

Saskatchewan Dental Assistants'
Association

Scaling: Our Perspective

*SDAA maintains that Scaling is not an
appropriate duty for Dental Assistants*



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Background Information

The Saskatchewan Dental Assistants' Association is the governing body for dental assistants in Saskatchewan. Our primary responsibility is that of public protection. The issue of scaling is not new in Saskatchewan; the initial bylaws for dental assistants in 1969 stated "shall not remove subgingival deposits". This left the removal of visible calculus in the domain of licensed dental assistants. The bylaws revisions of 1978 stated "removal of visible deposits and stain and the polishing of clinical crowns". The skill was never included in the curricula of any provincial dental assistant training program, although many dental assistants choose to remove visible deposits. In 1993 after extensive member consultation and discussion, the Board of Directors voted to replace scaling with a bylaw that stated "remove soft deposits, including stain from the clinical crowns by polishing". The membership, through the Annual General Meeting (1993) by vast majority supported the motion and it was presented to the College of Dental Surgeons of Saskatchewan. The College Council of the day called for the development of a scaling module; their request failed due to a general lack of support throughout the dental profession. Scaling finally became an ineligible skill for dental assistants when the Dental Disciplines Act was proclaimed for dental assistants in January, 1998.

Client Care

As health care professionals controlled by Dental Acts, Regulation or Bylaws, our first concern must be that of client care. Each skill considered by the dental assisting profession must be evaluated using this basic premise. Is this a valuable client service? What is in the best interest of the public? Are we really benefiting our client's utmost needs?

Periodontists have advised the SDAA that there is no value in removing visible calculus. If scaling is undertaken, it should be completed. SDAA would further conclude that if the client only has visible calculus, there is no rationale for removing it as it is not causing periodontal disease.

Presuming that the removal of calculus to a depth of 4 mm can be taught; since it is a partial treatment we need to consider “could the removal of supragingival calculus place the client at risk”? The response is yes, the removal of supragingival calculus will promote early healing with tissue tightening over undetected subgingival calculus increasing the potential for sites of infection, thus increasing the risk to the client. Any subgingival calculus must be detected and removed, and therefore a single action removing partial calculus cannot be seen as a valuable client service. The partial removal of calculus may actually increase the number of dental assistants who choose to work beyond their legal capacity. The dental assistant will be aware that the remaining calculus is detrimental to the wellbeing of the client. In addition, we are well aware that it is difficult to define an optimal scaling depth and then measure and teach to that depth.

We further need to consider, “Are there clients with only supragingival calculus”? A 1983 survey of students enrolled in the Saskatchewan Dental Plan aged 12 to 16 indicated that 26.3% had no calculus, 37.6% had supragingival calculus and 36.1% had subgingival calculus. The Adolescent Periodontal Survey involving 1,918 Saskatchewan youth aged 12 to 16, conducted November 1982 through January 1983 concluded, “Provincially, 73% of adolescents examined had supragingival calculus, subgingival calculus or retentive sites”. With calculus prevalence rates as high as 73%, every client will need to be evaluated for subgingival calculus. Will a short course on scaling include adequate evaluation skills? Does this now move the dental assistant into the realm of diagnosis? Can diagnosis and detection be included in a six month course, where the dental assistant would be called to diagnose a condition they could not treat? If a dentist or hygienist needs to undertake the assessment, on approximately 40% of the clients aged 12 to 16 to “finish the job” and on a higher percentage of the adult clients, does it make sense for the dental assistant to undertake any of the scaling? While these statistics are dated, no research has been conducted in Saskatchewan since this time [*verified by Wascana Dental Hygiene Program, and Saskatchewan Public Health*]. In addition, the students surveyed had the benefit of receiving annual restorative and periodontal treatment through the Saskatchewan Dental Plan which operated 1976 through to 1987. With the termination of the Saskatchewan Dental Plan in 1987 we have every reason to believe that the calculus prevalence rates will have increased. If it is safe to assume that in 2005, there is a higher prevalence of calculus, and few clients would qualify for the scaling services of the dental assistant.

Why do supra and leave sub? Who are we benefiting? The client, who will need multiple practitioners to complete their periodontal needs? Would the client for time management considerations be better served by one practitioner undertaking both actions at the same time? Does the dentist benefit, who now has a “fee-for-service” procedure provided by a team member who commands a lesser salary? Is this the next step to assembly line dentistry, and does assembly line dentistry have a “client care” component?

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As dental assisting skills are considered, the long standing consideration has been, “is the procedure reversible?” A quick review of all other dental assisting skills will reveal that to date, all procedures are reversible. Scaling procedures performed improperly are not reversible, for example inadvertent cutting of root surface creates irreversible damage.

Canadian Academy of Periodontology

The Canadian Academy of Periodontology, in a letter to the Canadian Dental Assistants Association, stated, “In fact, the CAP would find it difficult to support an argument in favour of any training program that included subgingival instrumentation that was not equivalent to current curricula for the training of a dental hygienist”.

Scaling Training in Saskatchewan

In the 1977, the Kelsey Dental Assisting program [10 month program] attempted to offer a scaling module. The program was lengthened by five weeks to accommodate the module. A few weeks into the training, the program called a halt to the module. Instructional staff determined the time allocated was insufficient to teach the skill and the students although nearing completion of the dental assisting training program had insufficient background knowledge in order to ensure success. Currently, with credit for prior learning, dental assistants are fast tracked through the Dental Hygiene Program [Two year accredited program at a Technical Institute].

The Saskatchewan Dental Therapist is a dental professional having completed a two year restorative education program. These professionals have been taught to remove some calculus. Of the hundreds of dental therapists trained in Saskatchewan from 1976 to 1986 at SIAST, only 61 remain licensed today solely as a dental therapist. See Appendix 1. To the knowledge of the Saskatchewan Dental Therapists Association, few of the SIAST dental therapists work in the area of periodontal services and the majority of these technicians retrained as dental hygienists. Apparently, the dental therapist recognized their scaling training was insufficient to provide comprehensive periodontal services. In addition, SDAA does not consider the dental therapists performing scaling to be comparable to a dental assistant, due to the fact that the dental therapist is a graduate of a two year program and has developed considerably more manual dexterity and fine motor skills due to an additional year of training. Their level of training would be more comparable to that of the Dental Hygienist.

Liability

What happens if scaling is not completed and calculus remains undetected? What is the liability/responsibility for calculus left? The dental assistant (and dentist) could be held legally liable for undetected calculus, even though the dental assistant could not legally remove it. Is scaling more responsibility and liability than what dental assistants are trained for with a one year (generalist) training program?

Professional Relationships

Dental Assistants and Dental Hygienists are co-workers. Will the profession of dental assisting set dental assistants up to be in conflict/competition with the dental hygiene profession and in turn decrease team morale?

Remuneration

The SDAA is of the opinion that remuneration is at the heart of the issue. Dental Assistants may choose to perform this skill, in anticipation of dental hygiene wages. Will the additional responsibility and liability be commensurate with additional pay? With a twenty year history of scaling in Saskatchewan, we saw no indication that dental assistants providing scaling service received any additional remuneration. In reality, there may well be interest on the part of the dentist to downsize the costs of dental hygiene services, by assigning duties to a lesser skilled, lower paid allied personnel. We need to be confident that the dentist is making a client care decision rather than an economic decision.

Risk of Misrepresentation

Dentists on occasion ask staff to perform “out of scope skills”. If the professional association sanctions this skill, the potential will exist for deeper scaling to occur without benefit of formal training. To what degree will dentists request dental assistants to practice out of scope? Is the dental assistant going to feel at risk of losing their job if they do not perform what is requested?

During the history of scaling in Saskatchewan, there were dental offices in which the dental assistant assumed the title of “hygienist”. Is it possible that this misrepresentation will proliferate with dental assistants trained to scale? Will the client be able to discern the type of allied personnel that has provided treatment?

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Conclusion

The SDAA realizes there may be pressure for dental assistants to scale should various other Canadian jurisdictions take up the challenge. However, we cannot consider adding scaling to our list of skills. We also understand that Saskatchewan's refusal to add this skill will not jeopardize the portability of Saskatchewan Dental Assistants. We do wish to advance our profession and skill base, but we also want to ensure that we are adequately educated, balanced with ethical considerations resulting in the highest standard of client care. The SDAA further asserts that training dental assistants to scale to a specified depth is a mystical concept. We have further demonstrated that the client base in society qualifying for this treatment is relatively small, and may well be too small to make the cost of training viable. Scaling for dental assistants becomes an ethical decision for professional associations, regulatory authorities and health ministries. The Saskatchewan Dental Assistants' Association encourages all of these agencies to make well researched, informed decisions.

Appendix 1

The Government of Canada offered the Federal Dental Therapy Program from 1976 to 1983 at Fort St Smith, NWT and in Prince Albert, SK from 1983 to present. These practitioners work across Canada on crown land doing restorative dentistry and providing limited scaling services. These practitioners are able to work in private practice in Saskatchewan only. The training for a Federal Dental Therapist is two years in duration.

Bibliography

“A survey of Periodontal Conditions in Adolescents Enrolled in the Saskatchewan Dental Plan”, November, 1983