The Dental Therapist Movement in the U.S.

The Dental Therapist: A Century of Controversy

By

Andrew I. Spielman, DMD, PhD
Professor of Molecular Pathobiology
Director, Rare Book Library and Historical Archives
NYU College of Dentistry

Introduction

Throughout history, humans have suffered from dental diseases and have needed help to alleviate pain, remove the offending tooth, or heal an oral wound. Historically, the list of those providing such intervention included barbers, blacksmiths, tooth-drawers, tricksters, operators for the teeth, surgeons, dentists, and dental surgeons, to name a few. Anyone with sufficient experience, education, or temerity could pick up a forceps and start extracting teeth. In the United States, the first state to regulate the practice of dentistry was Alabama, which passed a law in 1841.[1] Individual state dental practice acts were enacted between 1868 and 1913.[2] Over the decades, as demand for dental care expanded and became specialized, the dental team providing care also grew, from the solo dentist or dental specialist to include dental assistants, hygienists, lab technicians, and/or dental therapists. Today, the practice of dentistry is highly regulated and carefully demarcated with clear boundaries around the scope of practice for each team. Predictably, when a new oral health care provider role is proposed by legislators or public advocates – which potentially overlaps with existing practice roles – there will be resistance.

That is what happened when the profession of dental hygiene was first proposed[3] 122 years ago, and the first course to train these new oral health professionals was created by Dr. Alfred Fones in Bridgeport, Connecticut in 1913.[4] It was quickly torpedoed by organized dentistry and forced to close within three years of opening. However, after a decade-long fight with organized dentistry, the profession of dental hygiene

took off. Its acceptance was slow at the beginning, and it was confined to the northeast part of the country, but eventually it was deemed an important and indispensable addition to any dental practice.

It is no surprise that similar opposition to the newly introduced position of Dental Therapist (DT) exists today in the U.S. These midlevel providers have been around for more than 100 years in other parts of the world. This article will consider six questions regarding dental therapists: *why*, *who*, *where*, *what, how,* and *why not*.

Specifically,

1. *Why* is there a need for DTs in the first place?
2. *Who* are dental therapists?
3. *Where* are they practicing internationally and in the U.S.?
4. *What* education is required to become a DT?
5. *How* effective are dental therapists?
6. *Why not* eliminate DTs altogether? Opposition to Dental Therapists

1. WHY is there a need for dental therapists?

A recent report by the World Health Organization, "The Global Oral Health Status Report," indicates that "*almost half of the world's population, around 3.5 billion people from 194 countries suffer from oral diseases, and that 75% "of those affected live in low-and middle-income countries.*"[5] The trend over the past decades also showed that with all the advances in the field, access to prevention or treatment of oral diseases is limited. The U.S. Surgeon General's Report, "Oral Health in America," released in 2000,[6,7] highlighted the existence of a silent epidemic of dental disease and the health disparities among poor and minority children.

Access to care involves physical, economic, social, political, emotional, and/or temporal availability. But it is also the availability of sufficient numbers of individuals providing care. Educating dentists to deliver preventive care to whole populations and basic care to inaccessible populations is an economic challenge even in the developed world. That is the reason New Zealand designed a "dental nurse" program in 1921. Dental therapists – a rebranded version of the original dental nurses – are an efficient solution to an intractable problem, providing preventive care to large numbers of patients at minimal cost.

2. WHO are dental therapists?

One of the most comprehensive reports on dental therapy[8,9] concluded the following:

1. DTs are not licensed professionals, but rather practice as registered "auxiliaries."
2. They practice primarily in public clinics, typically among schoolchildren.
3. Their scope of practice is primarily in caring for children, and sometimes for adults.
4. They typically practice with general supervision by dentists.
5. DTs provide technically competent care.
6. They improve access to care, specifically for children.
7. They provide oral health care safely and effectively within their scope of practice.
8.

The public values them in the oral health workforce.

9 They can decrease the overall cost of oral health care.

3. WHERE are they practicing?

A timeline of major events in the development of the DT educational programs in the past 100 years is shown in Table 1. The educational program proved successful both locally and around the world and today, 54 countries have a dental nursing/dental therapy program (Table 2). Some of the earliest programs that introduced dental therapy were Malaysia (1948), Sri Lanka (1949), Singapore (1950), Tanzania (1955), and the United Kingdom (1959). The 54 countries permitting DTs to practice today are distributed by continent with 12 in North and Central America, 25 in Southeast Asia, Oceania, Australia, and New Zealand, two in Europe, and 14 in Africa. The New Zealand experiment was unique for its first 27 years. Out of the 54 countries, 33 belong to the Commonwealth of Nations, the association of countries that used to be part of the former British Empire.

Table 1. Timeline of the dental therapist movement.

Based on Mathu-Muju KR (2011).[25]

Date	Timeline Event
1921	New Zealand starts the first Dental Nurse (Dental Therapy, DT) program.
1948	Malaysia approves the DT program.
1949	Sri Lanka approves the DT program
1949	Massachusetts authorizes 2-year training program of personnel that can restore teeth under dentist's supervision.

1950	ADA House of Delegates opposes Massachusetts program - state governor rescinds legislation.
1950	Singapore approves the DT program.
1955	Tanzania approves the DT program.
1959	United Kingdom approves the DT program.
1966	Australia approves the DT program
1968	Thailand approves the DT program
1970	Jamaica approves the DT program
1972	Canada approves the DT program
	John Ingle and Nathan Friedman from University of Southern California propose 2-year “dental nurse” training program.

1972	Carl Laughlin, President of ADA, calls the proposal: “mediocre in conception and harmful in execution”.
1973	California Dental Associations opposes “dental nurses”. California State Legislature drops funding.
1973	Fiji approves the DT program
1974	Seychelles approves the DT program
1975	South Africa approves the DT program
1975	Trinidad and Tobago approves the DT program
1976	Suriname approves the DT program
1978	Hong Kong approves the DT program

2000	U.S. Surgeon General's Report on Oral Health released.
2001	Forsyth Institute, Boston meeting: advocates DTs working with American Indian Alaska Natives (AN) and to send locals for DT training in New Zealand.
2004	ADA unsuccessfully opposes the Indian Health Care Improvement Act.
2005	First six Alaska Natives Dental Therapists begin practice in Alaska. At the same time ADA and Alaska Dental Society launches lawsuit against the local Dental Therapists for "illegal practice of dentistry".
2007	Alaska Attorney General - "therapists certified under federal law". ADA drops lawsuit.

	Alaska starts 2-year DT program in Anchorage.
2008	Academy of General Dentistry opposes DTs in a white paper.
2009	Washington State Dental Assoc. approves 5-year initiative for “mid-level provider.” Minnesota legislature amends Minnesota Dental Practice Act to include DT. Connecticut State Dental Assoc. supports 2-year DT pilot project. Academy of General Dentistry asks Connecticut members to oppose it.
2010	Congress passes health care reform bill that includes “workforce pilot programs”. Bill opposed by ADA, AAPD, AGD, AAO, AAP and many state dental associations, but supported by APHA, AAPHD, AADR, ADEA, ASTDD, Pew, Kellogg, Children’s

	Dental Health.
2010	Kellogg Foundation report “Evaluation of the Dental Health Aide Therapist Workforce Model in Alaska” finds DT provide effective dental care to millions of children. AAPD states the newly released Kellogg report is a “flawed evaluation”. ADA House of Delegates adopt resolution that oppose non-dentists performing surgical/irreversible procedures. Kellogg Foundation provides $16 million Dental Therapist Project for New Mexico, Vermont, Ohio, Washington, and Kansas.
2011	“The Commonwealth Fund State Score card on Child Health System Performance” positively reviews the Alaska DT model.

2023	A total of fourteen U.S. States authorized the practice of Dental Therapy: Alaska, Arizona, Colorado, Connecticut, Idaho, Maine, Michigan, Minnesota, Montana (only on tribal land), New Mexico, Nevada, Oregon, Vermont, and Washington. Many are presently considering.

Abbreviations: ADA (American Dental Association), AAPD (American Academy of Pediatric Dentistry), AGD (Academy of General Dentistry), AAO (American Association of Orthodontists), AAP (American Academy of Pediatrics). APHA (American Public Health Association), AAPHD (American Association of Public Health Dentistry), AADR (American Association of Dental Research), ADEA (American Dental Educators Association), ASTDD (Association of State and Territorial Dental Directors).

Table 2. Countries around the world with dental therapists.

Area	Country
Americas	Anuilla Belize Bahamas Barbados Canada Costa Rica Jamaica Granada Guyana Suriname Trinidad Tobago United States

Area	Country
Africa	Benin Botswana Burkina Faso

	Gabon| Gambia Malawi Mali Mozambique Seychelles South Africa Sri Lanka Swaziland Tanzania Togo Zimbabwe

Area	Country
Southeast Asia Oceania Australia	American Samoa Australia Brunei Burma Cook Islands Federated States of Micronesia Fiji Hong Kong Kiribati Malaysia (1948) Marshall Islands Nepal Northern Mariana Islands New Zealand Palau Papua New Guinea Samoa Singapore Solomon Islands Sri Lanka Thailand Tokelau Tonga Vanuatu Viet Nam

Area	Country
Europe	Netherlands United Kingdom

The U.S. is a relative newcomer. There were two previous attempts to introduce DT, but both were unsuccessful. In 1949, the Commonwealth of Massachusetts proposed legislation that would have created a two-year training program for personnel who could restore teeth under the direct supervision of a licensed

dentist. The state dental association lobbied against it and the proposal was subsequently withdrawn.

In 1972, two progressive thinkers, Drs. John Ingle and Nathan Friedman from the University of Southern California proposed a two-year "dental nurse" training program. Both the California Dental Association and American Dental Association lobbied against it. The President of ADA at that time, Dr. Carl Laughlin, called the proposal: "mediocre in conception and harmful in execution."[8,9]

The discussion about DT was resurrected in the early part of the 21st century. In 2005, after a protracted court battle with the ADA, Alaska introduced a handful of dental therapists trained in New Zealand. They were working at Alaskan Native Tribal Clinics. In 2009, the University of Minnesota was the first to grant a degree in Dental Therapy. Throughout the ensuing years, several organizations have come out both for and against the establishment of such DT programs (Fig. 1).

Figure 1. *Lineup of organizations against and in support of dental therapy during the 2012 debate.*

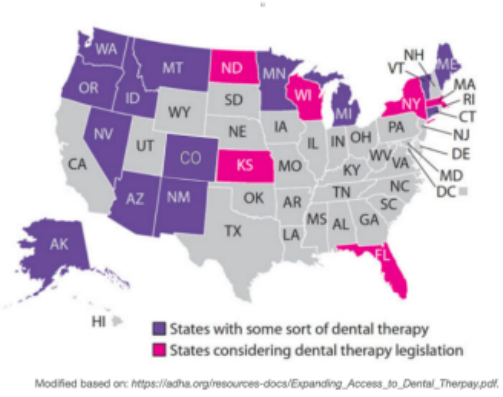

Figure 2. *States that have legislation for dental therapists (as of 2023).*

As of today, there are 14 states that authorize the practice of dental therapy (Fig. 2). These are: Alaska, Arizona, Colorado, Connecticut, Maine, Michigan, Minnesota, Montana (only on tribal land), New Mexico, Nevada, Oregon, Vermont, Washington, Idaho, and Montana (the last two, only on tribal land). Sixteen additional states have/had an active campaign for dental therapy and/or are considering passing legislation to the same effect.[10]

In 2015, The Commission on Dental Accreditation (CODA) established standards of education for Dental Therapy.[11] The U.S. currently has five training programs for dental therapists in three states: Alaska (1), Minnesota (3), and Washington (1). The latter is Skagit Valley College in partnership with the Swinomish Indian Tribal Community. Didactic education is provided at the college's campus in Mount Vernon, WA, and clinical practice takes place on the Indian Reservation in La Conner, WA. A DT program at Vermont State University, Williston Campus, will start admitting its first students in 2025.[11]

4. WHAT education is required to become a DT?

For dental therapists to be cost effective, training must be delivered in a shorter period than for dentists while also using less space and charging less tuition. Most countries that have adopted DT programs cannot afford large scale dental training programs. Around the world, the length of education for dental therapists

varies between two to four years, with two years being the standard for the majority of the 54 countries.

A comparison of seven DT programs (Fig. 3) from the U.S., Canada, U.K., Australia, New Zealand, Fiji, and Tanzania, shows an average of three years in length. In many countries where two-year dental nursing and two-year dental therapy programs coexisted as separate training programs previously, the two have now been consolidated to create a single 3-year program.[8,9] Australia and New Zealand are examples of such conversions. In many countries, dental hygiene (DH) leads to an associate or bachelor of science degree, while the DT in combination with DH leads to a master's degree.

Scope of Practice of Dental Therapists in Seven Countries

Dental Procedure /Country:	US	New Zealand	Australia	Canada	UK	Tanzania	Fiji
Years of training	3 years	3 years	3 years	2 years	3 years	3 years	3 years
Location: Dental School	✓	✓	✓		✓		
Location: Dental Therapy School				✓	✓	✓	✓
Location: University setting	✓	✓	✓	✓			✓
Exams	✓	✓	✓	✓	✓	✓	✓
X rays	✓	✓	✓	✓	✓	✓	✓
Prophylaxis	✓	✓	✓	✓	✓	✓	✓
Diagnosis	✓	✓	✓	✓		✓	✓
Coronal scaling	✓	✓	✓	✓	✓	✓	✓
Root planing	✓			✓			✓
Topical fluoride	✓	✓	✓	✓	✓	✓	✓
Sealants	✓	✓	✓	✓	✓		✓
Infiltration anesthesia	✓	✓	✓	✓	✓	✓	✓
Nerve block anesthesia	✓	✓	✓	✓	✓	✓	✓
Amalgam restoration	✓	✓	✓	✓	✓	✓	✓
Composite restoration	✓	✓	✓	✓	✓		✓
Atraumatic restorative therapy (ART)	✓		✓	✓		✓	✓
Preformed Stainless Steel Crown	✓	✓	✓	✓	✓		✓
Pulp therapy (deciduous)	✓	✓	✓	✓	✓		✓
Extraction (deciduous)	✓	✓	✓	✓	✓	✓	✓
Extraction (permanent)				✓		✓	✓
Orthodontics			✓	✓			
Children	✓	✓	✓	✓	✓	✓	✓
Adolescents	✓	✓	✓	✓	✓	✓	✓
Adults	✓	✓	✓	✓	✓	✓	✓

Figure 3. *Comparison of the scope of practice for dental therapists in seven countries.*

There are five current training programs in the U.S that offer slightly different programs. The oldest, in Minnesota, is 26-28 months in duration, requires a bachelor of science in dental Hygiene (BSDH) to be admitted and graduates earn the title of dental therapist (DT). After completing 2,000 additional hours of supervised practice and examination, they become Certified in Advanced Dental Therapy (ADT). This program is integrated into the School of Dentistry and shares many courses with students in the advanced Dental Hygiene program.

A second program at Minnesota Metropolitan State University at Normandale grants master of science degrees in Advanced Dental Therapy. Their curriculum involves interprofessional courses with graduate nursing students. Competency-based dental courses are taught by dentists.

A third program, in Alaska, trains Federally Certified Dental Health Aide Therapists (DHAT). The curriculum is 24 months in duration plus 400 hours of clinical practice. The first year of training is in health sciences, dental concepts, clinics, patient care, and facilities management. In the second year, DHATs get primarily clinical education.[12]

A fourth program instituted in Vermont is a three-year program or one extra year of training beyond those programs with a bachelor of oral health degree in dental hygiene and 400 extra hours in clinical training. This program is planning to admit the first cohort of students in 2025.[13]

Based on the CODA educational standards, the curriculum for DT must include at least three academic years of full-time instruction or its equivalent at the post-secondary college level and must be competency based, just as in dental education and dental hygiene education. They follow the national guidelines and standards issued by CODA.[11] In 2013, Community Catalyst, a civic non-profit organization, in collaboration with the Pew Charitable Trust, the American Association of Community Colleges, the W.K. Kellogg Foundation, and Pew Charitable Fund, released the recommended standards for the education of dental therapy.[14] It was the work of an Advisory Panel, chaired by Dr. Frank Licari, dean of Roseman University School of Dental Medicine. See related story **here**.

The Advisory Panel recommendation includes 44 competencies in six domains, very much like the ones set by other health professions. It states that "*graduates must be competent in providing oral health care within the scope of dental therapy to patients across the lifespan, to include care for the child, adolescent, adult, special needs, and geriatric patient.*" For a detailed list of competencies and domains, see Table 3. Should a dental school be interested in establishing a dental therapy program, it could leverage its existing curricula for dental hygiene and dental education programs, making it a relatively easy undertaking.

Table 3. Curricular competencies for the training of DT.

1. Assessment and judgment

1.1. Identify conditions requiring consultation and treatment that the dental therapist is competent to provide
1.2. Identify conditions requiring treatment by dentists, physicians, other healthcare providers, and manage referrals
1.3. Document existing oral conditions and the care that is provided (record keeping)
1.4. Perform and document information from tests & procedures (radiographs, pulp tests, impressions, and caries and periodontal disease risk assessments)
1.5. Evaluate patients' oral health knowledge and access to healthcare professionals, and identify personal, family, economic, geographic and other barriers to seeking and using care
1.6. Inform patients and recommend comprehensive oral care
1.7. Create and monitor comprehensive, customized long-term oral healthcare protocols for patients, in consultation with a collaborating dentist
1.8. Identify and use the full range of available dental, medical, and other healthcare resources available in the community
1.9. Provide Tx within the DTs scope of practice/referrals, based on PT's general/dental health & social & personal circumstances
1.10. Provide treatment and referral based on previously approved clinical protocols, patient's social and personal circumstances
1.11. Apply ethical, legal and regulatory practices and principles to the provision of oral health care to patients
1.12. Apply critical thinking and problem solving during the provision of evidence-based patient care

2. Preventive care, per protocol

2.1. Provide individualized oral health instruction and disease prevention education for patients
2.2. Provide caries prevention and therapeutic intervention based on age, risk factors, and cooperation
2.3. Deliver customized oral home-care instruction
2.4. Discuss substance abuse counseling, including tobacco cessation and offer appropriate referrals
2.5. Fabricate athletic mouth guards particularly in school settings
2.6. Place sealants and apply fluorides

3. Therapeutic care, provide treatment and referral that is based on previously approved protocols

3.1. Treatment of gingivitis
3.2. Extract primary teeth and mobile permanent teeth
3.3. Remove sutures and change dressings
3.4. Replant and stabilize teeth
3.5. Restore primary and permanent teeth with amalgam and composite restorations
3.6. Fabricate and place temporary crowns
3.7. Prepare and place preformed crowns
3.8. Manage pulp exposures and perform pulp therapy procedures
3.9. Repair defective prosthetic appliances
3.10. Re-cement permanent crowns
3.11. Perform Interim Therapeutic Restoration procedure

4. Pharmacological and emergency management, per protocol

4.1. Administer topical and local anesthetic
4.2. Administer nitrous-oxide analgesia
4.3. Dispense analgesics, anti-inflammatory agents, antibiotics necessary for oral health under the supervising dentist
4.4. Recognize and manage complications arising during performance of dental therapy
4.5. Recognize and manage medical emergencies occurring during performance of dental therapy services

5. Professional and community responsibility

5.1. Practice consistent with all applicable legal, regulatory, and ethical standards, and within the scope of one's competence
5.2. Pursue continuous learning, including periodic reassessment of needed training and continued competency
5.3. Demonstrate knowledge of practice management principles, including state and federal regulations for occupational safety and health and privacy of patient records
5.4. Participate in professional activities
5.5. Advocate/participate in needs assessment, oral epidemiol. surveys, establish systems to promote community level oral health
5.6. Work to enhance the oral health resources available in communities
5.7. Use telehealth and other technology to communicate with supervising dentists and other healthcare providers
5.8. Plan and participate in community oral health programs
5.9. Advocate for effective oral health care for underserved populations
5.10. Provide oral health care for individuals and populations in non-traditional practice settings and in communities/geographic regions with limited health care resources

V. Patient Care Services.

The clinical education of students should be in a model setting that provides oral health services to patients that adheres to contemporary policies and procedures regarding: (a) patient safety; (b) confidentiality of patient health information and records; (c) informing patients about their treatment needs and the scope of services available at the clinic; and (d) the rights of patients who receive services at the clinic.

Financing the creation of DT programs is a topic of intense debate and Congressional legislation. In a recent report to the Health Resources and Services Administration (HRSA),[16] there were five recommendations:

1 that Congress update the authorizing legislation for the Public Health Service Act Section 748(a)(1) to

explicitly include dental therapy programs and trainees.

2. that Congress increase the funded appropriation for Title VII, Section 748 by $6 million annually to be utilized for dental therapy training programs.
3. that faculty of dental therapy training programs be eligible for the Dental Faculty Loan Repayment Program (DFLRP) authorized under Title VII, Section 748, of the Public Health Service Act and that the DFLRP receive a funding increase of $1 million to be set aside for faculty of dental therapy programs.
4. that the Secretary, HHS, include dental therapy as an eligible profession for scholarship and loan repayment through the National Health Service Corps (NHSC).
5. That HRSA implement a longitudinal tracking mechanism for dental therapy trainees, faculty, and graduates, including data on trainee and faculty diversity, retention in the profession, educational debt load, graduate practice location, and populations served.

Unfortunately, the bill has not been passed. Although there was support in both houses, the bill did not survive except for reaffirming continued support for practicing dental therapists on federally sponsored tribal lands in Alaska and Washington State. The congressional debate is important nevertheless to keep the topic on the "front burner" of future appropriations bills. Louis W. Sullivan, former U.S .Secretary of Health and Human Services in the Clinton Administration, and Caswell Evans emeritus professor at the University of Illinois at Chicago College of Dentistry, wrote in a recent editorial17: *"For years, Congress has dismissed the evidence and ignored the return on investment by prohibiting funding to a grant program created to fund education programs for dental therapists and other emerging workforce models, like community dental health coordinators, advanced practice dental hygienists, dental therapists, dental health aides, and other health professionals deemed appropriate [….] Ending this prohibition will give States the flexibility to further expand access and equity in dental care, particularly in poor, underserved and rural communities.*"

Although there is wide support for it in both chambers, the bill is unlikely to become law this year.

5. HOW EFFECTIVE are dental therapists?

Every study that evaluated DT performance in NZ, Australia, Alaska, and Minnesota has found that the care provided was equal to that of dentists, providing savings and efficiencies with improved access, care, and patient satisfaction.

The NZ system, evaluated in 1975, provided care to 65% of preschool and 95% of school-age children. "*In 1925 there were 78.6 teeth requiring extraction for every 100 teeth that were restored. In 1974 this figure was reduced to 2.5 extractions per 100 restorations*" according to the study.[18]

A more recent survey of the New Zealand oral health system found that "… *large improvements in oral health have occurred for children since the 1980s, with the proportion of 12–13-year-olds who were caries-free almost doubling between 1988 (28.5%) and 2009 (51.6%). The average lifetime experience of dental decay in permanent teeth (DMFT)[1] had also significantly decreased (from 2.4 to 1.3 teeth) for this age group.*" This improvement was due to the dental therapy system that extends free care to all children in New Zealand up to age 18.[19]

In 2012, the Kellogg Foundation sponsored a comprehensive review of dental therapists worldwide. It showed DTs provide effective dental care to millions of children. It stated that "*countries using dental therapists*

have been effective in improving access and the care provided to children. In New Zealand, 96 percent of school age children, and 49 percent of preschool children are enrolled in the school dental service and cared for by dental therapists. In Malaysia, 96 percent of elementary school children and 67 percent of secondary school children are enrolled in the school dental service staffed by dental therapists. And in Hong Kong, 95 percent of children have access to dental care in school clinics."[8,9]

A 2014 study concluded that DTs deliver good care and are cost effective.[20] Furthermore, there was an increase in income and the number of treated patients in dental offices where dental therapists were utilized.[21] Between 2009 and 2019, in a Minnesota clinic that employed dental therapists, the average number of procedures per treatment day rose from 18.7 to 25.6. The average number of patient visits per treatment day increased from 10.0 to 13.8. Overall, "*the introduction of DTs to clinical teams enhanced capacity and productivity, enabling [the clinic] to meet increasing demand from the patient population.*"

Finally, the Dental Health Aide Therapists in Alaska Yukon-Koskwim Delta program provided more preventive care and fewer extractions at the community level than expected.[22]

6. WHY NOT eliminate DTs altogether? Opposition to DT.

No amount of data or logical arguments could reduce the animosity surrounding the DT workforce. Two previous attempts to introduce midlevel providers (1949[23] and 1972[24]) were successfully derailed by organized dentistry.[25] In the last decade, however, state legislators, patient advocates, civic groups, civic minded associations, and non-profits are pushing back, as evidence of the success in instituting DT programs and authorizing legislation in 14 states.

Do dental therapists (midlevel providers and dental nurses) improve oral health? If one listens to Sun Costigan, president of the California Academy of General Dentistry, the answer is no. He argues that "*high school graduates with a few years of training could end up performing delicate procedures with permanent consequences: Imagine how you would feel if your children were being taken care of by these people*".[26]

Cassamassimo, in a 2011 position paper, "*questioned the applicability of dental therapy in the United States and suggested that the debate on dental therapy in the country ignores crucial issues and will delay the likelihood of improvement in children's access to oral health care."*[27]

Conclusion

Listening to the voice of organized dentistry, one feels that the sky is falling. Looking at the data, evaluating the social need DT fulfills, and the spread of dental therapy from one state in 2009 to 14 states in 2023, speaks for itself. Similar to the difficult road dental hygienists had to take 100 years ago, dental therapists are gaining well-deserved recognition from the public with both sides of the debate claiming to represent their best interests. Dental therapists are here to stay.

Acknowledgments

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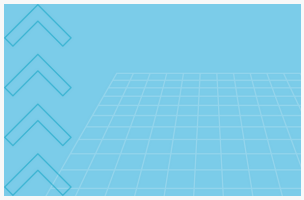
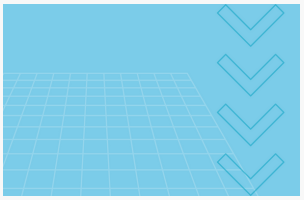


In Memory of Andrew Schenkel

A Message from the JADE Editorial Board Chair



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