head of periodontics at the University of Illinois College of Dentistry. "It's extremely difficult to tell the very early stages of periodontal disease and impossible for the patient himself to tell. It's a very sneaky disease."

"My typical patient has a median age of 40 plus with moderately severe disease," says Dr. Peter Robinson, head of periodontology a[t] Northwestern University School of Dentistr[y]. "That means they'll have several areas of [50] per cent or more bone loss. Moderate dise[ase] often will show no symptoms: No pain, no swelling, no loss of function, no odd feeling. The patient might not even have bleeding gums."

Dentists usually will ask their periodonta[l] patients if their parents lost their teeth at [an] early age to gum disease.

"HEREDITY IS BEING investigated," says Dr. Erwin Barrington, a periodontist on the faculty of the University of Illinois Coll[ege of] Dentistry and in private practice. "Ce[rtain] patients may have a hereditary predisp[osition] to the disease but to say periodontal disease is hereditary is to say the common cold is hereditary.

"As people get older they tend to have a greater predisposition to periodontitis, so there could be an age factor. But the prima[ry] causative agent is bacterial plaque. If it isn['t] we'll be a long time figuring out what is."

The role that sugar and refined carbohydrates play in dental disease is not clear to scientists, but Northwestern's Robinson say[s] "If one has a diet high in refined sugar, th[is] allows the plaque a better medium to grow[,] more food for bacteria."

Although a direct link between smoking and gum disease has not been established, many experts say smokers tend to have poorer o[ral] hygiene and therefore more periodontitis. Smoke stains leave rough surfaces on the tooth to which bacteria readily cling.

Hormonal changes in pregnancy or taking birth control pills may make the gums spongy and sensitive, but the hormone activity doe[s] not lead to a progression of gum disease.

"TENSION CAN lead to periodontal brea[k]down," Barrington believes. "I've had 10 to [..] patients in the last few years who I've asked, 'What's going on in your life?' and it turns out they're changing jobs or there's some upheaval."

Treatment of advanced gum disease gener[]ally begins by restoring the tissue to a health[y] state with several procedures — root scaling, removal of calculus, plaque and other deposits from the root surface; curettage, removal of diseased tissue from the inner wall of periodontal pocket; and root planing, smoothing the tooth and root surfaces after the debris have been scaled away. Periodontists generally refer to these treatments as surgical though they involve no cutting.

If signs of inflammation persist, dentists may decide they need better access to the deeper gum space with a surgical procedure called a modified Widman flap, in which th[e] gum flap is laid back and diseased tissu[e] removed.

However, in the last few years, Dr. Pau[l] Keyes, a general dentist and former research[]er at the National Institute for Dental Research, has advocated a nonsurgical periodon[]tal therapy that has the dental community in a bit of an uproar.

The Keyes technique has been dismissed a[s]

Periodontists' new treatments come to the rescue of disease-ravaged gums

More than 95 percent of Americans have or will suffer from some form of gum disease, called periodontitis, during their lives. Gum disease—not cavities—is the major cause of tooth loss among adults over age 35. The final part of a three-part series looks at current treatments.

By Connie Lauerman

DENTAL SPECIALISTS with patient cooperation are able to arrest gum disease if they see a patient before his mouth has broken down entirely. But they cannot cure it—yet.

Periodontitis is a sneaky disease that may show few or no symptoms until it has advanced to a severe stage. Researchers now have evidence that it does not progress steadily but in a succession of active and quiescent episodes.

Epidemiological studies show that periodontal disease is more prevalent in blacks than in whites, more common in the less educated and in those with less income, more prevalent in *men* than in

The invisible disease

women, more prevalent in rural than in urban populations and more prevalent in individuals with poor oral hygiene.

However, when the data are equated for age and level of oral hygiene, the differences between race, socioeconomic status, sex and other factors tend to disappear. The most important variable in the incidence of gum disease is the level of oral hygiene.

Studies also show a close relationship between bacterial plaque and calculus and gum disease. Almost every adult and child has plaque and calculus.

THE PROGRESS OF the disease can be retarded or stopped by a combination of good oral hygiene—brushing and flossing to remove plaque—and professional dental care.

General dentists may treat mild cases of gum disease, but the more severe cases generally are referred to a periodontist, a dentist who specializes in the treatment of gums. The specialty is more than 60 years old and the number of periodontists has increased markedly in the last two decades along with scientific knowledge of the causes of gum disease and its treatment.

The periodontist may work in conjunction with other specialists: Endodontists for root-canal treatment; prosthodontists for repairing damaged teeth and replacing missing teeth and jaw structures; oral surgeons for removing teeth and lesions in the mouth, repairing fractures and for plastic surgical procedures in the mouth; and orthodontists for straightening or changing the position of one or more teeth.

In earlier stages of gum disease most of the treatment involves root scaling [removal of plaque and calculus from the root surface], curettage [literally scraping plaque and inflamed tissue in the pockets around the tooth] and root planing [smoothing the tooth and root surfaces after the debris has been cleared away].

IF FAIRLY DEEP pockets of infection remain, they can be eliminated by a minor surgical procedure called the gingivectomy. In many instances a procedure is performed in which the gum tissue in an area is lifted away from the teeth. All the underlying inflamed tissue and calculus are removed, the bone may be reconstructed to a proper shape and then the gum is replaced and sutured into proper position.

Many of the procedures have a long history, according to the American Academy of Periodontology. Removal of calculus, hardened plaque, was done in the 11th Century by Arab dentists who designed special instruments for this purpose. Flap operations to clean out infection in the gum pockets were started in the 19th *Century*.

When periodontal disease wreaks destruction around teeth with more than one root, such as a molar, it may be treated by removing the one root and retaining the others. The nerve must then be removed from the remaining roots or it might lead to an abscess of the nerves on the remaining roots. This procedure was first described in the dental literature of the 1890s, but was not used routinely until recently.

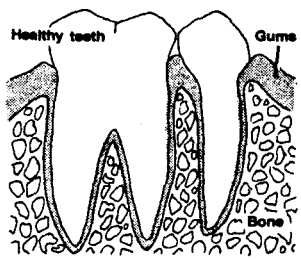
In advanced conditions, especially when some hopeless teeth have to be extracted, the remaining teeth may be splinted [joined to each other] to provide better support, using screws and metal pins.

MANY ADVANCES IN treatment have been made in the last 20 years. While treatment is aimed at eliminating the causes and effects of the disease, scientists also are working on ways to enable dentists to rebuild and replace some of the tissues that have been destroyed.

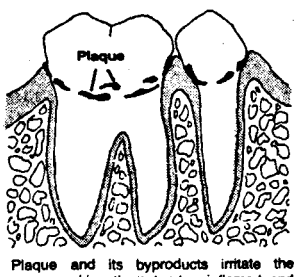
Bone grafting is a procedure used to build up missing bone. The donor bone may come from a nearby bony area in

Periodontitis

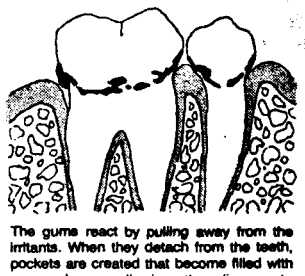
The disease that robs you of your teeth even if you have no cavities



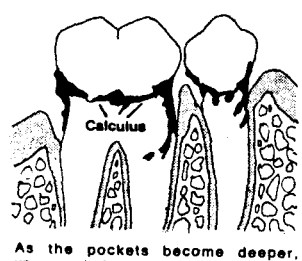
Healthy gums and bone surround the teeth—anchoring each tooth in place.



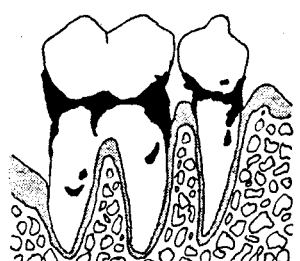
Plaque and its byproducts irritate the gums, making them tender, inflamed and likely to bleed.



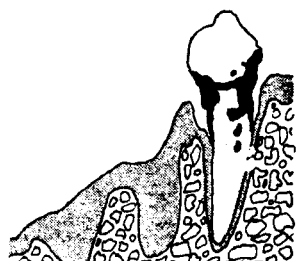
The gums react by pulling away from the irritants. When they detach from the teeth, pockets are created that become filled with more plaque, allowing the disease to worsen.



As the pockets become deeper, unremoved plaque hardens into a deposit called calculus [tartar], which cannot be removed without professional care. More plaque builds up on the calculus; calculus also makes cleansing more difficult.



Plaque now moves to the roots of the teeth. Eventually the irritants destroy the supporting bone.



Unless treated, affected teeth lose their support, become very loose, drift from their normal positions and fall out.

Chicago Tribune Graphic; Source: American Dental Association

'It's extremely difficult to tell the very early stages of periodontal disease and impossible for the patient himself to tell. It's a very sneaky disease.'

think that a lot of periodontists would agree that very deep pockets cannot be adequately cleaned out without surgery.

"One of the reasons for the controversy is probably that claims have been made and little concrete evidence in scientific form have been forthcoming. It's primarily nonsurgical nature goes against the main body of existing research."

Says Peter Robinson, head of periodontics at Northwestern University School of Dentistry:

"They [Keyes proponents] are advocating apple pie and motherhood. We all believe in plaque control. There is no data demonstrating baking soda helps. Peroxide in excess could have adverse effects."

THE EFFECTIVENESS of the Keyes method in controlling mild to moderate periodontitis is under scrutiny at the University of Minnesota, where a two-year study funded by the National Institute for Dental Research was begun in November, 1981.

The issue of motivation makes many dentists skeptical. "The major problem is getting patients to brush and floss properly," says Barrington of the University of Illinois.

"If a patient comes to me with a clipping of an article about the Keyes technique, I'll start him on it right away. But the Keyes technique has to fall down because it's so hard to motivate people."

Louis Stessl, a Chicago dentist, regards the Keyes technique as "one of a number of approaches" to periodontal problems.

"Some patients are reluctant to go to a periodontist because of cost or fear of pain—the same reasons why people don't go to general dentists. If you feel somebody is not going to be properly motivated, nothing works. I've had some nice results with the Keyes technique on patients who are cooperative. A lot of people think they can pick up salt and baking soda and end heavy periodontal problems. They can't. I refer patients to periodontists all the time."

HOWEVER, DR. Vincent Cali, a general dentist who practices in New York, believes so strongly in the Keyes technique that he wrote a book about it, "The New, Lower-Cost Way to End Gum Trouble Without Surgery" [Warner Books].

"Clinically, it works," asserts Cali. "Periodontal disease is an infection and our goal is to treat it as an infection. In periodontics you can have surgery done over and over again. The relapse rate is quite high.

"I'm not an extremist. I'm not saying 'never surgery,' but it's a valuable alternative—not second rate. It demands enthusiasm and involvement from both patient and doctor—an intangible."

The Keyes treatment includes root scaling and curettage in the dentist's office. "The periodontists now say that's a surgical technique," says Cali. "It's a matter of semantics. Periodontists have been trained as surgeons.

"The New England Journal of Medicine had an article a few months ago about how too many coronary bypass operations were being done. Years ago tonsillectomies were so common. You'd get your tonsils out at the drop of a hat. It had been the same thing with hysterectomies. I liken the Keyes controversy to [illegible]

the latest fad to hit and embraced wholeheartedly by some dentists. But most regard it as experimental, saying they're waiting to see hard scientific evidence that the Keyes technique works.

THE KEYES technique, officially called Biostimulated and Monitored Therapy [BMT], involves phase contrast microscopy as a diagnostic tool, monitoring device and patient motivator. Via a television screen hooked up to a microscope patients view bacterial activity in their mouths, the signs of periodontal infection. This sight is expected to spur the patients to follow the Keyes rigorous home-care program and then allow them to monitor changes in bacterial activity.

At home, patients must brush and floss their teeth daily with a mixture of baking soda, salt and hydrogen peroxide, then flush out the gum spaces with salt solution using a pulsating irrigation device.

For stubborn infections, Keyes advocates the use of antibiotics. Full-fledged surgery is reserved as a last resort.

"Yes, it is logical," allows Dr. John Crawford, of the University of Illinois. "But I

the patient's mouth where the bone is very thick or from the area behind the upper last teeth or even from a healed extraction site.

Scientists also are experimenting with bone marrow and tissue from patient's hips to fill in an excised area of jawbone. The hip is a readily accessible storehouse of active bone marrow and highly

'If we can learn how bacteria colonize in a person's mouth . . . we may understand how to treat periodontal disease.'

proliferative bone cells. A hematologist [blood specialist] extracts the hip marrow, which then is frozen for several weeks, partly because freezing seems to kill off certain cells that interfere with normal regeneration. The actual implantation of the marrow is done in the periodontist's office.

However, there are disadvantages. Patients may object to undergoing the biopsy and do not like the added expense. Clinically, only a limited amount of hip marrow may be extracted before the health of the hip may be impaired. And some periodontists report that after a few years, the grafted tissue may eat away at the roots of nearby teeth.

RESEARCHERS ALSO are experimenting with connective tissue from the eye called sclera, which may help the jawbone regrow damaged areas. They speculate that the firm sclera somehow acts as a framework that encourages host cells to grow and multiply at a faster pace. Periodontists must learn more about this technique before it can be put into general use, but its advantage is the availability of sclera. In thousands of cornea transplants performed annually, sclera is a byproduct that is thrown away.

At the University of Illinois' Center for Research in the Biology of Periodontal Diseases, an array of research projects are underway.

"If we can learn how bacteria colonize in a person's mouth and how to prevent that colonization, we may better understand how to treat periodontal disease and also subacute bacterial endocarditis [infection of the heart valves]," said Dr. Donald A. Chambers, director of the center.

"There are several potential antimicrobial treatments available right now. But there are other ways we could cure periodontal disease. By understanding the process of how bacteria adhere to the teeth and gums, we might be able to intervene at many different points."

Also being studied are the changes in fluids around the teeth that result in bone decay.

"PROBLEMS OCCUR WHEN the equilibrium between bone decay and regrowth is upset," Chambers said. "When a person breaks a bone, the bone usually repairs itself. We are trying to understand that ability to repair.

"The treatment for periodontal disease is aimed at arresting the disease, but we don't repair the bone already lost. We want to find out if such repair or replacement is possible."

Investigators also are seeking a chemical process that might stimulate connective tissue to reattach itself between the root of a tooth and the bone, and between the gum and the tooth.

"Our intent is to chemically treat the surface of the tooth to enhance reattachment of the periodontal membrane or ligament between the bone and the tooth and the soft tissue overlying the tooth," said Dr. Arnold Steinberg, professor of periodontics at the university's dental college, who is conducting the research with two other dentists on the faculty.

"We are not only trying to stop the disease, but to restore the original architecture of the tooth. We want to give back what has been lost."

AT LOYOLA UNIVERSITY School of Dentistry, periodontists often use the antibiotic tetracyline in a tiny slow release device placed in the mouth to treat each tooth separately. It usually is coupled with surgical treatment.

"You use far less of the antibiotic than you do by prescribing it orally. It oozes out slowly over a 24-hour period," said Dr. Kirk Hoerman, professor and chairman of preventive dentistry and community health at Loyola. "We find this treatment works very successfully."

Sometimes soft tissue [gum or similar tissue] is grafted to areas where the gum has progressively receded, exposing the tooth root. The graft helps to stop further recession and covers the root surface. A flap of gum from a neighboring tooth simply may be slid over or a free graft may be taken from the palate. But lately dentists have been re-evaluating such grafting and many now believe there is less need for the procedure than previously indicated.

Occlusal adjustment, reshaping the chewing and biting surfaces of the teeth so the pressure is evenly distributed, and orthodontic treatment, changing the position of one or more teeth, may help some patients who are prone to periodontal problems.

FOR THOSE WHO injure their gums by clenching and grinding their teeth at night [bruxism], special appliances to protect the teeth from excessive pressure are made to be worn while sleeping.

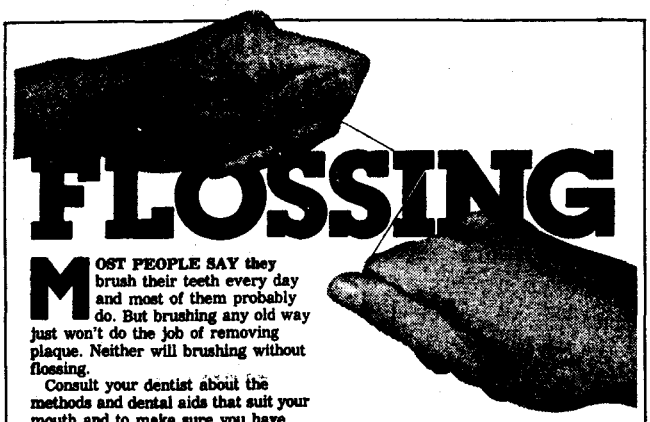
Vigilance cannot end after the initial periodontal therapy. In most cases, patients must return for periodic preventive treatments and re-examinations, and even repeats of the initial treatment.

"Even though it's treatable, it requires constant care," said Dr. Erwin Barrington, a periodontist at the University of Illinois and also in private practice.

Researchers have been experimenting with mouth rinses that dissolve plaque and periodontal toothpaste, but perfection of these developments lies several years away. The problem is that when it comes to destroying bacteria, it's difficult to be selective.

Chlorhexedrine mouthwashes that have been used successfully to prevent plaque formation in some European countries have not been approved for clinical trials here because there is evidence they may be carcinogen.

"There has been some modest success with the mouthwashes," says Dr. Clifford H. Miller, associate dean of Northwestern University School of Dentistry. "It hasn't swept the dental profession. But there may come a time when they're used along with proper home care [brushing and flossing] as part of the deterrent."



FLOSSING

MOST PEOPLE SAY they brush their teeth every day and most of them probably do. But brushing any old way just won't do the job of removing plaque. Neither will brushing without flossing.

Consult your dentist about the methods and dental aids that suit your mouth and to make sure you have mastered these techniques. It takes some practice.

Proper brushing involves both teeth and gums. Dentists now advocate the use of a *soft* bristle brush and gentle scrubbing; the hard-bristle brush and vigorous sawing motion advocated in the past can be harmful to the teeth and gums.

Place the brush at a 45-degree angle against the teeth and gums, aiming the bristles up on the upper teeth, down on the lower teeth, so that the bristles actually enter the gum space.

THEN MOVE THE brush from side to side in a quick, light scrubbing motion. Brush section by section until you go completely around your mouth. When you're finished brushing the outside teeth and gums, open your mouth wide and use the same technique to brush the inner surfaces of the teeth and gums and the chewing surfaces of every tooth.

It is important to prevent gum disease by cleaning thoroughly all around each tooth and into the gum space every day. Flossing is necessary to disrupt colonies of bacteria that regroup every 24 hours. If you don't remove bacterial plaque, it builds up into a hard deposit called calculus or tartar. More plaque forms on top of the calculus, irritating the gums and eventually forming a pocket between the teeth and gums, the first step toward toothlessness.

To floss your teeth:

Break off a strand of floss about 18 inches long.

Loop one end around the middle finger of one hand and the other end around the middle finger of the other hand.

Use your thumbs and forefingers with about an inch of floss between them to guide the floss between your teeth.

HOLD THE FLOSS tightly and use a gentle sawing motion to insert the floss between your teeth. Don't snap the floss into the gums. When the floss reaches the gumline, curve it into a C-shape against one tooth and gently slide it into the space between tooth and gum until you can feel a slight resistance.

While holding the floss tightly against the tooth, move the floss away from the gum by scraping the side of the tooth. Repeat the process on the adjacent tooth and gum space and on all the rest of your teeth, including the backsides of the last teeth.

Some dentists also recommend the use of gum stimulators made of balsa wood or rubber. These devices are inserted between the teeth to massage the gums and clean out the plaque. "It tightens up the tissue," said one periodontist. "I think healthy, tough tissue resists disease better."

Connie Lauerman

(This sheet to be used by those testifying on a bill.)

NAME: Tom Christensen DATE: ~~2/1/85~~ 2/1/85

ADDRESS: 7059 Nettleton

PHONE: 449-7392

REPRESENTING WHOM? MDHA

APPEARING ON WHICH PROPOSAL: - opposed to oral interview
- in favor of allowing anesthetic Administering By Hygienists

DO YOU: SUPPORT? X AMEND? _____ OPPOSE? _____

COMMENT:

- In FAVOR Allowing hygienists to Administer Local anesthetic
- I am in FAVOR of removing the oral interview from licensing requirements. It is expensive to wait For this interview and the questions are irrelevant. Hygienest have the training to administer anesthetic. Most important it gives the Dentist a choice in the manner. It would increase patient comfort, patient management and increase quality of care.

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

(This sheet to be used by those testifying on a bill.)

NAME: Roger Tippy DATE: 2/1/85

ADDRESS: Box 543

PHONE: 442-4451

REPRESENTING WHOM? Montana Dental Assoc.

APPEARING ON WHICH PROPOSAL: SB 214

DO YOU: SUPPORT? (Sec. 2) AMEND? _____ OPPOSE? _____

COMMENT:

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

(This sheet to be used by those testifying on a bill.)

NAME: MARJORIE FORAN DATE: 2-1-95

ADDRESS: 2213 COLUMBIA HELENA MT

PHONE: 449 3441

REPRESENTING WHOM? MONTANA DENTAL HYG. ASSOC.

APPEARING ON WHICH PROPOSAL: SENATE BILL 214

DO YOU: SUPPORT? ✓ AMEND? _____ OPPOSE? _____

COMMENT:

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

January 31, 1985

Judy Jacobson, Chairman
Senate Public Health, Welfare and Safety
State Capitol Building
Helena, Montana 59620

Senate Committee Chairman and Members:

I offer these written comments in regret that I am unable to attend today's hearing. I am Jeannette S. Buchanan of Columbia Falls, Montana. I am the dental hygienist member of the Board of Dentistry. I have severed as President of the Montana Dental Hygienists' Association and our National organization the American Dental Hygienists' Association.

I wish to divide the question.

I speak in support of the first part of SB 214 permitting certain qualified dental hygienists to administer local anesthetic agents.

Dental hygienists can be, and indeed are being, adequately prepared through education to administer local anesthetic agents. To limit this scope of practice from the dental practices where a dental hygienist is under direct supervision of a licensed dentist is a disservice to the consumer public, as well as the practitioners.

I speak in opposition to the second part of SB 214 removing the requirement for an oral interview in that the Board is in the process of developing a formalized format for the interview process with the assistance of the University of Montana. The interview is to fill more adequately the needs of the State in assuring the highest standards possible before permitting individuals to be licensed.

Thank you for your consideration.

Respectfully submitted,

Jeannette S Buchanan, R.D.H.

Jeannette S. Buchanan, R.D.H.
Columbia Falls, Montana

(This sheet to be used by those testifying on a bill.)

NAME: Shawn Aleziae DATE: 2-1-15

ADDRESS: 3604 5th Ave So

PHONE: 453-1521

REPRESENTING WHOM? Montana Nurses Assn.

APPEARING ON WHICH PROPOSAL: SB 214

DO YOU: SUPPORT? _____ AMEND? _____ OPPOSE? ✓

COMMENT:

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

Montana Nurses' Association

2001 ELEVENTH AVENUE (406) 442-6710

P.O. BOX 5718 • HELENA, MONTANA 59604

TESTIMONY ON SB 214

My name is Sharon Dieziger and I am representing the Montana Nurses' Association. We met with the Dental Hygienists this morning because we have some concern and some questions regarding the language of the bill and also the question of passing a law that is in conflict with the Montana Nurse Practice Act which places the act of administering medications under the license of the Registered Nurse or Licensed Practical Nurse under supervision of an RN. However, under our own Practice Act neither RN's nor LPNs administer local anesthesics unless they are a Certified Registered Nurse Anesthetist.

So there is the question of current law and what are the legal implications of that? And what happens where the laws are in conflict?

We had a question of direct supervision because we have been throught that ourselves so many times. And direct supervision language usually means just that not just on the premise.

As consumers advocates we believe you should give consideration to the common medications used in local anesthetic and the effects that epinefrine may have on the cardiac system which not infrequently causes tachycardia resulting in more serious arrythmias and even a potential cardiac arrest. These drugs are frequently contradicated when patients are on cardiac medications. We merely want to point our the seriousness of administering local anesthetic.

We believe that local anesthetic should remain under the practice of medicine and dentistry other than those people who have been certified as nurse anesthetists in the current practice acts.

FAMILY DENTAL GROUP
10 THREE MILE DRIVE
KALISPELL, MONTANA 59901
PHONE 755-7890

30 January 1985

Senate Public Health Comittee
Capital Station
Helena, MT

Dear Senators,

I strongly support Senate Bell 214. As a former member of the Montana Board of Dentistry 1977-1982 I was in favor of giving Carroll College Department of Dental Hygiene permission to teach their students the administration of local anesthetics. Carroll College has trained their students in the use of local anesthetics now for over five years.

There are many competent dental hygienists trained in procedures that need the pain control given by local anesthetics. They also have training in the use of local anesthetics and are allowed in almost all of the western states to administer local anesthetics. As a board member I had the opertunity to talk to member of boards of dentistry in states allowing this duty to hygienists and they all reported no problems. The State of Washington has allowed hygienists to use

FAMILY DENTAL GROUP
10 THREE MILE DRIVE
KALISPELL, MONTANA 59901
PHONE 755-7890

local anesthetics for over ten years now. Montana should also allow hygienists as outlined in S.B. 214 to administer local anesthetics.

The second part of the bill deleting the oral interview also meets with my approval. As a board member we made no real use of this part of the licensure procedure. The candidates for licensure have been tested on their clinical ability, their papers have been checked and verified and found in order before the oral interview. Because of the posibility of bias and the excellent clinical and written exam now used the interviews serve no purpose

Thank you for your consideration.

Sincerely yours,

Douglas E Wood, DDS

January 28, 1985

Susan M. Payne, R.D.H.
1250 Burns Way, Suite 2
Kalispell, MT. 59901

Senate Health and Human Services
Capitol Station
Helena, MT. 59620

Dear Sirs;

I am writing in regards to senate bill #214 (SB214) a bill for an act entitling the administration of local anesthesia by certain dental hygienists. The word "certain" pertaining to the qualified licensed hygienists who have had the proper education and training necessary for the procedure.

I support the bill for the following reasons: 1) better utilization of the education and training of the dental hygienist 2) more punctual facilitation of appointment scheduling and patient flow and 3) most important, greater patient comfort and acceptance.

Better utilization of the education and training of the dental hygienist would definately be met by the passage of this bill. Currently most hygiene schools, including Carroll College, require courses in local anesthetic administration in their curriculum. Most western states involved (i.e. Idaho, Utah, Oregon, Washington, and Wyoming) allow that particular function under state laws. In Montana this is not the current situation. Though the course is taught in a Montana college the training cannot be exercised except out of Montana jurisdiction. There is a void present that needs to be filled. For people wishing to remain in Montana they are unable to practice their skills at whichthey are trained. For career oriented people this could be a deterrant to remaining in this state to practice. Montana needs highly skilled professionals to remain in this state to contribute to Montana's prosperity and economy.

More punctual facilitation of appointment scheduling and patient flow would also be improved. In many offices patients must wait for considerable lengths of time before the dentist is able to see them to administer the local anesthetic. This not only causes unnecessary anxiety experienced by the patient in waiting but also anxiety by the dentist in running behind. In either case, if the local anesthetic requires extra time to take effect this can add to more time the patient is made to wait and a greater bog in the scheduling. Contrary to this situation if local anesthetic were administered by the hygienist scheduling could be arranged so that the patient could be seen early by the hygienist, local anesthetic administered, and then the actual work performed by the dentist. Thus the schedule would run more on time, the patient would not be kept waiting as long, and anxiety would be lessened in both the patient and dentist.

Lastly, greater patient comfort and acceptance would also be acheived through the lessening of anxiety by the scheduling improvements mentioned above. I believe patients, though not consciously aware of it at times, often associate the hygienists and assistants with gentleness while they regard the dentist (regrettably) as the person most to fear in the office setting. If the administration of anesthesia, often an act associated with discomfort, could be performed by the hygienist, associated with gentleness, this could alleviate some patient fears and help patients perceive the dentists for what they are; trained professionals to help them and meet their dental needs.

In conclusion, the passage of sentate bill #214 (SB214) would benefit not only the hygienists in the state of Montana but the dentists and patients as well. The administration of local anesthesia should be regulated under the state jurisprudence laws as are all functions performed by the hygienists in this state. Thus insuring patient safety and comfort, the single most important factor to consider.

Sincerely,

Susan Payne, R.D.H.

sp

(This sheet to be used by those testifying on a bill.)

NAME: Darrell Micken DATE: 2-1-85

ADDRESS: 366 Coulee Dr., Bozeman, Mt 59715

PHONE: (406) 587-8517

REPRESENTING WHOM? Mt. Hearing Aid Society

APPEARING ON WHICH PROPOSAL: SB 226

DO YOU: SUPPORT? ✓ AMEND? _____ OPPOSE? _____

COMMENT:

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

University of Montana
Communication Sciences and Disorders • Missoula, Montana 59812 • (406) 243-4131

January 29, 1985

Darrell J. Micken
Medical Arts Hearing Center
300 N. Willison 603-7
Bozeman, Montana 59715

Dear Mick:

I'm sorry that I am not going to be able to be in Helena to testify in support of Senate Bill 226. As I understand, this bill is designed to strengthen the current weak listener law that has not been effective in its primary responsibility, which in my judgement is to protect the consumer. I'm in support of this bill and the efforts to put more teeth into the hearing aid licensing law which will provide more protection to the hearing handicapped.

I would like to speak in support of the examination section particularly. As I understand it, all individuals--audiologists or hearing aid dealers--must pass an examination before they can begin dispensing aids. I think this is an excellent idea, but I don't think it goes far enough.

As I understand Section 37-16-103, physicians are exempt from this clause. I think this section should be struck on the basis that it includes all "licensed physicians," and in my judgement most physicians know very little about hearing aids and how to effectively use them as an aid for the hearing handicapped. I see no reason for the exemption and I am convinced that it is now in the best interests of the consumer. I would urge this section to be eliminated from this bill.

Sincerely,

Charles D. Parker, Ph.D.
Chair

CDP/tm

(This sheet to be used by those testifying on a bill.)

NAME: Dudley Anderson DATE: 2-1-85

ADDRESS: 4640 Spurgin

PHONE: 549-1951 549-5983

REPRESENTING WHOM? Self - Mont Hearing Aid Dispensers Board

APPEARING ON WHICH PROPOSAL: SB226

DO YOU: SUPPORT? X AMEND? _____ OPPOSE? _____

COMMENT: attachment

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

I will

January 31, 1985

Ladies & Gentlemen:

As acting chairman of the Montana Hearing Aid Dispensers Licensing Board, I would like to focus your attention to that portion of the law change in Section 37-16-405 (2). The change herein requires an applicant for licensor as a trainee to first pass the written portion of the examination, and then begin the training process which involves direct consumer contact.

I appeal to you on the basis of consumer protection. The consumer, often elderly and sometimes vulnerable as individuals, deserve competant service. Hearing problems are medically related, complicated problems, and often cause a breakdown in social involvement. Relations and contact with the world, neighbors, relatives, and loved ones are often impaired. At present, a trainee applicant submits an application answering affirmative to having an equivalent of a high school diploma, is of good moral character, has no contagious disease, pays a fee, and then becomes cleared to meet the consumer totally on his own after a brief two months of supervised consumer contact and sales. He is selling hearing aids on his own in two months. He's flying without passing the ground school requirements, as I see it. This is not consumer protective.

Ladies and Gentlemen, it goes without saying, that the new miniature electronic advances in recent years have changed the world, and hearing aid devices and equipment are no exception. Automatic volume controls, directional microphones, radio transmitter and receiver hearing aids, input, output, and frequency selective compression, are but a few of these advanced changes. Coupling design, earmolds, and tubing, is also complex much like musical instrument acoustical design. As many as six screw drive adjustments are available on heairng aids, all resulting in changed performance.

Education, skill, and knowledge are all a vital necessity in the hearing aid selection process and the consumer is the recipient of the presence or absence of the needed compitance by the dispenser.

Most hearing aid dispensers are career oriented, and consider themselves as helping the hearing handicapped in a professional way. Delivery systems vary tremendously however. One such system involves the employment of many numbers of trainees, who in short, are quickly dispatched to sell hearing aids for a commission as part of a sales force or team. Since the trainee can forestall passing the written portion of the licensing test for up to 1½ years, he can be fitting hearing aids for 16 months, while being totally incompetant. Several

trainees selling several hearing aids to several handicapped people result in several disappointed consumers.

Consumer protection is my goal ladies and gentlemen. Requiring a basic level of competance by passage of the written portion of the licensor test, is the only logical prerequisite to consumer contact, and is the right step to achieve needed consumer protection.

Respectfully,

Dudley Anderson
Chairman
Hearing Aid Licensor Board

(This sheet to be used by those testifying on a bill.)

NAME: CHRISTIAN GROVER DATE: 2/1/85

ADDRESS: 1124 Helena Ave.

PHONE: 443-6361

REPRESENTING WHOM? Private Practice Audiology

APPEARING ON WHICH PROPOSAL: HB220 Revision - Generally

DO YOU: SUPPORT? X AMEND? _____ OPPOSE? _____

COMMENT:

For consumer protection - support minimal competency + enforcement of disciplinary actions.

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

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(This sheet to be used by those testifying on a bill.)

NAME: William J. Simic DATE: 2-1-85

ADDRESS: 905 Helena Ave.

PHONE: 442-2410

REPRESENTING WHOM? MT. Board of Hearing Aid Dispensers.

APPEARING ON WHICH PROPOSAL: SB 226

DO YOU: SUPPORT? ✓ AMEND? _____ OPPOSE? _____

COMMENT:

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

(This sheet to be used by those testifying on a bill.)

NAME: William V. Fouts DATE: 2/1/85

ADDRESS: 2501 Catlin Missoula

PHONE: 721-6071

REPRESENTING WHOM? Montana Hearing Aid Society

APPEARING ON WHICH PROPOSAL: 226

DO YOU: SUPPORT? X AMEND? _____ OPPOSE? _____

COMMENT: Wish to support the bill as a whole, but several sections might have to be changed

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.