Interprofessional Collaboration in Dental Hygiene

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Interprofessional collaboration (IPC) has been growing in many sectors for some time now. But what does this mean for health care professionals? Petri defines health care collaboration as "an interpersonal process characterized by health care professionals from multiple disciplines with shared objectives, decision-making together to solve patient care problems."[1]

INTERPROFESSIONAL COLLABORATION AND THE DENTAL HYGIENIST

How does this description of collaboration apply to dental hygiene practice? As oral health professionals, dental hygienists are responsible for collaborating on their client's care with others to achieve the best oral health outcomes. This is played out in clinical practice with the collaboration between the clinicians in the workplace as they each treat clients within their scope of practice. Dental hygienists also enjoy collaborating with other oral health professions, for example, as may be seen in the process of referring a client to a periodontist and the (often) subsequent shared care of the client.

INTERPROFESSIONAL COLLABORATION VS COLLABORATIVE PRACTICE

Current thinking around IPC in health care has moved towards an emphasis on collaborative practice. In contrast to IPC, collaborative practice is a more inclusive model that centres the client in discussions as an active participant in goal setting and decision making.[2] Longitudinal studies have indicated that a collaborative practice approach produces better health outcomes and addresses some social determinants of health (SDoH), while providing empowerment and advocacy for clients.[2] Collaborative practice is embedded in the Federation of Dental Hygiene Regulators of Canada's *Entry-to-Practice Canadian Competencies for Dental Hygienists* released in 2021.[3] Considering dental hygienists are regularly engaged with their clients, it is incumbent upon them in Canada to implement collaborative practice with clients, other oral health professionals, and community networks.

COLLABORATIVE PRACTICE IN ACTION

An exciting example of collaborative practice is a community health centre model in the Northumberland district of Ontario.[4] The Community Health Centres of Northumberland (CHCN) is a non-profit interprofessional primary health care team comprising family physicians, nurse practitioners, registered practical nurses, dietitians, social workers, pharmacists, occupational therapists, behavioural support nurses, geriatricians, dentists, dental hygienists, and dental assistants. This comprehensive team offers services from oral health care to geriatric assessment and intervention and includes many programs to meet the population's needs. Organizing an interprofessional team under one umbrella affords the various health professionals the ease of discourse and collaboration as they seek to partner with their clients to meet their health care needs.

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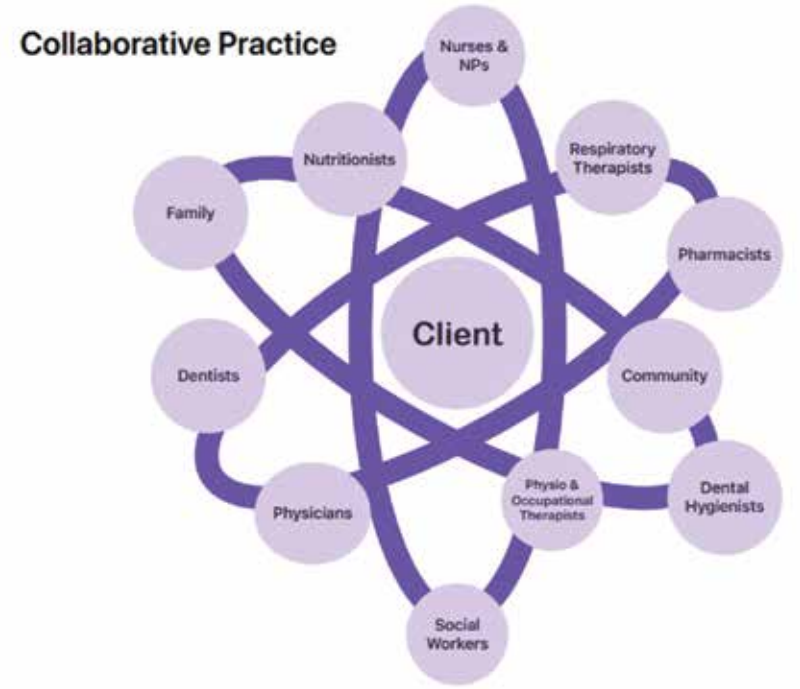
Interprofessional Collaboration…cont'd

LIMITATIONS OF IPC

A major limiting factor to IPC is the power imbalances experienced by many health care professionals in the workplace, to which oral health care teams are not immune. While there continues to be growth in the number of dental hygienists who choose to work in independent practice, the majority remain in traditional dental practices. This employer/employee relationship complicates the interprofessional collaborative dynamic. According to Okpala, the factors that contribute to power imbalances include inadequate allocation of time, deferral to the medical/dental hierarchy (i.e., respect given for designation rather than expertise and experience), lack of confidence in others' competencies, and poor communication.[5] These issues can be mitigated by moving towards an environment that embraces shared decision making, effective communication, education, and mentoring in collaborative practice.



In addition, the collaboration that allied health professionals seek with the medical field is hampered mainly by systemic factors. Our health care system still situates the primary care provider (PCP), family physicians, and nurse practitioners as the "gatekeeper" and the only means of referral to a specialist. For instance, a physiotherapist who assesses that their client would benefit from a consultation with an orthopedic surgeon must first relay their findings to the client's PCP to have the referral initiated. This step wastes resources, not only in clinician hours and wait time for the client, but also in health care spending. Furthermore, who is better positioned to describe their findings and concerns than the practitioner who specializes in this area and has intimate knowledge of the client and this specific concern?

FUTURE OF COLLABORATIVE PRACTICE

While we see some shining examples of collaborative practice, there are still great strides to be made for all health professionals to embody the principles of IPC. One positive outcome of IPC is the dismantling of the silos in health care. The most effective way of achieving this is via the educational system. Queen's University's Master of Health Professions Education program has IPC as a core principle in its programming.[6] IPC is not only taught in the curriculum, but it is also realized through the recruitment of candidates ranging from physiotherapists, anesthesiologists, and midwives to trauma surgeons and dental hygienists. Through learning and conversations, these health care professionals build relationships and form partnerships that ultimately benefit their patients and clients.

These educators then take their understanding of IPC and implement changes within their various disciplines and institutions. What better way to realize IPC than by the movement of health professionals between disciplines? Many subjects such as ethics, research, Indigenous cultural competency, and SDoH can be taught by educators outside of that silo of health care. Through such visionary programming at the educational level, the silos in health care can be dismantled…or at least diminished.

References

1. *Petri L. Concept analysis of interdisciplinary collaboration. Nurs Forum. 2010;45(2):73–82. DOI: 10.1111/j.1744-6198.2010.00167.x*
2. *McNaughton SM, Flood B, Morgan CJ, Saravanakumar P. Existing models of interprofessional collaborative practice in primary healthcare: a scoping review. J Interprof Care. 2021;35(6):940–52.*
3. *Federation of Dental Hygiene Regulators of Canada. Dental Hygiene Competencies [Internet]. Available from: fdhrc.ca/pages/dental-hygiene-in-canada/competency-project*
4. *Community Health Centres of Northumberland. Welcome to Your Community Health Centre [Internet]. Available from: chcnorthumberland.ca*
5. *Okpala P. Addressing power dynamics in interprofessional health care teams. Int J Healthc Manage. 2020;14(4):1326–1332.*
6. *Queen's University. Health Education Programs: MHPE Course Descriptions [Internet]. [cited 2024 May 27]. Available from: healthsci.queensu.ca/healthed-programs/mhpe-course-descriptions*