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Kathy Cooper

From: Pawlowicz, Elizabeth <pawlowiczec2@upmc.edu>
Sent: Tuesday, April 30, 2019 9:40 AM
To: IRRC
Subject: IRRC# 3228 PA State Board of Dentistry

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Regarding:
IRRC# 3228
Pennsylvania State Board of Dentistry
PA Code 49 Pa.Code Chapter 33.205b
Regulation #16A-4633: Public Health Dental Hygiene Practitioner Practice Standards

Dear Members of the PA State Board of Dentistry and State Legislators,

In regards to the proposed expansion of practice sites and procedures for dental hygienists referenced above:

It has been shown that there is a legitimate need for increased access to care for several population groups across our state. Patients in rural areas with barriers to care due to distance are one. Patients in long-term care facilities with barriers to care due to mobility are another. Patients who are uninsured or underinsured are a third. There are still other patient populations who desire and would benefit from greater access to dental care. It is our role, as a profession, to tackle these issues with sincerity and professional integrity.

The question however, becomes: ***What constitutes dental care?*** Prevention is clearly one *component* to care. Periodic prophylaxis and periodontal maintenance are proven to provide improved general health outcomes. However, without concomitant diagnosis of dental disease, radiographic exam, oral cancer screening and treatment, what is being provided is NOT dental care. We, as a profession, may feel better by providing hygiene services, but we cannot state that we are providing dental care.

There are many advances in telemedicine, digital radiography and intraoral cameras that may help us bridge this gap. But without looking into ways and defining protocols that include the dentist in these patient contacts, on at least an initial and then yearly basis, we run serious risk of first: diminishing the integrity and value of our profession and, second: being a party to sanctioning dental neglect. Even the most experienced, well-trained and highly educated dental hygienist does not bring the capability to replace the dentist's examination and diagnosis. Physicians, physician assistants, nurse practitioners and allied medical professionals in offices, schools or public health clinics are not a qualified substitute for the dentist either, as their scope of practice no more includes dental diagnosis than a dentist's includes treating congestive heart failure or diabetes.

Once the patient has the Public Health Dental Hygiene Practitioner visit with no dentist contact, who becomes the responsible party if that patient had an undiagnosed periapical abscess that becomes a life threatening Ludwig's angina or infraorbital cellulitis because routine radiographs and clinical diagnosis were not performed? Who is liable when an endocarditis is induced in a patient from a deep scaling? Who is responsible for the missed oral lesion that leads to a more complicated cancer treatment? The regulation states that patients will be encouraged and supported in finding a "dental home." But what are the specific regulations for this and who assumes the liability if the patient does not follow up with a dentist and disease is missed? How can patients be protected from assuming the PHDHP is as qualified to diagnose disease as a dentist, and that they have received a complete and competent dental exam? These and other legitimate discussions must be had before this regulation is implemented. We cannot spend years suffering the unintended consequences of well-intentioned yet harmful legislation.

Thank you for your consideration of my point of view. I am available for discussion or further comment if any board member or state legislator is interested in speaking with me.

Sincerely,
Dr. Elizabeth C. Pawlowicz
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Member PDA
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