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# STATE LICENSURE AND DISCIPLINE OF DENTISTS

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**OFFICE OF INSPECTOR GENERAL**  
**OFFICE OF ANALYSIS AND INSPECTIONS**

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AUGUST 1988

## **OFFICE OF INSPECTOR GENERAL**

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## **THIS REPORT**

Entitled "State Licensure and Discipline of Dentists," this report is part of an inspection conducted to promote a better understanding of State licensure and discipline practices concerning dentists, chiropractors, optometrists, and podiatrists.

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STATE LICENSURE AND DISCIPLINE OF DENTISTS

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## EXECUTIVE SUMMARY

PURPOSE AND OBJECTIVES: The overall aim of this inspection was to promote a better understanding of State licensure and discipline practices concerning dentists, chiropractors, optometrists, and podiatrists. It sought to identify the extent and type of changes occurring, the major issues being addressed, and the kinds of improvements that might be made. This report, which focuses on the licensure and discipline of dentists, is the first in a series of reports to be issued as part of the inspection. Subsequent reports will focus on chiropractors, optometrists, and podiatrists.

BACKGROUND: The inspection follows up on a similar inquiry that was conducted by the Office of Inspector General in 1985 and 1986 and that addressed medical licensure and discipline. It is based primarily on three lines of inquiry: (1) telephone discussions with board members or staff of State licensure and discipline bodies, (2) a review of pertinent literature and data bases, and (3) discussions with representatives of national professional associations.

### FINDINGS:

- o In both the licensure and discipline realms, State board officials tend to feel that they are seriously understaffed and that, as a result, the effectiveness of both licensure and discipline operations is compromised.

### Licensure

- o State dental board policies concerning licensure by credentials--the practice of granting a license on the basis of one already held in another State--tend to be extremely restrictive. Only 19 boards will issue licenses in this manner; of these, only 11 will issue them to dentists from any State.
- o The great majority of practicing dentists are concerned about this situation because they feel it inhibits their economic opportunity and freedom of interstate movement. Less obvious, but of greater concern to consumers, is that in a number of States it also tends to constrain access to dental services. It is striking that among the 32 States that will not grant licensure by credentials, 19 have dentist-to-population ratios below the national average.
- o Many board officials, particularly in larger States, feel an increasing sense of concern about the adequacy

of the background information they receive on applicants for licensure. This involves both the validity of the credentials being submitted and the completeness of the information being provided.

- o A major factor contributing to this concern is the widely perceived inadequacy of the two national clearinghouses that collect and disseminate information on disciplinary actions taken against dentists. Most board officials express serious reservations about the extent, quality, and timeliness of the data provided by these clearinghouses.
- o Among dental licensure and examination officials, there appears to be an increasing sense of concern about the preparedness of some licensure applicants to practice dentistry. This unease is triggered by the substantial number of foreign-trained dentists who have been seeking licensure, by declining dental admission test scores, and by rising failure rates in some State licensure dental examinations.

#### Discipline

- o During the past 3 years, the annual number of State board disciplinary actions against dentists has increased only slightly. Between 1984 and 1985, it rose from about 660 to 757. From 1985 to 1986, it remained essentially constant.
- o The most serious types of disciplinary actions--revocations, suspensions, and probations--account for most of the disciplinary actions against dentists. They have increased from 53 percent in 1984 to 60 percent in 1986.
- o Disciplinary action rates concerning dentists are higher than for those concerning medical doctors. In 1985, dental boards disciplined about 5.4 dentists per 1,000 active dentists, while medical boards disciplined doctors at a rate of 4.2 per 1,000.
- o Variation in disciplinary performance is also substantial when State dental boards are compared among themselves. These facts stand out:
  - In 1985 and 1986, two boards were disciplining dentists at a rate that far exceeded that of any other board. In 1985, one of these boards accounted for about 23 percent of all disciplinary actions taken against dentists in the United States.

- Larger States have been less active in disciplining dentists than smaller ones. The 10 largest States account for 57 percent of all active civilian dentists in the United States, but only 42 percent of all reported disciplinary actions between 1984 and 1986.
  - The rate of disciplinary action has been disproportionately high in the West and low in the Northeast. Although western States account for 22 percent of active civilian dentists, they account for 32 percent of the reported disciplinary actions between 1984 and 1986. For the Northeast, the comparative rates are 25 percent and 16 percent.
- o Comparatively low license renewal fees appear to be closely associated with low rates of disciplinary action. Of the 14 State boards with annual renewal fees of \$25 or less in 1984, 11 had a 1984-86 rate of disciplinary action below the median rate for State boards.
  - o Self abuse of alcohol or drugs is the most common type of violation upon which disciplinary action is based. Clinical misjudgment is the second most common type.
  - o The dental boards in States with the smallest number of practicing dentists tend to be the least likely to discipline dentists on the basis of clinical misjudgment.
  - o Consumer complaints are the major source of disciplinary actions against dentists. In contrast, relatively few such actions emerge as a result of referrals from State dental societies or investigations initiated by the boards themselves.
  - o In about one-third of the States, the boards are experiencing a significant backlog of cases to be investigated. Included among them are the two largest States, which, together, account for about 22 percent of active civilian dentists in the United States.
  - o State dental board officials tend to be supportive of the national data bank to be established under P.L. 99-660. However, they raise a number of concerns associated with its implementation. Among them are concerns about the accuracy, confidentiality, timeliness, and accessibility of the data that will be in the bank.

#### RECOMMENDATIONS:

- State governments should assure that State dental boards have sufficient resources to carry out their responsibilities effectively.
- State dental boards should join together to establish and use a high quality national clinical licensure examination.
- State dental boards should explore workable, cost-effective approaches to continuing competency assessment.
- State dental boards should shore-up their credential verification processes.
- The American Association of Dental Examiners (AADE) in close consultation with the American Dental Association, the American Association of Dental Schools, and the Council of State Governments should develop guidelines for State dental practice acts.
- The AADE should accumulate and disseminate, on a regular basis, changes in State practice acts and regulations.
- The AADE should identify and disseminate to State boards the most effective techniques of credential verification.
- The American Dental Association (ADA) should encourage more extensive and effective interaction between its State societies and State dental boards.
- The Public Health Service (PHS) should assist the AADE to carry out a more effective leadership role in working with its member boards.

#### COMMENTS:

The PHS and AADE were in general agreement with the recommendations directed to them. The ADA noted that most State dental societies already have guidelines addressing referrals to State dental boards and did not comment on whether further encouragement was needed. Detailed comments of these and other organizations as well as our responses to them appear in Appendix IV.



## INTRODUCTION

In June 1987, the Office of Inspector General began an inspection on State licensure and discipline practices concerning dentists, chiropractors, optometrists, and podiatrists. The overriding purpose of the inspection was to provide the Federal and State governments and the respective professional communities with a better understanding of these practices. More specifically, it sought to identify the extent and type of changes taking place, the major issues being addressed, and the kinds of improvements that might be made. (For more background on why the study was undertaken, see Appendix II.)

This report, which focuses on the dental profession, is the first in a series of reports to be issued as part of the above-noted inspection. It is based on three major lines of inquiry:

(1) telephone discussions with board members or staff associated with dental licensure and discipline bodies in 50 States and the District of Columbia (hereafter referred to as a State); (2) a review of pertinent literature and data bases, including journal articles, studies, prepared speeches, and statistical compilations of public and private organizations; and (3) discussions with representatives of various professional associations. These include the National Clearinghouse on Licensure, Enforcement and Regulation (CLEAR), the American Dental Association (ADA), American Student Dental Association, American Association of Dental Schools, American Association of Dental Examiners (AADE), Council on Dental Education, Joint Commission on National Dental Examinations, and the four regional examination boards. (For more methodological background, see Appendix III.)

Dentists are a major presence on the national health care scene. In 1985, there were about 141,000 practicing dentists<sup>1</sup> who accounted for about \$27 billion in expenditures (about 6 percent of national health expenditures).<sup>2</sup> Under the Federal Medicare program, however, the role of dentists is quite limited as coverage is confined to "surgery related to the jaw or any structure contiguous to the jaw, or the reduction of any fracture of the jaw or any facial bone." Thus, dental services represent a very small part of total Medicare expenditures. In FY 1983, Medicare Part B expenditures for dental services were \$6.6 million; in FY 1984--\$7.2 million.

Under Medicaid, the role of dentists and the level of expenditure they account for are more prominent. As of April 1987, 43 States were providing dental services to the entire Medicaid eligible population.<sup>3</sup> During 1985, total Federal-State Medicaid expenditures were about \$500 million, a level that has been more or less constant in the 1980s.<sup>4</sup>

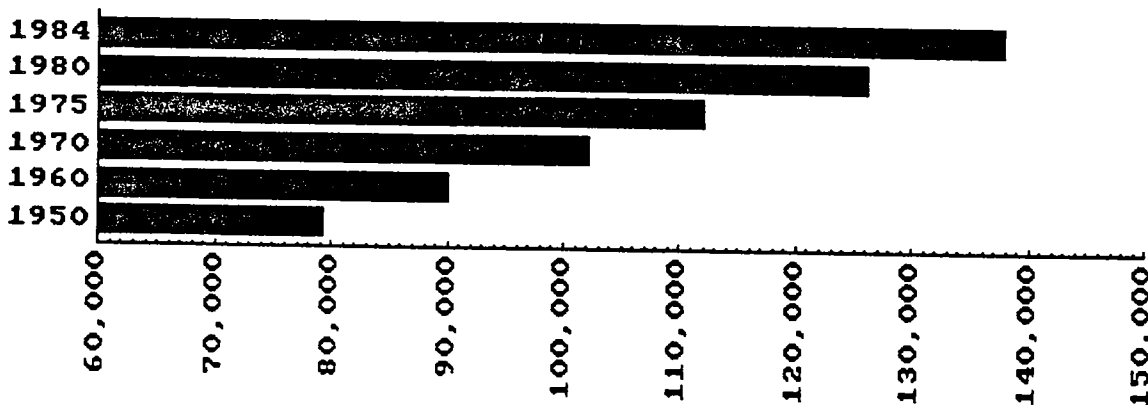
The report starts out with brief overviews of dental practice and State dental boards. It then turns to an examination of the major changes and issues affecting licensure and discipline. It closes with some suggested areas of action, directed primarily to State dental boards.

### DENTAL PRACTICE

One of the most striking characteristics of practicing dentists is their relative isolation. Whereas medical doctors typically are on hospital staffs and thus interact frequently with their peers in the hospital environment, dentists usually confine their work to the office setting. And even in this setting, the great majority of dentists work alone. In 1985, about 58 percent of all dentists were sole proprietors.<sup>5</sup> Among independent dentists (those who own or share in the ownership of dental practice), 61 percent were sole proprietors, compared with 31 percent who were shareholders in an incorporated practice and 8 percent who were in a partnership arrangement.<sup>6</sup> About 85 percent of the independent dentists were general practitioners; the others were specialists in areas such as orthodontics, oral surgery, periodontics, and pedodontics.<sup>7</sup>

Because of an increasing supply of dentists and improving dental health, some dentists, particularly younger ones, are expressing concerns about their income prospects. In recent years, however, the median income of independent dentists has continued to climb, from \$50,000 in 1981 to \$65,000 in 1985.<sup>8</sup> For these dentists, about one-half (49 percent) of their income in 1985 was derived from direct patient payment. This compares with 45 percent from private dental insurance, 5 percent from government programs, and 1 percent from other sources. During 1985, one-half of all independent dentists received no income at all from government programs. In contrast, only about 4 percent received no income from private dental insurance.<sup>9</sup>

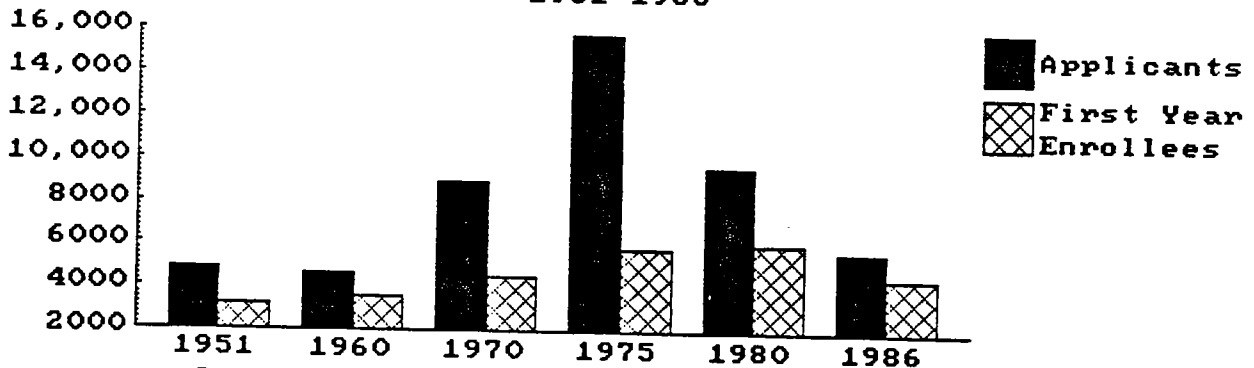
**FIGURE I  
ACTIVE DENTISTS IN THE UNITED STATES,  
SELECTED YEARS, 1950-1984**



Source: Fifth Report to the President and Congress on the Status of Health Personnel in the U.S., March 1986

The increasing supply noted above has been a major phenomenon in the dental community. Over the past four decades, the number of active dentists has been rising substantially, with particularly sharp increases in the 1970s that were stimulated by Federal financial support to schools and students (See Figure I). Throughout this period, the number of dentists per 100,000 population has grown from 51 (1950) to 58 (1984)<sup>10</sup>. The distribution, however, has remained uneven. In 1984, for instance, there were 68 dentists per 100,000 population in the Northeast, 62 in the West, 58 in the Midwest, and 46 in the South.<sup>11</sup>

**FIGURE II**  
**APPLICANTS TO AND FIRST YEAR ENROLLEES IN**  
**UNITED STATES DENTAL SCHOOLS, SELECTED YEARS,**  
**1951-1986**



Sources: American Association of Dental  
 Examiners and American Dental  
 Association

Perhaps the more significant point at the present time is the tapering off of growth. This is dramatized by the recent decisions of three dental schools to close, which will reduce the total number in the United States to 57, and is reflected in the declining number of applicants to and first years enrollees in U.S. dental schools (Figure II). Between 1951 and 1975, the number of annual applicants tripled from 4,852 to 15,734. From that high point, however, the number has regularly been declining, to a level in 1986 that was 63 percent less than that of 1975. Although not quite as steep, the decline in first year enrollees has also been prominent, dropping from a 1978 high of 6,301 to a 1986 low of 4,554. This resulted in a 1986 applicant to first year enrollee ratio of 1:3, well below the 1975 peak of 2:7, but about equal to the level maintained in the 1950s.

Within the next two decades, the American Association of Dental Schools warns that the "continued and haphazard reduction of dental school enrollment levels may result in a manpower supply that is inadequate to meet the dental care demands of the

changing population in the United States..."<sup>12</sup> Yet, at least for the remainder of this century, the Public Health Service projects that the number of active dentists will continue to increase, citing a low estimate of about 158,900 active dentists in the year 2,000 (59.1 dentists per 100,000 population) and a high of 167,020 (62.6 per 100,000 population).<sup>13</sup>

### STATE BOARDS OF DENTISTRY

Two decades ago, State dental boards, like State medical boards, were little noticed entities of State government, dominated almost completely by dentists. Most were independent bodies, having little operational interaction with other professional boards or even with dental boards in other States. Although their responsibilities typically covered licensure and discipline, they focused primarily on the former and in particular on the development and administration of their own licensure examinations. They would discipline dentists periodically, but their authority and readiness to do so were quite limited.

Now, the picture is somewhat different. With the growth in the number of dentists, the development of the consumer movement, the emergence and reemergence of malpractice crises, the heightened concern about Acquired Immune Deficiency Syndrome (AIDS) and other infectious diseases, and the increased attention to the cost and quality of health care, the State dental boards function in a more visible environment with a greater degree of public accountability. While the scope and intensity of the change has not been as great as for State dental boards, it has still been significant.

About 60 percent of State dental boards are now part of a centralized State agency<sup>14</sup> and at least 70 percent have one or more non-dentist members on their board of directors.<sup>15</sup> Nearly all of the boards (90 percent) have responsibility for both licensure and discipline, but instead of preparing and administering their own licensure examinations, most (34) now participate in one of four regional testing organizations that have been established.<sup>16</sup> Also, nearly all (92 percent) have assumed responsibility for the licensure and discipline of dental hygienists as well as dentists.

The staff and financial resources available to the boards are not as readily determined. About 70 percent of them report that they have two or fewer staff members, but in many cases this does not include staff reporting to a central agency that may provide some assistance to a board. Similarly, the budget of a board is often obscured within the budget of a larger agency.

It is clear, however, that in nearly all States the board revenues derive entirely from fees imposed on dentists and any

other occupational groups covered by the board. These include application, examination, and various other fees. However, the major source of fee revenue is the license renewal fee imposed on practicing dentists. In 1985, these ranged from an annual level of \$8 to \$200; the median was \$40.<sup>17</sup> For about one-half of the boards, there have been fee increases either imposed during the past 2 years or scheduled to be imposed during the next year. Yet, because boards typically are part of the State budget process and subject to the same budgeting and personnel controls as other State agencies, fee increases do not necessarily mean increased resources for the boards. Thus, even though dental licensure and discipline has grown to become an estimated \$9 million a year enterprise,<sup>18</sup> many board representatives feel that they are seriously under-funded in carrying out their extensive responsibilities.

#### LICENSURE

Over time, State dental boards have come to judge applicants on the basis of three major requirements: (1) graduation from an accredited or approved dental school, (2) passage of the National Board Dental Examinations (NBDE), and (3) passage of a State or regional clinical examination.<sup>19</sup>

Of these three requirements, the NBDE one is the most consistently and formally applied by the 51 States. All except Delaware, which imposes a 1-year residency requirement, require that applicants pass the NBDE written examination. It is a two-part test, which is devised and administered by the Joint Commission on National Dental Examinations. Part I, usually taken after 2 years of dental school, focuses on the basic biomedical sciences; Part II, generally taken during the final year, addresses various clinical subjects.

State practice concerning the other two requirements tends to be more variable. In regard to the educational requirement, most State boards require that an applicant be a graduate from a dental school accredited by the national accrediting body, the Commission on Dental Accreditation. However, some get involved themselves in determining the adequacy of a school's program and some make exceptions for foreign trained dentists.

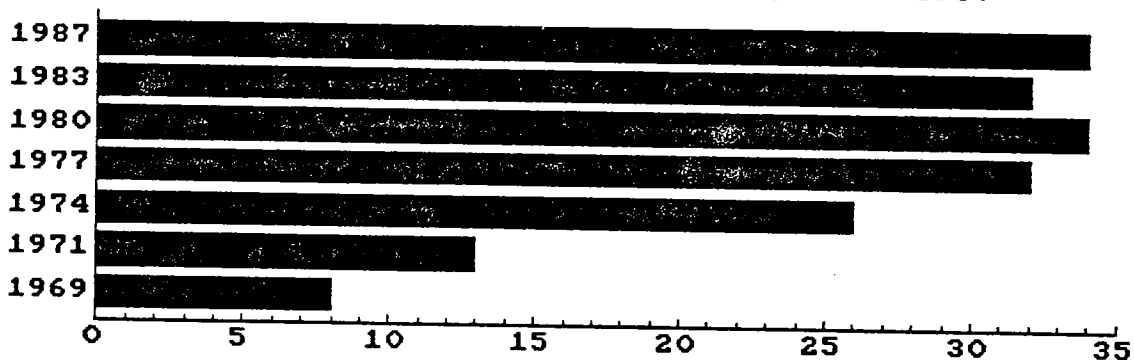
The greatest variation is apparent with respect to the clinical examination requirement. Although the situation is much less heterogeneous than in years past, it is still quite diverse, given that as of late 1987, 17 States still give their own tests and 34 others rely upon 1 of 4 regional tests. Each of those tests seek to assure the clinical readiness of candidates and in so doing requires them to conduct procedures on patients. Yet the contents of the tests vary as do the determinations of acceptable performance.

During the past 3 to 4 years, State dental licensure requirements have been receiving increased attention. In this period, about one-third of the States have made major legislative or regulatory changes in these requirements. Many other States are or have been considering such changes. The type of change that is most prominent involves licensure by credentials, the practice of issuing a license to a dentist on the basis of a license held in another State. Somewhat less prominent are modifications concerning two other matters: the adequacy of background information on applicants and the preparedness of applicants to practice dentistry.

LICENSURE BY CREDENTIALS

State board policies in granting licensure by credentials are extremely restrictive. Only 19 of the 51 boards will issue licenses in this manner, and of these, only 11 will issue them to all dentists from all States. The remaining eight boards apply limitations of various kinds. Two of the States, for instance, will grant licensure only to dentists from States that extend equal rights and privileges to dentists in all States.<sup>20</sup>

FIGURE III  
STATES PARTICIPATING IN REGIONAL TESTING  
SERVICES, SELECTED YEARS, 1969-1987



Sources: Regional Testing Services  
(CRDTS, NERB, SRIA, AND WERB)

Of the 32 States that do not issue licensure by credentials, 16 participate in 1 of the 4 regional testing services. Thus, they will license dentists who pass the regional examination, whether or not they are licensed in another State. However, this route to licensure is not necessarily available if an applicant has not passed the examination within 5 years and, as Figure III shows, the number of States participating in the regional consortia has not increased for some time. Today, as in 1980, 17 States construct and administer their own clinical examinations. Of these, only one (Indiana) will grant licensure by credentials.

As the number of dentists has been growing, the professional dental community across the United States has become increasingly concerned about these restrictive policies. In a 1986 survey, the ADA found that about 77 percent of its membership favored licensure by credentials, an increase of about 15 percent from 1972, when its members were last polled. In 1980, a national organization, the National Dental Council, was established strictly to promote licensure by credentials in all of the States.<sup>21</sup>

The dentists' concerns are rather basic ones. They feel that overly protective licensure policies are inhibiting their economic opportunity and freedom of interstate movement. They feel that it is unfair and unduly burdensome to expect them, after years of practice, to take a clinical examination in order to become licensed in another State. And many feel that out-of-staters often do not do as well as others on State licensure tests for reasons that have little to do with clinical competence.<sup>22</sup>

Although the connection is less obvious, much of the general public may also have good reason to be concerned about restrictive State board policies in licensing dentists already licensed in other States. It is striking, for instance, that of the 17 Boards that limit interstate mobility by requiring applicants to pass a State clinical examination, 13 are in States where the ratio of active dentists is less than the national average. More specifically, they are in States where the average number of active civilian dentists per 100,000 civilian population is below the national average of 56.3, in some cases by a substantial margin. In these 13 States, it does not necessarily follow that the public is being inadequately served. But it is quite clear that the boards' examination requirements inhibit increased public access to dental services.<sup>23</sup>

Similarly, among the 32 States that will not grant licensure by credentials, 19 have dentist-to-population ratios below the national average.<sup>24</sup> Again, the net effect is to restrict the greater availability of dental services to many people.

Although mindful of these and other concerns, many State boards are still reluctant to widen their gateways to licensure for dentists now practicing in other States. They ask why they should be expected to license dentists from States that might have less exacting standards than their own States. Moreover, many express reservations about the extent, quality, and timeliness of information provided by the two national clearinghouses on disciplinary actions. In this context, there seems to be a good deal of awareness of Ohio's decision a few years ago to discontinue licensure by credentials after using it for about 10 years. During that period (1974-1984), of the 142 dentists licensed by credentials in Ohio, 9 subsequently had their

licenses revoked for felony convictions. Each of the nine, it turned out, had left their home States with disciplinary action pending.<sup>25</sup>

Another reservation is less openly addressed, but must still be recognized as a factor. It involves a concern about how licensure by credentials might lead to an influx of dentists to the State. Such a concern appears to be especially prominent in the sunbelt States, none of which are included among the 19 States that will grant licensure by credentials.

In this context, the director of one State board which allows for licensure by credentials has remarked: "It is not the business of the dental board to limit the number of dentists in our State." He added that "any qualified practitioner who has sound professional morals and ethics should not be denied the right to practice" in the State.<sup>26</sup> Yet, another observer with more than two decades of experience in dental licensure and examination commented as follows in a discussion with us:

"Economic discrimination is the big issue. Let's face it. State board licensure policies are supposed to have nothing to do with supply/demand issues. Yet in all too many cases, they have everything to do with such issues."

In a number of States, the controversy over licensure by credentials has led to some change in State board policy concerning this practice. During the past 3 to 4 years, at least 15 States have amended their licensure by credential policies, with about 10 of them making them more restrictive and 5 more lenient.

#### ADEQUACY OF BACKGROUND INFORMATION

During the early 1980s, State medical boards were severely shaken by scandals involving fraudulent credentials from two Caribbean medical schools and by breaches of security on some medical licensure examinations. State dental boards during this period have not had to face any comparable developments. Yet many of them, particularly in the larger States, reflect an increasing sense of vulnerability about the adequacy of the background information they review on applicants for licensure. This concerns both the validity of the credentials cited in an application and the completeness of the information bearing on an applicant's professional conduct.

In the past 3 to 4 years, about one-fifth of the State boards report that they have introduced changes which call for more detailed information in application forms and/or more vigorous efforts in verifying the credentials of applicants. Other boards are now considering changes of this sort. Most of the changes made involve application form extensions intended to promote a



fuller accounting of how applicants have spent their time and of any disciplinary or drug problems they may have had. In a few cases, they involve more diligent verification efforts through telephone inquiries, fingerprinting requirements, or even Federal Bureau of Investigation checks.

Overall, however, the scope of these changes is limited and, many board officials suggest inadequate. The major reason cited by the boards for the failure to take more substantial actions is the insufficient resources available to the boards: most specifically, the lack of funds to hire additional staff. The result, many boards report, is that the backgrounds of many individuals are checked superficially, if at all, and the boards are compelled to rely too heavily on the assumption that applicants are telling the truth. They add that this situation seems to present a particular vulnerability in the case of applicants who are already licensed in other States or who received their dental degrees in countries other than the United States or Canada. In this regard, it is pertinent to note that in 1984, the Council on Dental Education/Commission on Dental Accreditation reported that a "majority of state boards make little or no effort to obtain verification beyond requiring notarization of documents. Sometimes, the notarization applies only to accuracy of translations."<sup>27</sup>

Given this vulnerability, some boards are devoting more emphasis to background checking, even if it means some slowing down of the time involved in processing applications. Although such slowdowns do not appear to be a major nationwide problem at this time, about one-fifth of the boards report that the time devoted to processing applications has increased significantly during the past 3 to 4 years.

A second factor that inhibits more effective board action in reviewing applicant backgrounds is the widely perceived inadequacy of the national disciplinary action clearinghouses maintained by the American Association of Dental Examiners and the National Clearinghouse on Licensure, Enforcement and Regulation. Although 63 percent of the boards report that they use one or both of these clearinghouses,<sup>28</sup> the great majority of them feel they are of only limited usefulness. Primarily, this is because of the fact that neither of them offers a complete listing or even close to a complete listing of all the disciplinary actions taken by the 51 States. There are other reasons as well, bearing on the insufficient data held by the clearinghouses on dentists who have been disciplined, the time involved in sending the data to the boards, and, in the case of AADE, the fact that the data is not sent in regular summary reports, but must be requested in writing for a particular dentist.

The unease generated by these limitations is especially significant in the States that grant licensure by credentials and

thus are more likely to be reviewing applications from dentists licensed in other States. But it is felt to a considerable degree in most other States as well. Expressing much frustration over the deficiencies of the current system, one board representative emphasized that the inability to track "bad" practitioners is "a major, major problem" warranting immediate attention.

#### PREPAREDNESS OF APPLICANTS

Another type of vulnerability concerns the skill of the applicants rather than their credibility. Some long time participants in dental licensure and examination are beginning to express concern about the preparedness of licensure applicants to practice dentistry. Although they are not talking in terms of a crisis, they are pointing to danger signals that may warrant attention.

The most noted of these signals is the substantial number of foreign-trained dentists who have been seeking and obtaining dental licenses in the United States.<sup>29</sup> Since 1969, when California became the first State to extend eligibility for licensure to such dentists, more than 3,000 foreign-trained dentists have been licensed to practice dentistry in the United States.<sup>30</sup> At present, graduates of non-accredited dental schools (which, in essence, means foreign-trained dentists) are eligible for licensure in 18 States, among which are some of the largest.

Among the professional dental community, there appears to be a strong and pervasive feeling that these dentists are not as adequately trained as those who graduated from U.S. dental schools. This seems to be corroborated by their comparatively poor performance on the dental licensure examinations. For example, in 1986, 55 percent of the graduates of foreign dental schools failed Part I of the National Board Dental Examination compared with 13 percent of the U.S. graduates; for Part II, 41 percent of the former failed, compared with 10 percent of the latter.<sup>31</sup> Over the years, such wide differentials have been typical.

Of late, however, the concerns about preparedness are also being expressed about some graduates of dental schools in the United States. This appears to emerge from the declining enrollment levels in dental schools and a feeling by some individuals that they are not as attractive to the "better" students as used to be the case. One official, long involved with dental examinations, commented as follows:

"We're graduating students now that aren't as good as they used to be. I've had deans admit, off the record, that at least 25 percent of the students they admit should not be in dental school. So the failure rates on the exams rise and the schools get annoyed with us."

This perception may be a somewhat exaggerated one and has certainly been expressed in previous eras. But there is data to support the view that the trend in ability levels may be down rather than up. Thus, since 1976, when the grade point average of dental school applicants reached its high point of 3.27, it has declined to a 1986 level of 3.02 (which is, however, higher than that of the 1960s and similar to the trend in other professions). Similarly, dental admission test (DAT) scores have declined from 1976 highs of 4.92 for the academic portion and 5.12 for the perceptual part, to a 1986 level of 4.33 and 4.46. These DAT scores are more nearly equal to the levels that were characteristic of the 1960s.<sup>32</sup>

It is more difficult to gauge whether overall performance on dental examinations has been declining. Because the NBDE examination is norm-referenced, the fluctuation in the failure rate from year-to-year is minimized. This is not necessarily so for the regional and State clinical examinations, which, it appears, have shown considerable fluctuation. There is no aggregate data available to indicate the overall trend in applicant performance on these examinations, but failure rates on them often appear to be 20 percent or higher.<sup>33</sup>

Thus far, nearly all the action taken in response to the concerns about preparedness has focused on the foreign-trained dentists. Since 1984, three States that used to license graduates of non-accredited schools have taken action to preclude that practice.<sup>34</sup> A number of others have continued to allow them to be eligible for licensure, but have added certain supplementary requirements, the most common of which is 2 years of additional education in an accredited dental school. Still other States are actively considering the imposition of stricter requirements on foreign-trained dentists. In one of these States, a board official noted that in his State the current licensing practices involving these dentists were "loose as a goose."

There are no counterpart developments focusing on a tightening of requirements for licensure applicants in general. However, dental educators are becoming increasingly active in promoting the case for a postdoctoral training requirement, similar to the residency requirement imposed on medical doctors.<sup>35</sup> Much less so, one even hears some expressions of support for a national clinical examination that would replace the current regional and State examinations.

#### DISCIPLINE

Over the years, the authority of State boards to discipline dentists has gradually been increasing, with respect to both the grounds upon which they can take disciplinary action and the type of action they can take. During the past 3 to 4 years, about two-fifths of the boards have experienced some legislative or

regulatory change concerning their disciplinary authority. Nearly all of this change has increased their authority in one way or another; most often, it has served to expand the range of disciplinary options available to them.

As of 1984, the latest year for which aggregate data are available, all of the boards had the authority to revoke or suspend dentists' licenses if proper grounds were identified. In most States, however, the additional types of disciplinary action that could be imposed were quite limited: 25 had the authority to invoke probations, 22 to issue reprimands, 17 to apply restrictions on dental practice, 14 to impose censure, and 14 to levy fines ranging from a low maximum of \$1,000 to a high of \$10,000.<sup>36</sup>

Since 1984, these numbers have increased, with more States having a greater range of disciplinary options available to them. Yet many States still lack a full complement of options as well as other basic authorities, such as the authority to issue subpoenas or to suspend immediately the license of a dentist who poses a clear and present danger to the public.

#### INCIDENCE AND TYPE OF DISCIPLINARY ACTIONS

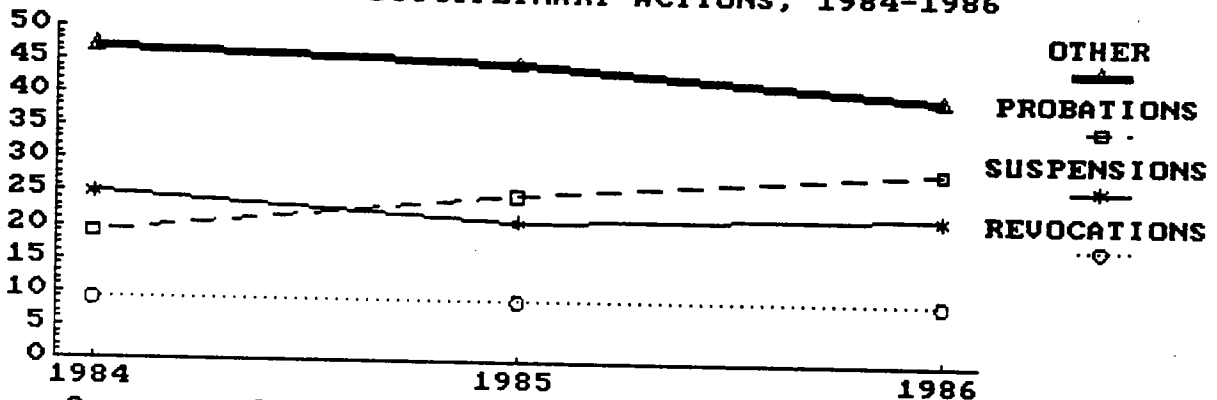
How many and what type of disciplinary actions are being taken against dentists in the United States? The question is a basic one, but one that we learned could not be answered.<sup>37</sup> The existing information bases were too limited, even to provide reasonable estimates.

Accordingly, in our discussions with representatives of the 51 State boards, we asked them to indicate the number and type of disciplinary actions imposed on dentists during each of the past 3 years. We received the data from 48 States (all except Louisiana, New Hampshire, and West Virginia). In two cases (Arizona and Indiana), the information was not available for 1984 and in a few other cases, the information for total disciplinary actions was available but not the breakdown by type.<sup>38</sup> The result was a nearly complete picture of the extent and nature of disciplinary actions taken in 1984, 1985, and 1986.

What is most striking about this picture is that during a period of much increased national concern about the quality of health care being delivered, the annual number of disciplinary actions imposed on dentists by State boards increased only slightly. In 1985 and 1986, the annual total essentially remained constant, at about 750. From 1984 to 1985, our data revealed a 35 percent increase, from 560 to 756. However, the 1984 total excludes information from one State, which in each of the succeeding years reported more than 100 disciplinary actions. Thus, if its total

for 1984 was at or close to its subsequent levels, the national increase from 1984 to 1985 would be about 15 percent rather than 35 percent.

FIGURE IV  
TYPE OF DISCIPLINARY ACTIONS, AS A PERCENTAGE OF  
ALL REPORTED DISCIPLINARY ACTIONS, 1984-1986



Source: State Dental Boards as Reported to the  
Office of Inspector General

In this 3-year period, tier 1 actions--the more serious ones involving revocation, probation, or suspension--have regularly accounted for the bulk of the disciplinary actions and have increased from 53 percent in 1984 to 60 percent in 1986 (see the top three lines in Figure IV). The tier 2 actions involving less serious actions such as reprimands and fines (and designated in Figure IV as "other") have decreased accordingly, from 47 to 40 percent.

When the performance of State dental boards is compared to that of State medical boards, there are some notable differences concerning both the incidence and type of disciplinary actions. First of all, the dental boards have been more active in disciplining dentists than medical boards have been in disciplining medical doctors. In 1985, the latest year for which comparative data is available, dental boards disciplined about 5.4 dentists per 1,000 active dentists, whereas medical boards disciplined doctors at a rate of about 4.2 per 1,000--a difference of about 29 percent.<sup>39</sup> It is important to recognize, however, that the differential has been decreasing and that since a much smaller proportion of dentists are subject to hospital peer review practices, the reviews of the State dental boards may be of somewhat greater overall significance.

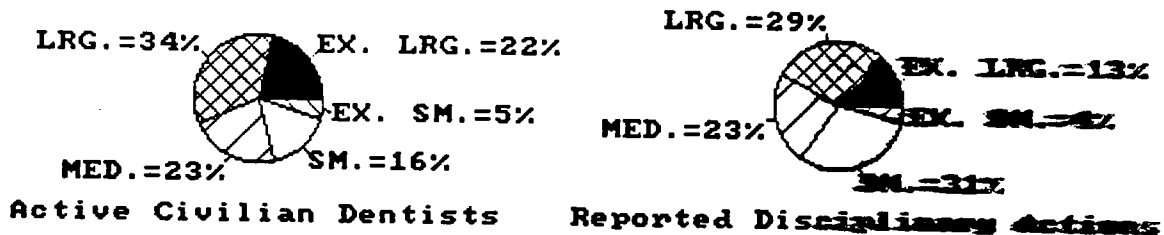
A second notable difference involves contrasting trends in the proportionate emphasis given to the more severe, tier 1 disciplinary actions by the two types of boards. While such actions have been increasing as a share of all disciplinary actions taken by dental boards against dentists, they have been declining as a

proportion of all disciplinary actions taken by medical boards against medical doctors, from 63 percent in 1982 to 53 percent in 1985. As a result, in 1985, tier 1 actions accounted for slightly more than one-half of all disciplinary actions imposed on both dentists and medical doctors. However, within this tier 1 category, the medical boards have been much more inclined to impose the severest action of all: the revocation of a license. While revocations have accounted for 19 percent of all the disciplinary actions these boards have taken against medical doctors in both 1984 and 1985, they have represented only 9 percent of such actions taken by dental boards against dentists in each of those years.<sup>40</sup>

The variations in disciplinary performance are no less apparent when State dental boards are compared among themselves than with State medical boards. In 1985 and 1986, for instance, two such boards (Arizona and Missouri) had been disciplining dentists at a rate that far exceeds that of any other board. In fact, the disciplinary actions of one of these States accounts for about 23 percent of such actions taken by dental boards in the United States in 1986; 14 percent in 1985.

Substantial variations among the boards are also apparent when their rate of disciplinary activity is correlated with size and location. Since year-to-year fluctuations in this regard may be misleading, we have aggregated and analyzed the data over a 3-year period, 1984 to 1986.

FIGURE V  
 PERCENT DISTRIBUTION OF ACTIVE CIVILIAN DENTISTS  
 (1984) AND OF REPORTED DISCIPLINARY ACTIONS  
 (1984-1986), BY SIZE RANKING OF STATES

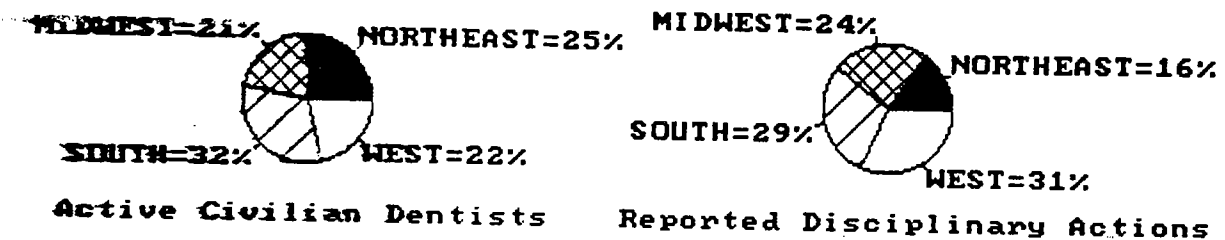


Sources: Fifth Report to the President and Congress on the Status of Health Personnel and State Dental Boards as Reported to the DHC

Out of this comparative examination, it becomes clear that the rate of disciplinary actions against dentists tends to be much lower in the States with the largest number of practicing dentists than in those with the smallest. Thus, among the five categories of States (ranked in accord with their number of

active civilian dentists), the top two categories, which account for about 57 percent of all active civilian dentists in the United States, represent only 42 percent of all reported disciplinary actions imposed on dentists from 1984 to 1986 (Figure V).<sup>41</sup>

FIGURE VI  
PERCENT DISTRIBUTION OF ACTIVE CIVILIAN DENTISTS  
(1984) AND OF REPORTED DISCIPLINARY ACTIONS  
TAKEN AGAINST DENTISTS (1984-1986), BY REGION



Sources: Fifth Report to the President and Congress on the Status of Health Personnel and State Dental Boards as Reported to the OIG

With respect to regional comparisons, the disciplinary action rate is highest in the West and lowest in the Northeast. Although the Western States have about 22 percent of the active civilian dentists licensed in the United States, they are responsible for 31 percent of the reported disciplinary actions. On the other hand, for the Northeastern States, the comparative rates are 25 percent and 16 percent (Figure VI).<sup>42</sup>

Why is the rate of disciplinary action higher in some States than in others? Is it because practicing dentists in some States are more incompetent, dishonest, or unprofessional than in others? Is it because of differing levels of board commitment to take action? Is it because of operational constraints associated with inadequate authority or insufficient resources? Each of these factors may be explanatory to some extent, but, in the case of one—insufficient resources—we have some data to suggest an association.

We found that of the 14 State boards with annual renewal fees of \$25 or less in 1984, 11 had a rate of disciplinary action in the 1984-1986 period below the median rate of State boards. On the other end, however, the association was not as strong. Of 11 State boards with annual renewal fees of \$75 or more, 6 had a 3-year rate above the median and 5 below. Indeed, of the five, two had no disciplinary actions at all during the entire 3-year period. Thus, a comparatively high renewal fee in itself is no guarantee of a higher level of disciplinary activity.

Finally, it is important to recognize that the State dental boards are not the only forums for disciplining dentists. Another, as noted in Appendix I, is the Office of Inspector General (OIG) which can impose sanctions on professionals who have committed fraud or abuse concerning Medicare or Medicaid. During the past 5 years, OIG sanctions against dentists have averaged about 9 percent of all the OIG sanctions imposed, rising from 9 in FY 1982 to 28 in FY 1986.

Also, there are the peer review efforts of State dental societies. Although they do not often result in disciplinary action per se, they do involve reviews and determinations of the adequacy of a dentist's performance which can affect a dentist's membership status in the society. Some individuals familiar with these efforts discount them as the relatively inconsequential activities of an "old boy network" committed to protecting dentists more than the public.

But in many States, the societies are quite active in conducting peer review. As part of an annual survey of these societies the ADA found that in 1986 they initiated 4,067 peer review cases, a 5 percent increase over 1985. Of the 1986 cases, 77 percent involved the quality or appropriateness of care. About 45 percent of the cases were handled through mediation, with about one-half of them resolved in favor of the patient. Of the roughly 55 percent that went to formal review, 36 percent were decided in favor of the patient.<sup>43</sup>

#### TYPE OF VIOLATION

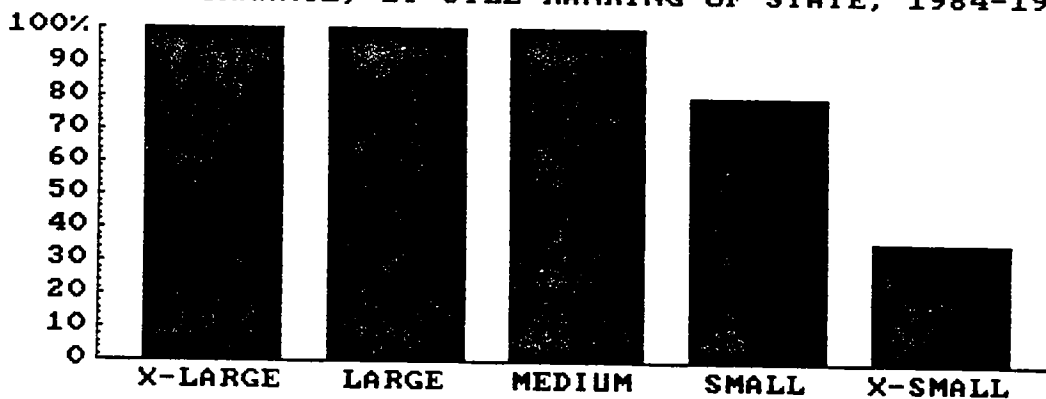
In our prior review of State medical boards, we found that the inappropriate writing of prescriptions was, by far, the most common violation upon which disciplinary actions taken against medical doctors were based. This was followed by violations concerning the self-abuse of drugs or alcohol. Together, both accounted for about three-quarters of all disciplinary actions. Despite the sharp rise in medical malpractice cases in recent years, very few actions were based on inadequate clinical performance.

For dentists, the information available is less definitive, but on the basis of our discussions, it appears that the pattern is quite different. Among the 51 boards we contacted, 33 percent cited self-abuse of alcohol or drugs as the most common type of violation upon which disciplinary action was based and 25 percent indicated clinical misjudgment (which by some respondents may have been interpreted to include cases involving unlawful delegations of authority to dental hygienists). Only 3 percent identified inappropriate writing of prescriptions as the most common type; however, 16 percent referred to it as the second most common type.



The greatest discrepancy appears to be in the propensity to take action because of poor clinical performance. In the case of medical doctors, we cited three factors that seemed to account for the minimal performance: (1) the complexity, length, and cost of such cases, (2) the substantial burden of proof required, and (3) the considerable variations among medical doctors themselves about what constitutes acceptable practice. In the case of dentists, it appears that boards find it somewhat easier to take action on the grounds of poor performance, apparently because the documentation is more readily provided through x rays of the teeth and gums and because consensus on acceptable practice involving this one area of the body seems to be more widely established.

**FIGURE VII**  
**PERCENT OF STATES DISCIPLINING AT LEAST ONE**  
**DENTIST PRIMARILY ON BASIS OF CLINICAL**  
**PERFORMANCE, BY SIZE RANKING OF STATE, 1984-1986**



Source: State Dental Boards as Reported to  
 Office of Inspector General

Not surprisingly, then, 75 percent of all the dental boards report that within the past 3 to 4 years, they have disciplined at least one dentist primarily on the basis of clinical performance. Among the 14 States with the smallest number of licensed dentists per State, however, the picture is quite different. Only 36 percent of them report any such disciplinary actions taken during the past 3 to 4 years, compared with 100 percent of those in the top 3 categories and 80 percent of those in the fourth category (Figure VII). The reason for this differential is not readily apparent.

In most States, whatever their size, there has not been much discussion over the kind of actions that might be taken to avert the poor clinical performance that could lead to disciplinary action. For a time, mandatory continuing education (MCE) requirements seemed to be catching on. But the movement never gathered significant momentum among dental boards, with only 12 having them in place in 1984.<sup>44</sup> More recently, there appears to

be increasing interest in encouraging or even mandating various kinds of self-assessment.<sup>45</sup>

Thus far, the most visible and consequential of the early intervention efforts, intended to correct problems before they lead to violations, are the rehabilitation programs directed to impaired dentists. In our review, 86 percent of the boards indicated that such programs were available, typically under the auspices of the State dental association.

#### SOURCE OF DISCIPLINARY ACTIONS

Consumer complaints are the major source of disciplinary actions against dentists. In about three-fourths of the States, dental board representatives report that such actions are attributable to consumer complaints more than to any other source. This pattern holds regardless of a State's size or region.

In contrast, relatively few disciplinary actions appear to be based on referrals from State dental societies. Such referrals account for the most common source in only one State and the second most common source in only three States. Typically, State societies will refer to State boards all cases involving alleged fraud. However, with respect to their own peer review cases, most tend to refer only those who are repeat offenders or are responsible for a single serious offense.<sup>46</sup> Whether the rate of disciplinary actions taken by State dental boards in response to referrals from State dental societies is significantly different than that from other referral sources is not known. It is an important issue warranting further exploration.

Similarly, the dental boards themselves are responsible for identifying relatively few cases on which disciplinary action is eventually taken. They are the most common source for these actions in only three States; the second most common in only three others. Generally, it appears, they lack sufficient investigatory staff of their own to assume a more active role in this area.

In this environment, individual practicing dentists have been among the least frequent referral sources. However, of late, their tendency to refer cases to State boards appears to have been increasing. In part this may be attributable to State required reporting laws, which exist in about one-third of the States, to State and Federal legislation extending immunity to dentists who make referrals for good cause, and to the increasingly competitive environment characterizing dental practice. Even more so, it seems to emerge from concerns about malpractice suits. In this context, one board director commented as follows:

"Dentists are frightened to death  
to do work on a patient whose work

is sub-quality and will call the board for advice. The board tells them to take pictures of the teeth and write-up their condition."

In one State, Iowa, the board in accord with a State law, has established an arrangement that appears to encourage referrals from multiple sources and to enable it to maximize the effectiveness of its own limited resources. The arrangement is with the State dental society and calls for that society, and its district peer review committees, to serve as the board's official investigatory mechanism for complaints involving dentists. Typically, these committees will try to settle a case through arbitration.

If that fails, a three member committee is appointed to conduct an investigation and report its findings to the dental board. The board at that point may recommend a settlement to the dentist and the complainant or issue an order for a formal hearing.

#### THE ADMINISTRATIVE PROCESS

During the past 3 to 4 years, about one-third of the dental boards have been experiencing a significant increase in the backlog of cases to be investigated. Among them are the boards in New York and California, which, together, account for about 22 percent of active civilian dentists in the United States.

Board officials in these States identify a number of factors that have contributed to this situation. Most of all they point to severe staffing limitations that prevent them from responding adequately to an increasing number of complaints. But they also cite a number of other factors, including the complexity and length of the hearing process, the dependence on State attorney general offices, and the readiness of dentists facing serious charges to maximize their due process rights.

Board representatives from nearly one-half of the States report that there have been major changes made in recent years with the intent of expediting the board's investigatory and review activities. Most prominent of these changes are those involving the hiring of additional investigators and the establishment of informal hearing procedures to handle the increased volume of cases. In some States, these changes appear to have minimized the backlog, but in others the backlog remains significant, sometimes involving hundreds of cases.

#### INFORMATION SHARING

"We have a critical need for more national sharing of information. We do not have a good system for

doing this now. This is our number one national problem."

The above comment, by the director of a State dental board, reinforces our earlier finding on the inadequacy of the national disciplinary action clearinghouses maintained by the American Association of Dental Examiners and the National Clearinghouse on Licensure, Enforcement and Regulation. Simply put, most dental boards discount the current clearinghouses as relatively ineffective mechanisms and tend to rely more heavily on communications among themselves.

In our review, 44 of the boards report that they are regularly sending information on disciplinary actions to AADE and/or CLEAR: 23 to only AADE, 16 to only CLEAR and 5 to both. In recent months, the number of boards regularly sending reports to the AADE clearinghouse, which includes 45 member boards and the Department of Defense, has declined substantially, as a number of State boards have been awaiting the establishment of the national data bank called for under P.L. 99-660 and P.L. 100-93. (See Appendix II.)

But in addition to the level of participation, there are a number of other factors that severely limit the effectiveness of the two clearinghouses. State boards typically do not report on licensure denials or on informal actions (the latter of which often accounts for the bulk of actions taken by a board). Many do not report in a timely manner, sometimes waiting for months before sending the data to a clearinghouse. When they do report, the data provided on disciplined dentists is quite limited, sometimes not including their American Dental Association membership number, social security number, dental school, or even date of birth. And, while their reports always do specify the type of disciplinary action taken, they reflect widespread inconsistencies in how the underlying violations are described and, indeed, on the type of disciplinary action imposed for a particular type of violation. Within their individual States, only eight boards note that they have a clearly defined set of guidelines for determining the appropriate level of disciplinary action.

The great majority of the board officials we talked with are supportive of the soon to be established national data bank. They tend to see it as a helpful national response to the need for better information sharing on disciplinary actions. At the same time, they raise a number of questions that reflect concerns associated with the implementation of the data bank. Among the most prominent of these questions are the following:

- o How accurate will the data be? What steps will be taken to help ensure its accuracy?

- o Will the confidentiality of the data be maintained? Might State laws assuring confidentiality be compromised?
- o How quickly will the data be accessible? What will be done to ensure that the system does not bog down because of administrative overload?
- o How extensive will be the reporting demands placed on State dental boards? Will all the boards be able to meet these demands?
- o Will the new reporting requirements discourage the imposition of formal disciplinary actions? Will informal, low-key actions become more prominent?
- o Will the national data bank produce aggregate data summaries that will facilitate an understanding of trends and help shape risk management efforts?
- o Will dentistry be associated with medicine in a way that might be to the disadvantage of the profession? Will the uniqueness of its single practice setting and the fewer layers of peer review be recognized?

Finally, it is important to recognize that the information sharing that occurs within a State is also of significance. In this sphere, dental boards are becoming somewhat more open, sometimes because of legislative mandate, in disseminating information within the State on disciplinary actions taken against dentists. Most of this dissemination, however, occurs via a board newsletter sent to dental societies, State Medicaid Fraud Units, State insurance agencies, and other State or local entities. In relatively few States does it involve an active effort to share the information with the general public through general circulation newspapers or other popular media outlets.

#### RECOMMENDATIONS

Given the situation described in the previous pages, our central recommendation is the following:

- o State governments should assure that State dental boards have sufficient resources to carry out their responsibilities effectively.

In most cases, that is not now the case. In both the licensure and discipline realms, resource limitations (mainly, staff limitations) are undermining the capacity of the boards to do their jobs. With the forthcoming implementation of the national

data bank and the additional responsibilities it will place on the State boards, the strains generated by the current resource shortfall are likely to become even greater.

Early in 1987, the ADA's Office of Quality Assurance reached much the same conclusion. After reviewing various quality assurance efforts concerning the dental profession, it included the following among its five recommendations:

" . . . the licensure and re-licensure system must be strengthened. It is difficult even to obtain data from the various states on disciplinary cases. The licensing boards are a key element in fulfilling the profession's contract with society and must pursue their responsibilities vigorously if the public is to be assured that its well-being is protected." 47

Since most of the revenue of the State boards derives from renewal fees charged to practicing dentists, they are probably the best source for generating additional revenue for the boards. As noted earlier, the median annual renewal fee in 1985 was only \$40.

In addition to our central recommendation concerning resources, we have a number of more specific ones directed to the State Dental Boards, the American Association of Dental Examiners, the American Dental Association, and the U.S. Public Health Service. The directions set forth by these recommendations will, we believe, contribute to the improved performance of State dental boards and enable States to enact, with confidence, more lenient policies concerning licensure by credentials.

#### State Dental Boards

In many States, the boards must have a fuller range of disciplinary options available to them and a greater degree of enforcement authority; it is particularly important that they be able to issue subpoenas and be able to suspend immediately the license of a dentist who poses a clear and present danger to the public. But even more important is that they carry out existing enforcement authorities more rigorously. This means that they must not only react swiftly and effectively to complaints and referrals, but also assume a more active investigatory role of their own.

Such a strengthening is important primarily because it will help boards protect the public from those few dentists who perform in an unprofessional, incompetent, or fraudulent manner. Not to be overlooked, however, is that it will also support the case for licensure by credentials. If State boards have more confidence in one another's enforcement and discipline efforts, they will have all the more reason to enact policies that allow for licensure by credentials.

- o State dental boards should join together to establish and use a high quality national clinical licensure examination.

Among State dental board officials, this is a very sensitive topic because it involves States' rights and prerogatives. Yet, from a 51-State perspective, the presence of 17 separate State clinical examinations and 4 regional examinations has become increasingly counter productive. It restricts mobility of practicing dentists. It suggests that the professional community can not agree on the minimum level of knowledge and skills necessary to practice dentistry. It results in a duplication of resources devoted to testing. And it diverts State board attention and resources that might otherwise be devoted to enforcement and discipline activities. Other professional boards have successfully established a national clinical licensure examination; it would appear to be constructive for State dental boards to do the same.

Among some State board officials, there is sentiment for moving in this direction. One such official commented as follows:

"I believe in national reciprocity and testing. I would like to see the regional boards join each other and I would like the Northeast Regional Board of Dental Examiners, as the largest regional board, to take the initiative in this area. This would put pressure on the autonomous States to join."

- o State dental boards should explore workable, cost-effective approaches to continuing competency assessment.

Continuing educational requirements appear to be losing support across the country. But there appears to be increasing interest in other approaches such as self-assessment examinations, periodic re-examination, chart audits, peer review, and computerized simulation.<sup>48</sup> The State boards should explore such approaches to help assure that practitioners maintain a minimum level of competency and to help avert disciplinary actions taken on the basis of inadequate clinical performance.

In that context, States might also consider investing boards with the authority to require that a dentist take and pass a clinical examination when sufficient cause exists to suspect that his clinical know-how is below professional standards.

- o State dental boards should shore-up their credential verification processes.

A number of boards have already moved in this direction. But, as many State board officials indicate, more must be done in terms of the extent and type of (1) information requested of licensure applicants and (2) verification undertaken by board officials. Without such additional safeguards, many boards will remain too vulnerable to irregularities that could result in some undeserving individuals receiving a dental license and in an undermining of public confidence in the entire licensure process.

#### American Association of Dental Examiners

For 104 years, the American Association of Dental Examiners has provided a forum for State dental board officials to address common concerns and chart directions that are in their mutual interest. In recent years, these officials have used the AADE to establish a national clearinghouse of disciplinary actions and to develop two sets of guidelines--one for clinical examinations, the other for infection control during the administration of clinical examinations. We feel that it is important for the AADE to supplement these important actions by taking initiatives that will help individual State boards move in the directions recommended above. Given that the AADE recently decided that it would discontinue its clearinghouse upon establishment of the national data bank and that many State boards must clearly improve their enforcement and disciplinary efforts, we feel it is particularly important for AADE to exert leadership that will encourage and support such efforts. To accomplish this improvement, it would appear to be necessary for AADE to increase its limited financial and staffing base. More specifically we offer the following recommendations:

- o The AADE in close consultation with the American Dental Association, the American Association of Dental Schools and the Council of State Governments should develop general guidelines for State dental practice acts.

Such guidelines were developed in 1979 under the auspices of the Council of State Governments. However, they have not been updated and appear to be used only rarely. The AADE would appear to be the most appropriate forum to establish an up-to-date set of general guidelines that States might use as helpful reference points in reviewing and revising their dental practice acts. This is particularly so with respect to the enforcement and disciplinary authorities of State boards, since we have found that in many States, board officials feel that such authorities must be enhanced.

- o The AADE should accumulate and disseminate, on a regular basis, changes in State practice acts and regulations.



An ongoing, formalized information dissemination of this kind would be extremely useful to the State boards. It would enable them to stay more fully abreast of developments in other States and to assess what, if any, significance such developments have for their own States. It would serve as a valuable, more comprehensive supplement to the interaction that now occurs by word of mouth.

- o The AADE should identify and disseminate to State boards the most effective techniques of credential verification.

Because this is not now a crisis area, it is an easy one to overlook. Yet it does involve a danger that should be addressed. The AADE can help individual boards in this regard by identifying and distributing information about some of the best practices undertaken by member boards.

#### The American Dental Association

- o The American Dental Association should encourage more extensive and effective interaction between its State societies and State dental boards.

Such action is important because most State societies make few referrals to State dental boards. The ADA's own Office of Quality Assurance recently noted that "the peer review system must be strengthened, with the objective of identifying substandard practice and helping such a practitioner to improve either technical skills or behavior."<sup>49</sup>

At their October 1987 annual meeting, the ADA House of Delegates took an important step in the direction called for in the above recommendation. For the first time in about 10 years, it changed ADA policy on peer review. Included among the changes was a statement that State society peer review committees should have a "clearly outlined process" for dealing with repeated adverse decisions against a practitioner.

In the manual instructions that will be developed in response to this policy change, ADA will offer more specific directions on desirable practice. We urge that those instructions clearly call for State peer review committees to refer to State dental boards (or to the appropriate State agencies) those dentists who have committed actions that warrant disciplinary action.

#### The Public Health Service

- o The Public Health Service (PHS) should assist the AADE to carry out a more effective leadership role in working with its member boards.

The PHS has long provided such assistance to professional bodies, but in recent years has had minimal association with the AADE, the national body that is most closely and directly tied to the State dental boards. It is now an opportune time to extend whatever support is possible to AADE to help it play a more effective leadership role vis a vis its member boards. At a minimum this role should encompass the three areas identified earlier: (1) the development of guidelines for State practice acts, (2) the accumulation and dissemination of changes in State practice acts and regulations, and (3) the identification and dissemination of effective techniques of credential verification.

APPENDIX I

NOTES

1. U.S. Department of Health and Human Services, Public Health Service. Fifth Report to the President and Congress on the State of Health Personnel in the United States, March 1986, p. 5-35.
2. U.S. Department of Health and Human Services, Health Care Financing Administration. Health Care Financing Notes: National Health Expenditures, 1985, p. 6.
3. American Dental Association. Dental Programs in Medicaid: The 1987 Survey, p. 1.
4. Health Care Financing Notes, p. 22.
5. American Dental Association. The 1986 Survey of Dental Practice: Employment Status of Dentists, February 1987, p. 4.
6. The 1986 Survey of Dental Practice: Employment Status of Dentists, p. 7.
7. The 1986 Survey of Dental Practice: Employment Status of Dentists, p. 4.
8. American Dental Association, Income from the Private Practice of Dentistry: Statistical Results from the 1982 Survey of Dental Practice, April 1983, p. 4 and American Dental Association, The 1986 Survey of Dental Practice: Income from the Private Practice of Dentistry, 1986, p. 6.
9. American Dental Association, The 1986 Survey of Dental Practice: Source of Payment for Dental Services, February 1987, p. 4.
10. Fifth Report to the President, pp. 5-19.
11. Fifth Report to the President, pp. 5-22.
12. This is taken from an official policy statement of the organization. See American Association of Dental Schools. Journal of Dental Education, July 1987, p. 406.
13. Fifth Report to the President, pp. 5-36.

14. Here and elsewhere in this report, unless otherwise noted, the data is derived from our survey of the 51 States. See Appendix III.
15. Council of State Governments, State Regulation of the Health Occupations and Professions: 1985-86, March 1987, pp. 38-39.
16. Information obtained from the Central Regional Dental Testing Service (CRDTS), Northeast Regional Board of Dental Examiners (NERB), Southern Regional Testing Agency (SRTA), and Western Regional Examining Board (WREB).
17. This information is derived from data presented in State Regulation of the Health Occupations and Professions, pp. 48-49.
18. We developed the \$9 million estimate as follows. For each State, we multiplied the total number of licensed dentists in 1985 by the renewal fee for that year. That resulted in a total of \$6 million. We then assumed that renewal fees accounted for two-thirds of overall fee income from dentists and, accordingly, added one-third to the above noted total. This resulted in a new total of \$9 million.  
  
Given that total fee income certainly has increased since 1985, one might well expect a current total of more than \$9 million. However, we balanced that consideration with the consideration that all fee income is not necessarily passed on to the boards.
19. See American Dental Association, Facts About States, 1986.
20. "Licensure by Credentials," ADA News, July 6, 1987, p. 7.
21. Ibid., pp. 5-6.
22. Prepared remarks of Mario V. Santangelo, Secretary, Council on Dental Education and Commission on Dental Accreditation, at American Association of Dental Examiners' Mid-Year Meeting, Chicago, Illinois, February 4, 1984.
23. Fifth Report to the President, p. 5-21.
24. Ibid.
25. Journal of the American Dental Association, July 1985, p. 23.
26. Ibid., p. 24.

27. "Licensure of Foreign-Trained Dentists," 1984 Annual Report of the Council on Dental Education/Commission on Dental Accreditation, Appendix 1, p. 7.
28. Of the 32 boards that indicated they used the AADE and CLEAR clearinghouses, 13 reported that they used CLEAR, 13--AADE, and 6 noted that they used both. These numbers, it should be recognized, refer to the State boards' use of the data in the process of reviewing licensure applications; they do not refer to whether or not the boards send disciplinary data into the AADE or CLEAR clearinghouses.
29. Here and elsewhere in this report, "foreign-trained" refers to those dentists graduating from dental schools in countries other than the United States or Canada.
30. From 1969 to 1982, the ADA reports that about 2,300 foreign-trained dentists were licensed in the United States, with an average annual addition in the 1980's of about 300. In the succeeding years, even if that yearly average were reduced by one-third, which almost certainly has not been the case, the accumulative total of foreign-trained dentists licensed in the United States since 1969 would exceed 3,000. See "Licensure of Foreign-Trained Dentists," pp. 4-5 and American Dental Association, Dentistry in the United States: Information on Education and Licensure, 1986, p. 6-14.
31. Joint Commission on National Dental Examinations.
32. American Dental Association, Trends in Enrollment and Academic Qualifications, 1987, and American Association of Dental Schools, Applicant Analysis Entering Class 1986, 1987.
33. In at least two States in recent years, the controversy associated with a high failure rate on the State clinical examination has been instrumental in the State deciding to join a regional testing service.
34. See "Licensure of Foreign-Trained Dentists," p. 5 and Dentistry in the United States: Information on Education and Licensure, p. 6.
35. The journal of the professional association of dental schools devoted an entire issue to this subject recently. See "Symposium on Required Postdoctoral Education Programs in General Dentistry," Journal of Dental Education, American Association of Dental Schools, June 1987.

36. See the National Clearinghouse on Licensure, Enforcement and Regulation (CLEAR) and the Council of State Governments, State Regulation of the Health Occupations and Professions: 1985-86, pp. 42-3.
37. The national data bank now being established under Title IV of the Health Care Quality Improvement Act of 1986 will provide a basis for answering this question in the years ahead.
38. The information on type of disciplinary actions was not available in 1984 for MD, NY, HI, and GA; in 1985 for MD, HI, and CA; and in 1986 for MD and GA.
39. See Federation of State Medical Boards and Fifth Report to the President, p. 3-115. The actual rate of discipline is probably slightly less than that indicated in the text, because in a few instances, the disciplinary action totals involve actions against the same dentist or medical doctor.
40. From Federation of State Medical Boards and Office of Inspector General discussions with State dental board representatives.
41. Even without including the total for the State with the most disciplinary actions, the proportionate share of disciplinary actions for the largest States (48 percent) is less than their share of active civilian dentists (57 percent).
42. Without the above-noted State included, the proportionate share of disciplinary actions for the West (22 percent) is about equal to the West's share of all active civilian dentists. However, the Northeast (at 18 percent), still accounts for less than its share of all such dentists (25 percent).
43. American Dental Association. The data were provided to us in response to the draft report of this study by AOA.
44. Council of State Governments, pp.52-3.
45. Ibid, pp. 5-6.
46. See American Dental Association, "Survey of State Boards of Dentistry on the Peer Review Process." July 10, 1987.
47. American Dental Association, Office of Quality Assurance, Journal of the American Dental Association, Volume 114, February 1987, p. 248.

48. See the Council of State Governments, State Regulation of the Health Occupations and Professions: 1985-86, March 1987, p.6.
49. American Dental Association, Journal of the American Dental Association, Volume 114, February 1987, p. 248.

## APPENDIX II

### BACKGROUND

The licensure and discipline of health care professionals is a traditional function of State Government. It dates back to the pioneering efforts of the American colonies in the 1600s. But it did not gain permanence until the late 1800s, when Texas passed the first modern medical practice act (1873) and the U.S. Supreme Court upheld West Virginia's act as a valid exercise of State police powers (1889).

In recognition of this traditional State role, Congress, when it established the Medicare and Medicaid programs in 1965, left it to the States to determine whether physicians and other health care professionals were legally authorized to participate in these programs. Subsequently, Congress has empowered the Department of Health and Human Services and its predecessor, the Department of Health, Education and Welfare, to impose sanctions on those professionals (and other provider groups) who have abused or defrauded these programs. However, the Federal Government has continued to depend on the States to serve as the disciplining agent for transgressions that do not directly relate to the Medicare or Medicaid programs.

Thus, States have been providing an important front line of protection for beneficiaries of these two federally funded programs. This protection has been at no cost to the Federal Government and at only minimal cost to State government. Nearly all the costs have been covered by licensure fees imposed on the health care professionals.

As Medicare and Medicaid expenditures have grown to a point where they now account for more than one-fourth of U.S. health care expenditures, Federal interest in the effectiveness of State licensure and discipline practices has increased. For the most part, this heightening interest has focused on those practices concerning medical doctors. In essence this is because they are the most prominent of the health care professionals and because they account for a larger share of Medicare and Medicaid expenditures than any of the other groups. More specifically, serious concerns about the adequacy of State medical licensure and discipline practices were raised by General Accounting Office reports, media investigations, and scandals involving fraudulent medical credentials from two Caribbean medical schools.

Accordingly, in 1985 and 1986, the Office of Inspector General (OIG) conducted an inspection examining the activities of State medical boards. Based primarily on visits to 14 State boards and telephone discussions with the executive directors of another 10, the inspections sought to provide an overview of the major



developments and issues facing the boards. The final report, issued in June 1986, received widespread publicity and helped generate reforms to improve the effectiveness of State medical boards, particularly with respect to their disciplinary practices.

Given the positive response and effects of that inspection, the OIG decided that a similar one directed to other health care professionals eligible for Medicare or Medicaid reimbursement would also be warranted. For these other professionals no less than for medical doctors, State licensure and discipline boards offer a vital front line of protection for the beneficiary.

We chose dentists, podiatrists, chiropractors, and optometrists as a focus because, like medical doctors, they are direct care professionals who have diagnosing and prescribing responsibilities, who can receive direct Medicare reimbursement, and who, overall, represent a major presence on the health care scene. Dentists, podiatrists, chiropractors, and optometrists, together with doctors of medicine and osteopathy are the six groups of health care professionals defined as "physicians" under Medicare law.

Recognizing the value of obtaining a better national picture of the licensure activities of these and other health care professions, HHS (through the Public Health Service) awarded a 3-year contract in July 1984 to the Council of State Governments (CSG) and the National Clearinghouse on Licensure, Enforcement and Regulation (CLEAR) to develop a composite State-by-State information system on the credentialing of health professions. The project generates informational reports on the various professions, drawing primarily on State practice acts and State board regulations. The reports present data in separate tables that address such matters as the organizational pattern of the State boards, the administrative and enforcement functions of the boards, the types of examinations required, and the fees imposed. Overall, the descriptive information provided focuses more on licensing than on disciplinary activity. The CSG and CLEAR have published reports on each of the four groups to be addressed in this inspection--chiropractors (1986), podiatrists (1986), dentists (1987), and optometrists (1987).

CLEAR, which is composed of State officials involved with occupational licensing and regulation issues, also runs the National Disciplinary Information System (NDIS). This is an interstate service that provides participating State agencies with bimonthly reports on disciplinary actions taken against licensed professionals in a number of professional disciplines. Dentists, podiatrists, chiropractors, and optometrists are among the occupation groups included in the system. The disciplinary actions taken against these and other groups are sent to NDIS on a voluntary basis and at this point involve 32 States. The

Federation of State Medical Boards operates a similar but more detailed and complete system that focuses on disciplinary actions taken against medical doctors.

Two recent congressional actions provide an important stimulus toward the further sharing of data on disciplinary actions. First of all, the Health Care Quality Improvement Act, (P.L. 99-660), passed in 1986, calls for the establishment of a national data bank to be run by the HHS Secretary (or a designee thereof). It stipulates that entities making malpractice payments associated with the work of physicians and other licensed health care professionals must report pertinent information concerning those payments to the data bank. Similarly, it mandates the reporting of disciplinary and peer review actions taken against medical doctors, osteopaths, and dentists. The information maintained in the data bank is to be available, upon request, to State licensure and discipline boards, health care entities, attorneys who filed a malpractice complaint with a court against a specific practitioner, and individuals interested in records on themselves.

The second pertinent congressional action (P.L. 100-93) is the Medicare and Medicaid Patient and Program Protection Act. Passed in 1987, this legislation includes a provision that would extend the national reporting responsibility of State licensure and discipline boards to encompass disciplinary actions taken against podiatrists, chiropractors, optometrists, and other licensed health care practitioners.

Thus, on the basis of the authority provided by these two acts, State boards will be able to draw upon a national data bank to determine if any disciplinary actions have been taken against an applicant for licensure. It is expected that this data bank will be operating in 1988.

Finally, with respect to dentists, on whom this report focuses, it is important to add that since 1984, the American Association of Dental Examiners (AADE) has operated a national clearinghouse on disciplinary actions taken by State dental boards. Forty-five State boards and the Department of Defense are members of the clearinghouse, but with widespread anticipation of the establishment of the national data bank, participation in the AADE clearinghouse has dropped in 1987. The information in the AADE clearinghouse is available to members only upon written request. Overall, there have been more requests for information by the Department of Defense than by any individual State. Among the States, those that issue licenses on the basis of credentials have tended to be the most active users.

### APPENDIX III

#### METHODOLOGICAL NOTES

We held discussions with representatives of 51 State boards. Usually, we talked with the executive director of the board. Often we talked with a board chairman or other member of the board. Our aim was to obtain information and discuss issues with a board representative who was well-informed about board activities both at present and over the past 3 to 4 years.

The major area in which we sought quantitative information from the board officials concerned the disciplinary actions taken by the boards against dentists in 1984, 1985, and 1986. Here, we asked for the number of formal actions taken and a breakdown of the type of actions--designated as revocation, suspension, probation, or other.

Forty-six of the boards were able to provide us with totals for disciplinary actions taken in each of the 3 years. Two (AZ and IN) were able to provide the data for only 1985 and 1986. Three (LA, NH, and WV) could not provide the data within a sufficient time frame.

In a few instances, the boards were able to specify the total number of actions, but not the type. This was the case in 1984 for GA, HI, MD, and NY; in 1985 for CA, HI, and MD; and in 1986 for GA and MD.

We cannot confirm that the information is all-inclusive or completely accurate. However, we did stress that we sought all board disciplinary actions against dentists and did often check back when we suspected there might be errors. The board officials, typically, were quite responsive in checking their records and providing the data in a timely fashion.

In analyzing the differential performance of the States in disciplining dentists, we decided to aggregate the disciplinary data over the 3-year period. We felt that comparisons over only a 1- or 2-year period would be of questionable value because of the distortions that might be associated with year-to-year fluctuations.

In this context, we treated performance as a dependent variable and considered two major independent variables: size and region. With respect to size, first of all, we identified the number of active civilian dentists in each State and, then, using variance analysis, identified five clusters of States differentiated on the basis of the number of active civilian dentists. The clusters and associated States are as follows: (1) extra small (AK, DC, DE, HI, ID, ME, MT, ND, NH, NM, NV, RI, SD, WY, and VT);

(2) small (AL, AR, AZ, CO, IA, KS, KY, LA, MS, NE, OK, OR, SC, VT, and WV); (3) medium (CT, GA, IN, MD, NM, MO, NC, TN, WA, WI, and VA); (4) large (FL, IL, MA, MI, NJ, OH, PA, and TX); and extra large (CA and NY).

With respect to region, we used United States Bureau of the Census categorizations to identify four regions of the country. The categorizations and associated States are as follows: (1) northeast (CT, ME, MA, NJ, NH, NY, PA, RI, and VT); (2) south (AL, AR, DE, DC, FL, GA, KY, LA, MD, MS, NC, OK, SC, TN, TX, VA, and WV); (3) midwest (IA, IL, IN, KS, MI, MN, MO, NE, ND, OH, SD and WI); and (4) west (AK, AZ, CA, CO, HI, ID, MT, NV, NM, OR, UT, WA, and WY).

## APPENDIX IV

### COMMENTS ON THE DRAFT REPORT AND OIG RESPONSE TO THE COMMENTS

Within the Department of Health and Human Services, we received comments on the draft report from the Public Health Service (PHS) and the Health Care Financing Administration (HCFA). In addition, we received comments from a number of organizations outside the Department: the American Association of Dental Examiners (AADE), the American Dental Association (ADA), the American Association of Dental Schools (AADS), the National Dental Council (NDS) and the National Clearinghouse on Licensure, Enforcement and Regulation (CLEAR).

#### PHS COMMENTS

In reference to our recommendations that called for PHS to assist the AADE "to extend and improve its technical assistance and information dissemination activities," PHS commented as follows:

"We concur in general with this recommendation. However, we believe that additional PHS assistance would do little to improve the Association's technical assistance or information dissemination capabilities because of its limited staffing. We believe it would be more beneficial for PHS to assist the dental profession in developing necessary guidelines for State dental practice acts and improving techniques for the verification of credentials. In this regard, the Health Resources and Services Administration, PHS, is evaluating the OIG findings of the report in order to determine the actions to be taken to provide technical assistance to the dental profession."

In reference to the three recommendations we directed to the AADE, PHS responded that they "are good, but may be unrealistic, because the Association has a very limited staff and therefore, would be unable to comply adequately."

In response to our recommendation calling for State boards to "explore workable, cost-effective approaches to continuing competency assessment," PHS cautioned that while "continuing educational requirements are not the sole indicators of clinical and professional proficiency...no single alternative method provides an assurance of clinical and professional competency."

Finally, PHS urged that we consider an additional recommendation calling for "more extensive and effective interaction between the dental schools and State dental boards." It felt that we should make some reference to the role of the American Association of Dental Schools and the dental schools in preparing licensure applicants and should consult with the AADS about "the types of

training necessary to meet State or national standards and how best to meet existing standards."

#### OIG Response

We share PHS' concerns about AADE's staffing limitations. We assume that if AADE is to be responsive to our recommendations directed to them that it will have to expand its staffing base. In the paragraph preceding our recommendations to AADE, we added a sentence reflecting this assumption. Also, we reworded the recommendation to PHS to make it a more general statement calling for PHS to assist AADE in playing a more effective leadership role. We suggest what some of the components of that role might be, but urge PHS and AADE to explore the most constructive type of assistance that might be extended by PHS.

We also share PHS' concern about the importance of the interactions between dental schools and State dental boards. However, because that was not a focus of our study and did not arise as a major issue in our discussions with State boards we do not feel that we have sufficient basis to make a formal recommendation in this area.

#### HCFA COMMENTS

Because none of our recommendations were directed to HCFA, it did not offer any specific comments on the draft report. It did, however, make the following general statement:

"HCFA has always been a strong advocate of the provision of high quality health care to all citizens--not only Medicare and Medicaid recipients. We support the efforts of the OIG to improve the quality of care of dental services through State reforms in the licensure and discipline of dentists."

#### AADE COMMENTS

In response to the recommendations we directed to it, the AADE executive director commented as follows:

"I believe that all of the recommendations for the AADE are reasonable and would be helpful to State dental boards. This would be possible if financial and technical assistance could be obtained. The AADE appreciates the report recommending the Public Health Service's support of the AADE."

In addition, the AADE response identified a few technical corrections, which we addressed, and expressed some concern that the dental board officials questioned did not have access to the questions before the interviews were conducted.

## OIG RESPONSE

We are pleased with the positive response to our recommendations. However, we caution that all the financial assistance needed to carry them out will not necessarily be forthcoming from the Federal Government. The AADE should also explore other means of increasing its financial base.

We did not send the State board officials a set of our questions before the interviews, but we did send them a letter identifying the purpose and thrust of our questions and requesting some specific information on disciplinary actions. We feel that we afforded the respondents ample opportunity to reflect on our questions. In some instances, we called back a second time to obtain more detailed information.

## ADA COMMENTS

The ADA's comments focused on five of the specific recommendations we made in the draft report. Those recommendations and ADA's comments on them follow.

### OIG Recommendations

- o State governments should assure that State dental boards have sufficient resources to carry out their responsibilities effectively.

### ADA Response

The ADA concurs that adequate staff and resources are essential if State dental boards are to appropriately fulfill their responsibilities. In that regard, we believe that licensing and renewal fees should be earmarked for Board activities, which would help stabilize funding for these agencies.

### OIG Recommendation

- o State dental boards should join together to establish and use a high quality national clinical licensure examination.

### ADA Response

The intent of this recommendation appears to be primarily to facilitate licensure by credentials. Association policy supports licensure by credentials and provides guidelines for evaluating the theoretical knowledge and clinical skill of an applicant for licensure who holds a dental license in another jurisdiction. The written examination programs conducted by the Joint Commission on National Dental Examinations have achieved broad recognition by State boards of dentistry, but no clinical

examination has achieved this level of recognition. ADA policy supports the principle of regional clinical examinations and further recommends that satisfactory performance within the last 5 years on any State or regional clinical examination at least equivalent in quality and difficulty to the State's own clinical examination be considered adequate testing for clinical skills. The ADA certainly would be willing to participate in a study of the feasibility of a national clinical licensure examination.

#### OIG Recommendation

- o State dental boards should explore workable, cost-effective approaches to continuing competency assessment.

#### ADA Response

Since 1970 the Association has supported dental society peer review as a mechanism to monitor competency and assure patient satisfaction with the dental care provided. More recently, the ADA has been involved in development of a quality assessment system for dentistry that would provide an objective, in-office evaluation mechanism for dental practices. Such an evaluation system might be used by State boards as a screening mechanism to identify practices needing further investigation. Dental society peer review committees might use the system in dealing with quality of care issues related to a particular practitioner or in a proactive assessment of members. Association policy is further supportive of continuing competency assessment by encouraging States to 1) require dentists to show evidence of continuing education as a condition for re-registration of their licenses; 2) require proof of remedial study for dentists identified through peer review mechanisms as being severely deficient and 3) provide supplemental clinical education opportunities for those dentists who lack clinical proficiency.

#### OIG Recommendations

- o The AADE should develop guidelines for State dental practice acts, accumulate and disseminate changes in State practice acts and regulations and identify and disseminate to State boards the most effective techniques of credential verification.

#### ADA Response

Given previous experience with the development of dental practice act guidelines by the Council of State Governments, the practicality and usefulness of such guidelines must be questioned. What is probably more useful to State dental boards is receipt of regular information on changes in other States' practice acts and regulations. Compilation and dissemination of such information



already is a service provided by the ADA and we question the recommendation that AADE perform a duplicative function, especially when that organization has limited resources. On the other hand, the ADA concurs that the AADE could assist State dental boards by identifying effective techniques of credential verification. The establishment of the national data bank and policies established for its operation may also help establish guidelines for credential verification.

#### OIG Recommendation

- o The ADA should encourage more extensive and effective interaction between its State societies and State dental boards.

#### ADA Response

The 1987 revisions to ADA peer review policy do indeed specifically recommend that peer review committees "have a clearly outlined process for dealing with repeat adverse decisions against a practitioner." It should be noted that 32 State dental societies already have peer review guidelines supporting referral to State dental board instances of repeated faulty treatment, which can indicate a pattern of practice, as well as single serious offenses. Such State guidelines are clearly in accord with ADA policy. In reviewing this recommendation, I must take exception to the statement that "societies own peer review efforts are often quite limited." Every dental society has a peer review system that provides patients with access to fair complaint adjudication. In 1986 the number of new peer review cases increased five percent over the previous year. The suggestion by the Office of Quality Assurance that peer review systems must be strengthened reflects a desire to see peer review incorporate a quality assessment component in the future. This, of course, is dependent on development of an appropriate quality assessment instrument and feedback mechanism, which is currently being pursued by the ADA.

#### Other ADA Comments

In addition, ADA offered comments in three other areas where it found OIG statements or conclusions to be outdated or misleading. These involved our use of statistics on State dental society peer review efforts, our statement about how some feel that the lesser access to dental services in some of the smaller States may make dental boards less inclined to discipline dentists in those States, and our observation that few State board disciplinary actions emerge as a result of referral from State dental societies.

### OIG Response

In each of the three areas noted above, we included the more recent data or made clarifications addressing ADA's comments.

We are pleased by ADA's positive comments on the recommendations concerning State dental board resources, a national clinical licensure examination, continuing competency assessment and dissemination of information concerning changes in State practice acts and in effective techniques of credential verification. However, we regret its lack of enthusiasm for general guidelines concerning State dental practice acts. If the AADE, ADA, and AADS were to commit themselves to the development of such a set of guidelines, we feel that the product could, indeed, be a useful reference point to the individual States, much as A Guide to the Essentials of a Modern Medical Practice Act, developed by the Federation of State Medical Boards, has been with respect to State medical practice acts. Further, we feel that collaborative efforts of this kind are vital if substantial progress is to be made in improving State dental board performance and facilitating licensure by credentials.

In response to ADA's objection to our statement that State "'societies' own peer review efforts are quite limited," we have eliminated that statement because, we acknowledge that it may be misleading and contradict our earlier statement that the societies "are quite active in conducting peer review." Yet given the few referrals that most State societies make to State dental boards, we feel there is still sufficient basis for our recommendation encouraging ADA to encourage "more extensive and effective interaction between its State societies and State dental boards." We are disappointed that ADA, in its comments to us, did not indicate whether or not it would offer such encouragement in its forthcoming manual instructions.

### AADS COMMENTS

The AADS noted that it was "generally supportive" of the recommendations presented in our report. However, as indicated in the following, it did raise two concerns:

"Our only concern with regard to the recommendations is the substantial role reserved for the AADE, without equal responsibility suggested for our Association and the ADA. In dental accreditation matters, responsibility is equally shared by the AADE, the ADA, and our Association. Perhaps this model would be useful in recommending responsibilities for implementing changes in the dental licensure system.

We also wonder why no role is recommended for the Council of State Governments in developing guidelines for State dental practice acts and in accumulating and disseminating changes

in State practice acts and regulations. As noted in your report, the Council has previously developed recommendations for dental practice acts."

In regard to our findings, AADS commented that it was "generally in agreement" with our findings concerning licensure and "not in a position to question" any of our findings concerning discipline. However, it called for some clarification and corrections concerning our statements about the preparedness of licensure applications to practice dentistry, the number of dental schools in the United States, the projections of active dentists in the United States, and the implementation of the national disciplinary action data bank.

Finally, AADS identified what it regarded as an important omission in our discussion of clinical examination for licensure. It expressed its concern as follows:

"Nowhere in the discussion of clinical examination for licensure does the report discuss the problems caused by the inclusion, in various states, of outdated or regionally-biased procedures in the examination. Testing a student's mastery of a procedure that will rarely be used in practice lessens the validity of a clinical examination. Similarly, requiring dentists to utilize a particular technique which is favored in a region of the U.S., but which has not been shown to be superior to other techniques, can lead to unnecessary failures. Your report is incomplete if it fails to comment on this questions."

#### OIG Response

We agree that AADS, ADA, and the Council of State Governments have important roles to play in matters concerning dental licensure and discipline. As a reflection of that, we amended our recommendation concerning the development of guidelines for State practice acts to specify that AADE should work "in close consultation" with AADS, ADA, and the Council of State Governments in preparing these guidelines.

In regard to AADS' comments on how our report is incomplete without addressing problems and biases associated with State clinical examinations for licensure, it may very well be that there are serious issues here that warrant investigation. Once the word about our draft report spread among the professional dental community, a number of individuals contacted us and expressed their concerns about the fairness of some States' clinical examinations, particularly with respect to dentists already licensed in other States. Yet, we do not feel we can comment on this matter because we have not conducted a detailed inquiry concerning it.

Lastly, we did make minor changes in our report based on AADS' comments concerning various descriptive and explanatory statements.

#### NDC COMMENTS

The National Dental Council (NDC) is an organization established in 1980 to promote licensure by credentials for practicing dentists. In a number of communications to us, the NDC expressed its deep-seated concerns not only about how restrictive some States are in granting licensure by credentials, but also about how unfair they sometimes are in considering the qualifications of out-of-state dentists seeking licensure in their State. The NDC indicated that it could cite numerous "horror stories" that give substance to these concerns.

In support of its case for licensure by credentials, the NDC offered the following observation:

"If all states would have licensure by credential laws, this would have the effect of improving the quality of care rendered, moderating dental fees in areas where dental fees are too high and increasing the availability of dental care to the general public. We seriously doubt that if such laws would come into existence, dentists would "flock to the desirable states" because the financial commitment a dentist must make in order to set up a practice is tremendous and the risk of failure in an area over crowded with dentists is so great."

#### OIG Response

While we are not in position to comment on the fairness of State licensure practices in particular instances, we do stress that licensure by credential policies are "extremely restrictive." Moreover, we indicate that through the development of workable, cost effective approaches to continuing competency assessment and more effective enforcement and disciplinary practices, State boards should be able to enact, with confidence, more lenient policies concerning licensure by credentials.

#### CLEAR COMMENTS

In its comments, CLEAR called for a number of clarifications of particular statements or phrases. Many of these were addressed in the revised report.

With respect to our recommendations, it raised a question concerning our call for the development of guidelines for State practice acts and it suggested two other recommendations.

The question raised by CLEAR was the following:

"Does 'develop guidelines' mean develop model state legislation and administrative rules? If so, that is a very big task. Since the AADE is a one-person operation, I would remove this recommendation or provide funding for the project."

The additional recommendations suggested were as follows:

"State dental boards should support and maintain a national database of information on disciplinary actions taken against licensed professions. Boards should forward information, in a timely manner, on disciplinary actions they have taken to a central information source for national distribution."

"Dental boards should provide training and educational opportunities to board members and administrators. If training is unavailable on-site, board members should be given travel allowances to attend appropriate national conferences and training seminars."

#### OIG Response

In calling for State practice act guidelines, we do not mean to include administrative rules. We have in mind general guidelines, such as those set forth in the Federation of State Medical Board's, A Guide to The Essentials of a Modern Medical Practice Act.

With respect to the proposed recommendation that State dental boards should maintain their own data base on disciplinary actions and should forward information on disciplinary actions to a central information source, we have two comments. First, given the forthcoming establishment of the national disciplinary action clearinghouse, we are not sure if State boards should maintain their own national disciplinary action data bureau. We feel that issue is best determined by them. Second, we see no need to call for States to send disciplinary action information to a central information source, because that will be required under Federal law.

Finally, on the matter of boards providing training and educational opportunities to board members and administrators, we regard that as a sound practice and one that boards would regularly carry out if as we recommend they "have sufficient resources to carry out their responsibilities effectively."