

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**THE LICENSURE OF OUT-OF-STATE  
DENTISTS**



AUGUST 1993

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AUGUST 1993    OEI-01-92-00820

# EXECUTIVE SUMMARY

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## PURPOSE

To describe and assess State dental board policies for licensing dentists already licensed in another State.

## BACKGROUND

Dentists who have a license in one State and wish to obtain one in another face two different paths to licensure. In one group of States, they can get a license through a process called "licensure by credentials." It allows for the granting of a license on the basis of established credentials, with no further examination requirement. In the other group of States, the out-of-State dentists must pass a clinical examination, regardless of their experience and credentials. The examination is the same one given to those seeking an initial dental license. It involves the use of a live patient and calls for the applicant to find a willing patient with the necessary oral problems.

The chairman of the Subcommittee on Small Business Opportunities and Energy of the House Committee on Small Business asked the Office of Inspector General to conduct an inspection. He was concerned that the failure of many States to provide licensure by credentials might be detrimental to consumers and might impede access to dental services for those living in underserved rural or inner-city areas.

This report responds to his request. It draws on a survey of the dental boards for 50 States and the District of Columbia (hereafter referred to as a State), a review of the professional literature and existing data on State licensure policies, and interviews with representatives of State dental boards and national dental organizations.

## FINDINGS

**Twenty-nine States grant licensure by credentials, an increase of 11 since 1987.**

- The 29 States are concentrated in the Northeast and Midwest.
- The core argument in favor of licensure by credentials is that it facilitates freedom of movement by practicing dentists.

**Twenty-two States do not grant licensure by credentials.**

- They are concentrated in the South and West and include six of the seven States leading the nation in population growth between 1980 and 1990.

- The core argument in opposition to licensure by credentials is that it fails to offer adequate assurance of the competency of the out-of-State dentists seeking licensure.

The clinical examination which 22 States require of out-of-State dentists seeking licensure provides a check on the continued competency of practicing dentists. But these States do not apply the requirement or any similar assessment of competency to dentists already practicing within their borders.

The examination requirement can impede efforts to recruit individual dentists willing to locate in underserved areas within the States. Yet we found no data, nor any studies, to support a contention that it has much overall bearing on access to dental care in these areas.

## CONCLUSION

Since 1987 dentists have come to enjoy somewhat greater freedom of movement as more States have established licensure-by-credentials policies. Yet, within the profession, controversy over the issue remains and may even have intensified.

Our inquiry has not provided a basis for supporting or opposing licensure by credentials. It has, however, identified two closely related issues that are of considerable significance to dentists and the general public. These are:

- the minimal degree to which States currently assess the continued competency of practicing dentists, and
- the questionable performance of many State dental boards in carrying out their enforcement and discipline responsibilities.

If State governments and dental organizations, such as the American Association of Dental Examiners, the American Dental Association, the American Association of Dental Schools, and the Association of State and Territorial Dental Directors, focus constructively on these issues, support for licensure by credentials could broaden considerably. More importantly, the public could receive increased protection for the close to \$40 billion a year it is spending on services provided by about 145,000 dentists across the United States.

## COMMENTS ON THE DRAFT REPORT

We received comments on the draft report from the American Association of Dental Examiners, the American Dental Association, the American Association of Dental Schools, and The Association of State and Territorial Dental Directors. In appendix C, we present each set of comments in full. In response to the comments, we have made some technical corrections and some updates in our data on States' practices concerning licensure by credentials.

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**TABLE 1**  
**THE AMERICAN DENTAL ASSOCIATION AND LICENSURE BY CREDENTIALS:**  
**AN HISTORICAL SKETCH**

YEAR	SIGNIFICANT ACTIONS
1972	American Dental Association (ADA) survey of membership indicates that 62 percent favor licensure by credentials.
1973	ADA House of Delegates passes a resolution calling for States to "consider including in their practice acts" provisions for waiving the written and clinical licensure examination requirements for candidates who are licensed in another State.
1976	ADA House passes a resolution setting forth guidelines for licensure by credentials. The resolution notes that the ADA "believes that an evaluation of a practicing dentist's theoretical knowledge and clinical skill based upon his performance record can provide as much protection to the public as would an evaluation based upon examination."
1986	ADA survey of its membership shows that 77 percent favor licensure by credentials.
1988	ADA House adopts a resolution calling for ADA "to appoint a committee to study the freedom of movement and licensure issues" and to report back to the House in 1989. It also calls for ADA in cooperation with the American Association for Dental Examiners (AADE) to study "(1) the comparability of clinical examinations in use for dental licensure and (2) the feasibility of identifying reliable standards for evaluating clinical competency."
1989	The committee to study freedom of movement and licensure issues surveys States with and without licensure by credentials. Drawing on the committee report, the ADA House passes resolutions extending the ADA's licensure-by-credentials guidelines for the States, calling for ADA and AADE to study the development of mutually acceptable continuing competence criteria, and urging State boards of dentistry to grant mutual acceptance to State or regional clinical licensure examinations found to be comparable.
1990	ADA/AADE study produces "Guidelines for Developing Dental Licensure Clinical Examinations." It identifies the minimum common core for a clinical licensure examination.  Congressman Bob Livingston (LA) introduces in the U.S. House of Representatives H.R. 5444 to require State dental boards to grant licensure by credentials. No action taken on bill.
1991	Congressman William Jefferson (LA) introduces in the U.S. House H.R. 2691, a bill "to prohibit discrimination by the states on the basis of nonresidency in the licensing of dental health care professionals." ADA House of Delegates narrowly votes down a resolution calling for the ADA to "actively support H.R. 2691."
1992	ADA/AADE committee produces "Guidelines for Valid and Reliable Dental Licensure Examinations" in order "to further inform dental testing agencies concerning test procedures that will comply with professional testing standards." The ADA and AADE convene a national conference to address the document. Examination committee chairs of 20 of the 22 regional and State testing agencies make up the primary audience.  ADA convenes a national conference on licensure by credentials. It draws together more than 230 participants in an effort "to find common ground."  ADA House passes resolutions on licensure by credentials. Among them are ones calling for "all dental jurisdictions to follow the recommendations of the Joint ADA/AADE Guidelines for Valid and Reliable Dental Licensure Clinical Examinations," offering further elaboration of ADA's Guidelines for Licensure by Credentials, and urging State dental boards "to implement specialty licensure by credentials and/or specialty licensure examination as a top priority."  ADA House of Delegates, by a considerable margin, votes down a resolution in support of H.R. 2691. H.R. 2691 dies with the close of the 102nd U.S. Congress in 1992.
1993	Congressman Michael McNulty (NY) introduces H.R. 729, parallel to H.R. 2691 of 1991.

In 1992, Congressman Ron Wyden, Chairman, Subcommittee on Small Business Opportunities and Energy, House Committee on Small Business, began his own investigation of the matter. He was concerned that the reluctance of many States to grant licensure by credentials might be detrimental to consumers and might be countering efforts to improve access to dental services in underserved rural or inner-city areas. As a result, he asked the Office of Inspector General to conduct an inspection on the nature and implications of State dental board policies in licensing out-of-State dentists. This report responds to his request and follows up on a report concerning State dental boards that we issued in 1988 ("State Licensure and Discipline of Dentists," OAI-01-88-00580). It describes the current situation concerning the licensure of out-of-State dentists. It explains the primary rationales for and against licensure by credentials. And it identifies some key factors relevant to an understanding of the consequences associated with the practice of granting licensure by credentials.

## **METHODOLOGY**

In the report we drew on five major sources of information. Each is identified briefly below.

- **A survey of all State dental boards.** We conducted a mail survey of all State dental boards. We sought information concerning board resources and authorities and board actions involving licensure, enforcement, and discipline.
- **The professional literature.** We reviewed articles identified through a search of the National Library of Medicine's on-line data base.
- **Existing data and materials available from the ADA and the American Association of Dental Examiners (AADE).** We reviewed existing data on State licensure policies, reports on existing policy positions of the organizations, task force reports, and other internal documents.
- **Personal interviews.** We interviewed representatives of national dental organizations, regional testing agencies and State boards, and individual dentists. Our attendance at the August 1992 ADA conference on licensure by credentials offered a good opportunity to conduct many such interviews.
- **Focus group sessions.** During the ADA and the AADE annual meetings in October 1992, we conducted focus group sessions addressing the rationales and consequences of licensure-by-credentials policies. One group was composed of representatives of States granting licensure by credentials; the other of representatives of States that do not.

We conducted our review in accordance with the **Quality Standards for Inspections** issued by the President's Council on Integrity and Efficiency.



# FINDINGS

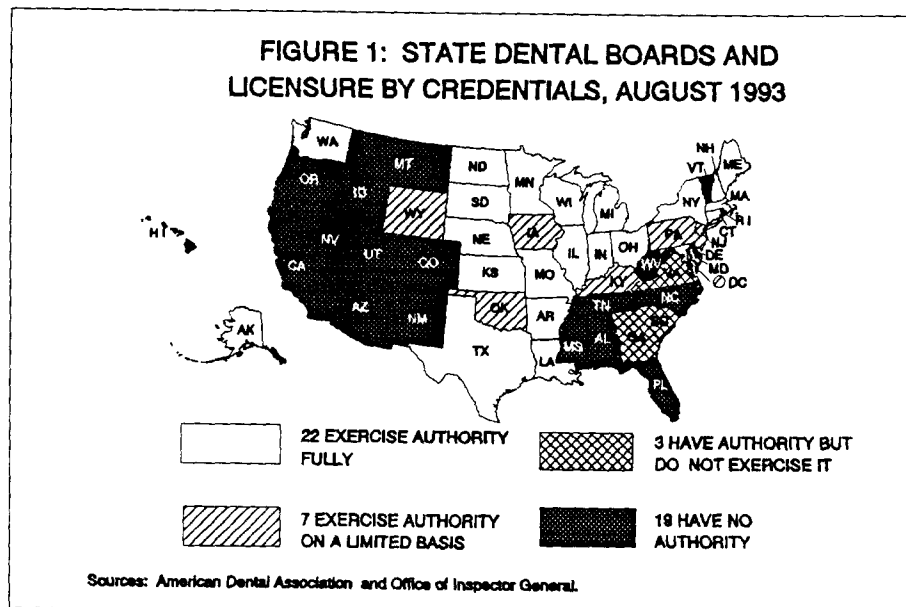
## CURRENT PRACTICES

Twenty-nine States grant licensure by credentials, an increase of 11 since 1987.

- The 29 States are concentrated in the Northeast and Midwest.
- Twenty-two of them grant licensure by credentials to applicants from all States; 7 do so only for applicants from States with similar practices.
- States that provide licensure by credentials still impose various requirements on applicants. Most common are those calling for applicants to be in active practice, receive a favorable report from the dental board in their former State, and agree to a personal interview.

In 1909, in a book on the history of dental surgery, the author noted that eight States had a system for granting licensure by credentials and that in time such practice "will become general throughout the country."<sup>3</sup> Eighty-four years later, the practice has increased but is still far from general. About half of the States will grant a dental license on the basis of a licensed dentist's credentials; about half will not (see appendix A).

Since our review of dental licensure practices in 1987, the number of States that exercise licensure-by-credentials authority (on either a complete or restricted basis) has increased by one-half.<sup>4</sup> The growth, however, has reinforced a long-existing geographic concentration of such States. They remain heavily concentrated in the middle and northeastern portions of the country (see figure 1).



In the 29 States that offer licensure by credentials, out-of-State dentists seeking a license do not automatically receive one. Their credentials are still subject to review. This review varies widely among the States in terms of both the type and extent of requirements (see appendix B). One State has a particularly exacting review process that calls for applicant dentists to submit a sample of patient records for board review. It reports denying licensure to 5 to 10 percent of its licensure-by-credentials applicants.

**Twenty-two States do not grant licensure by credentials.**

- They are concentrated in the South and West and include six of the seven States leading the nation in population growth between 1980 and 1990.
- In 19 of these States, the dental board has no authority to provide licensure by credentials; in 3 it has the authority but does not exercise it.

The 22 States that do not grant licensure by credentials represented the major growth areas of the country in the 1980's. Collectively, their population grew by 19 percent from 1980 to 1990 while that of the other 29 States grew by 5 percent. Included among the 22 are 6 of the 7 States with the largest population increases during the decade: California, Florida, Georgia, Arizona, Virginia, and North Carolina.

Among the States that do not grant licensure by credentials, there are some signs of change. Whereas in 1987 only one had the authority to engage in such practice (see appendix A), by 1993 three had such authority. In others there is active inquiry into the matter that could well result in some liberalizing changes.

Yet in these 22 States, the entry-level clinical examination remains as a major gateway to licensure, even for dentists who have specialty practices and/or have many years of experience. Eleven of these States devise and conduct their own examinations; the other 11 typically rely upon 1 of the 4 regional dental testing services.<sup>5</sup>

## **RATIONALES**

The core argument in favor of licensure by credentials is that it facilitates freedom of movement by practicing dentists. Supporting arguments are that it:

- presents minimal risk because of the disciplinary action clearinghouses run by the National Practitioner Data Bank (NPDB) and AADE, and
- rests on a base of positive experiences in States granting licensure by credentials.

To practicing dentists living in a highly mobile American society, licensure by credentials makes good sense. It facilitates their freedom of movement from one State to another. Whatever their motives for moving--be it to live in a better climate, establish a more lucrative practice, accommodate a spouse who has an attractive

employment opportunity, accept a teaching position at a university, or work in a clinic in an underserved area--the availability of licensure by credentials makes it easier and more possible for them to move than if they had to pass an entry-level examination in general dentistry.

Dentists recognize that the examination requirement is not an impenetrable barrier to licensure and that most applicants pass the examination.<sup>6</sup> Yet they raise concerns about it. Most prominent among them is the cost and inconvenience associated with taking the examination and finding patients who will be part of the examination.<sup>7</sup> Another concern is the relevance of the examination for experienced dentists who are specialists in fields such as periodontics or orthodontics. Still another is that the examination requirement might have more to do with reducing competition to dentists already practicing in highly desirable States than with assuring appropriate qualifications of out-of-State dentists.<sup>8</sup>

In response to those who argue that licensure-by-credentials States will be vulnerable to "bad apples" who move from State to State, proponents point to the establishment and operation of the national clearinghouses on disciplinary actions run by NPDB and AADE. Between them the clearinghouses provide all State boards with access to the names of dentists disciplined by other State boards, professional associations, or hospitals.

For example, in a letter to Congressman John Dingell (MI), one dentist stressed the significance of the NPDB and concluded: "There is no longer a need to restrict the movement of all dental health care professionals because this national clearinghouse of information detects the few who try to move around for unprofessional reasons."<sup>9</sup>

To further their case, proponents also point to the experiences of those States that have granted licensure by credentials for a number of years. If the practice were harmful to the public, would these States continue to practice it, they ask. Before 1987, one State did rescind its licensure-by-credentials practice, largely because of concerns about a few dentists who had been licensed by this route and who it later found had been disciplined in another State. But it has since reestablished the practice and reports no subsequent problems. Similarly, representatives from other States that engage in the practice reported to us that they have had no bad experiences and expressed confidence in their own credentials review process as a way of weeding out problem cases.

Two States we contacted had actually reviewed the number of disciplinary actions they had taken against dentists to whom they had granted licensure by credentials. One State found that of 59 dentists issued a license in this way since 1974, only 1 was subsequently disciplined. The other reported that of 171 dentists licensed by credentials in the last 10 years, only 1 had a complaint lodged against him. This represented less than one-half of 1 percent of all complaints lodged during this period.

The core argument in opposition to licensure by credentials is that it fails to offer adequate assurance of the competency of out-of-State dentists seeking licensure. Supporting arguments are that:

- the NPDB and AADE clearinghouses have limited information and can not compensate for the inadequate enforcement efforts of some State dental boards; and
- the clinical licensure examination requirement is a vital safety valve, especially for States to which large numbers of dentists seek to move.

From the opponents' camp comes the message that what licensure-by-credentials advocates are seeking is "licensure by convenience," without regard for a board's obligations to protect the residents of its State. In that context, they cite two fundamental bases for their contention that licensure by credentials fails to provide adequate protection.

One is that some of the out-of-State applicants may not be sufficiently competent. This reservation rests largely on perceived variations in the quality of dental schools and their graduates. Indeed, a committee formed by the ADA to study freedom of movement and licensure issues reported in 1989 that these perceived variations were a primary reason why five States surveyed opposed licensure by credentials.<sup>10</sup> The reservation about out-of-State dentists, however, involves more than dental schools; it also extends to dental boards and to their capacity and readiness to identify and then respond to incompetent and/or unprofessional dentists. Dental board officials we met with doubted the adequacy of the enforcement efforts of many State boards and even the willingness of some boards to strengthen these efforts.<sup>11</sup>

The other fundamental basis offered for opposing licensure by credentials is that, in itself, it is not a credible basis for granting licensure. The argument is that the credentials available for review, the lack of any disciplinary action, the receipt of a supportive letter from a board or character witness, the conduct of a personal interview, and the like simply fail to offer adequate assurance of the competency of a dentist. A dental board owes the residents of its State greater assurance than such factors provide.

In this context, the fact that the NPDB and AADE clearinghouses offer a source of information about disciplined dentists presents little assurance. The latter, they point out, does not receive reports from a number of States and the former does not include any disciplinary actions taken prior to October 1990. Even more significant, they add, is that both of these clearinghouses identify only those individuals who have had formal action taken against them. That a dentist's name does not appear in either clearinghouse is no assurance that he or she is competent; nor does it preclude the possibility that the dentist is under investigation.

Thus, the opponents of licensure by credentials hold to the argument that a clinical examination provides a minimum necessary check to impose on any dentist wishing to practice in a State. Many of them will grant that the examination itself is not a sure measure of competence and that better mechanisms can probably be developed. Yet, even as it is, they assert it provides better protection than that offered through licensure-by-credentials reviews. For example, one dental board member told of a dental school dean who on paper had excellent credentials and would have easily passed a licensure-by-credentials review, but failed the board's clinical examination three times.

Further, representatives from States facing a major influx of out-of-State applicants for licensure say that they have a particularly compelling need to go beyond a case-by-case review of a candidate's qualifications and rely upon a standardized examination to help them assess a candidate's capacity to practice dentistry. For dental board officials from California, which had 1,294 dental licensure applicants in 1991 or from Florida, which had 631, the positive experiences of Iowa (70 applicants), Minnesota (93), or other States which have much smaller number of applicants (and can more readily give each candidate individual attention) seem of little relevance.<sup>12</sup> It is not, they note, a matter of keeping out the competition, but giving their residents the assurance that licensed dentists are sufficiently competent to practice.<sup>13</sup>

## CONSEQUENCES

It is reasonable to ask what if any notable consequences are associated with the practice of granting licensure by credentials. We addressed that question as part of the rationale offered by those favoring licensure by credentials. They cite the results as positive, with no particular dangers presented to their States' residents.

We gave more attention, however, to any consequences associated with the practice of not granting licensure by credentials--that is, of requiring all out-of-State applicants to take a clinical examination. We did that because the controversy concerning licensure by credentials has focused on the possibly negative effects caused by the 22 States falling in the latter category. Our inquiry in this regard was not a comprehensive assessment of the many possible consequences. At a general level, however, it surfaced two central findings that are pertinent to further discussions of the pros and cons of licensure by credentials.

**The clinical examination which 22 States require of out-of-State dentists seeking licensure provides a check on the continued competency of practicing dentists. But these States do not apply the requirement or any similar assessment of competency to dentists already practicing within their borders.**

Dentistry is often referred to as one of the last "cottage industries."<sup>14</sup> The relevance of this analogy is indicated by the fact that 69 percent of dentists practice alone and that 89 percent practice alone or with 1 other dentist.<sup>15</sup> Thus, dentists tend to have

relatively little day-to-day contact with colleagues, other health care professionals, or with hospitals.<sup>16</sup>

Dentists also tend to have little if any exposure to quality assurance reviews once they receive their initial dental license.<sup>17</sup> Few, for instance, are exposed to the kind of ongoing oversight which hospitals and the Medicare-funded Peer Review Organizations conduct on the hospital-based medical practice of physicians.<sup>18</sup> Among the 51 States, 30 require some continuing education courses as a condition of dental licensure, but none calls for any assessment of what a dentist actually learned from a course.<sup>19</sup>

Thus, the clinical examination that 22 States require of out-of-State dentists seeking licensure represents the most significant quality assurance check that licensed dentists are likely to face in their entire career. Whatever the examination's limitations as a competency assessment tool, it affords some basis for determining a dentist's current clinical knowledge and skill.<sup>20</sup>

Notwithstanding the quality assurance benefits associated with the clinical examination requirement, the fact remains that the 22 States imposing it on licensed out-of-State dentists seeking licensure apply it selectively. They require these out-of-State applicants to take it regardless of their credentials or the nature of their practice, but they impose no similar requirement on the much larger number of dentists already practicing in their own States. As in all other States, licensed dentists practicing in these States are not subject to any ongoing State-imposed assessment of their competency. In 11 of the 22 States that do not grant licensure by credentials, dentists do not even have the minimal State-imposed obligation of attending continuing education courses.<sup>21</sup>

Some representatives of these States defend this inequity on the grounds that their own licensees have already passed the clinical examination they require out-of-State applicants to take. Yet, when questioned, they acknowledge that could have been as many as 30 to 40 years ago and offers insufficient basis for assuming current competency.

Thus, however much a clinical examination may help ensure a certain minimum level of competency, the selective manner in which these States use it makes them vulnerable to the charge that it is intended to reduce competition more than to protect patients. One educator who has studied this issue described this situation as imposing a "secondary burden" on out-of-State "competitors" that does not exist for in-State "commercial interests". He adds:

"State licensing bodies would be hard pressed to maintain that they are ensuring the safety and health of in-state residents and not establishing a barrier to commercial interests when in-state practitioners may maintain licensure for a lifetime without some system of retesting and/or continuing education."<sup>22</sup>

**The examination which 22 States require of out-of-State dentists seeking licensure can impede efforts to recruit individual dentists willing to locate in underserved areas within the States. Yet we found no data, nor any studies, to support a contention that it has much overall bearing on access to dental care in these areas.**

Another concern associated with the clinical examination requirement for out-of-State dentists is that it might serve to hinder efforts to improve access to dental services in underserved areas. There are data that lend some support to this concern. Among the 22 States, 16 have dentist-to-population ratios below the national average of 57.5 per 100,000 population. Further, while the 22 States account for 36 percent of the licensed dentists in the United States, they account for 54 percent of the 771 dental shortage areas and 55 percent of the 423 shortage areas with 20 percent or more of the population below the poverty level.<sup>23</sup>

A State requirement that licensed out-of-State dentists take and pass a clinical examination as a condition of licensure clearly does not facilitate the movement of such dentists to shortage areas in these States, nor does it encourage the retention of National Health Services Corps dentists who work in underserved areas in these States and do not have a State license. Indeed, we have been informed of individual cases of these kinds.

Yet we found no data, nor any studies, to indicate that licensure-by-credentials policies have much overall bearing on the access to dental services in underserved areas. If dentists enjoyed complete freedom of movement, it is not at all clear that many more would work in underserved areas than is now the case. Representatives from most of the States we covered in our focus groups--whether or not they grant licensure by credentials--reported significant difficulties in having dentists work in underserved areas, even in those underserved areas where they have the opportunity to make a substantial income.

## CONCLUSION

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Since 1987 dentists have come to enjoy somewhat easier freedom of movement across the United States as more States have established licensure-by-credentials policies. Yet within the profession, the controversy has continued and perhaps even intensified. The core of that controversy focuses on the restrictive practices of a few large sunbelt States and perhaps three to five others to which significant numbers of dentists might wish to move.

The ongoing operation of the NPDB and AADE clearinghouses, the slow but clear movement toward a standardized clinical licensure examination acceptable to all States,<sup>24</sup> and the continuing pressure exerted by many dentists could lead to wider adoption of licensure by credentials in the years ahead. Such direction would obviously contribute to the interstate mobility of dentists; its consequence for the public at large is less clear.

Our inquiry has not provided a basis for supporting one side or the other in the controversy concerning licensure by credentials. In examining the arguments for and against it, however, we have identified two closely related issues that are of major significance to dentists and the general public. These are:

- the minimal degree to which States currently assess the continued competency of practicing dentists, and
- the questionable performance of many State dental boards in carrying out their enforcement and discipline responsibilities.

If State governments and dental organizations, such as the American Association of Dental Examiners, the American Dental Association, the American Association of Dental Schools, and The Association of State and Territorial Dental Directors, focus constructively on these issues, the support for licensure by credentials could broaden considerably. More importantly, the public could receive increased protection for the close to \$40 billion a year<sup>25</sup> it is spending on services provided by about 145,000 dentists across the United States.<sup>26</sup>



## COMMENTS ON THE DRAFT REPORT

We received comments on the draft report from the American Association of Dental Examiners (AADE), the American Dental Association (ADA), the American Association of Dental Schools (AADS), and The Association of State and Territorial Dental Directors (ASTDD). In appendix C, we present each set of comments in full.

The AADE agrees with our concluding observations about the minimal attention given to continued competency and the questionable performance of boards' in carrying out their enforcement responsibilities. It asked for any additional information we could provide on continued competency to facilitate its own efforts in that area. We have followed up with AADE to provide such information.

The ADA provided some updated information on licensure by credentials policies of the States and indicated it would alter some of our observations on which States engage in the practice. It agreed with our conclusion about continued competency, but suggested we report the importance of continuing education as a mechanism to address such competency. Finally, it reviewed its position and actions concerning licensure by credentials.

On the basis of ADA's information and follow up conversations with representatives from Texas and Arkansas, we have added them to the group of States that is now fully exercising the authority. But, as figure 1 indicates, it remains that this group is concentrated in the middle and northeastern portions of the country and still does not include 6 of the 7 States with the largest population increases during the 1980's (California, Florida, Georgia, Arizona, Virginia, and North Carolina).

In regard to continuing education (CE), we agree, as ADA suggests, that mandated CE is important to consider among the array of approaches that are relevant to continued competency. Yet, we also point out that, its overall value in this regard remains questionable.<sup>27</sup> In a proposal seeking funding for computer-based patient simulations, the major national dental organizations, including ADA, note: "It is widely agreed that a major weakness in mandatory continuing education requirements is that frequently there is little relationship between the continuing education activity and the professional development needs of the individual."<sup>28</sup> The ASTDD, in its comments on this report, reinforces this point by noting: "Many practitioners take courses they like, rather than courses they need. Assessment of what a dentist actually learned from a course (e.g. knowledge), does not necessarily translate into changes in practice or attitude."

The AADS offered some technical suggestions, cited two recent articles in the *Journal of the American Dental Association* (JADA) that were relevant to our discussion, and urged that we more fully address antitrust issues. We made corrections that addressed their technical suggestions, referenced one of the articles at an appropriate point in

our text, and did not address the antitrust implications - mainly because they would call for judgments by the Federal Trade Commission.

The ASTDD's president urged that State public health dental programs be more closely tied in with State licensing and credentialing efforts, emphasized its concern about insufficient access to oral health services, expressed its support for periodic assessment of the competency of dentists, and suggested that it is time to move toward a national clinical licensure examination for dentists. He did not call for any changes in our draft report.

# APPENDIX A

## STATE DENTAL BOARD AUTHORITIES AND PRACTICES IN GRANTING LICENSURE BY CREDENTIALS TO OUT-OF-STATE CANDIDATES: 1987 AND 1993

	BOARD <u>HAS</u> AUTHORITY TO GRANT LICENSURE BY CREDENTIALS						BOARD HAS <u>NO</u> AUTHORITY TO GRANT LICENSURE BY CREDENTIALS	
	BOARD EXERCISES* ITS AUTHORITY				BOARD HAS NOT EXERCISED ITS AUTHORITY			
	BOARD AUTHORITY EXTENDS TO CANDIDATES FROM ALL STATES		BOARD AUTHORITY LIMITED TO CANDIDATES FROM STATES WITH SIMILAR PRACTICES					
STATE	1987	1993	1987	1993	1987	1993	1987	1993
AL							X	X
AK		X					X	
AZ							X	X
AR		X					X	
CA							X	X
CO							X	X
CT		X					X	
DE							X	X
DC			X	X				
FL							X	X
GA						X	X	
HI							X	X
ID							X	X
IL		X					X	
IN	X	X						
IA	X			X				
KS	X	X						
KY				X			X	
LA		X					X	
ME	X	X						

**STATE DENTAL BOARD AUTHORITIES AND PRACTICES IN GRANTING  
LICENSURE BY CREDENTIALS TO OUT-OF-STATE CANDIDATES: 1987 AND 1993**

	BOARD <u>HAS</u> AUTHORITY TO GRANT LICENSURE BY CREDENTIALS						BOARD HAS <u>NO</u> AUTHORITY TO GRANT LICENSURE BY CREDENTIALS	
	BOARD EXERCISES* ITS AUTHORITY				BOARD HAS NOT EXERCISED ITS AUTHORITY			
	BOARD AUTHORITY EXTENDS TO CANDIDATES FROM ALL STATES		BOARD AUTHORITY LIMITED TO CANDIDATES FROM STATES WITH SIMILAR PRACTICES					
STATE	1987	1993	1987	1993	1987	1993	1987	1993
MD	X	X						
MA	X	X						
MI		X	X					
MN	X	X						
MS							X	X
MO	X	X						
MT							X	X
NE	X	X						
NV							X	X
NH	X	X						
NJ				X			X	
NM							X	X
NY	X	X						
NC							X	X
ND		X			X			
OH		X					X	
OK			X	X				
OR							X	X
PA			X	X				
RI			X					X
SC						X	X	
SD		X					X	
TN			X					X

**STATE DENTAL BOARD AUTHORITIES AND PRACTICES IN GRANTING  
LICENSURE BY CREDENTIALS TO OUT-OF-STATE CANDIDATES: 1987 AND 1993**

	BOARD <u>HAS</u> AUTHORITY TO GRANT LICENSURE BY CREDENTIALS						BOARD HAS <u>NO</u> AUTHORITY TO GRANT LICENSURE BY CREDENTIALS		
	BOARD EXERCISES* ITS AUTHORITY				BOARD HAS NOT EXERCISED ITS AUTHORITY				
	BOARD AUTHORITY EXTENDS TO CANDIDATES FROM ALL STATES		BOARD AUTHORITY LIMITED TO CANDIDATES FROM STATES WITH SIMILAR PRACTICES						
STATE	1987	1993	1987	1993	1987	1993	1987	1993	
TX		X					X		
UT							X	X	
VT			X					X	
VA						X	X		
WA		X					X		
WV							X	X	
WI		X					X		
WY				X			X		
<b>TOTALS</b>	11	22	7	7	1	3	32	19	
		<b>29 BOARDS GRANT LICENSURE BY CREDENTIALS</b>					<b>22 BOARDS DO NOT GRANT LICENSURE BY CREDENTIALS</b>		
<p><i>Sources: American Dental Association, ADA News, July 8, 1987 and October 5, 1992. Updated through August 1993 by Office of Inspector General telephone contacts with ADA and State boards.</i></p> <p><i>* We sought data from the individual States on how often they actually exercised their licensure-by-credentials authority in Fiscal Year 1991. However, most of the States were unable to provide us with the data.</i></p>									

## APPENDIX B

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### CREENTIALING REQUIREMENTS IMPOSED BY STATES THAT GRANT LICENSURE BY CREDENTIALS, 1993

REQUIREMENT	NUMBER OF STATES REQUIRING
Active practice within former State immediately preceding application	24
Board in former State must attest that the subject was in legal and reputable practice (no unresolved complaint, review procedure, or disciplinary proceeding, and license has not been revoked)	20
Must be personally interviewed	14
Affidavits or letters from practicing dentists regarding moral character	8
Good moral character	6
Physician's statement of physical and mental health	3
Intends to establish practice	2

Source: American Dental Association, *Report of the Division of Education: Dental Licensure, April 1992.*

# APPENDIX C

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## DETAILED COMMENTS ON THE DRAFT REPORT

In this appendix, we present the complete comments on the draft report received from the American Association of Dental Examiners (AADE), the American Dental Association (ADA), the American Association of Dental Schools (AADS), and The Association of State and Territorial Dental Directors (ASTDD).

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Mr. Bryan B. Mitchell  
Principal Deputy Inspector General  
Office of Inspector General  
Department of Health & Human Services  
Washington, DC 20201

Dear Mr. Mitchell:

Thank you for giving the American Association of Dental Examiners an opportunity to comment on the draft report "The Licensure of Out-Of-State Dentists".

The report concludes that "Our inquiry has not provided a basis for supporting or opposing licensure by credentials. It has, however, identified two closely related issues that are of considerable significance to dentists and the general public. These are:

- the minimal degree to which States currently assess the continued competency of practicing dentists, and
- the questionable performance of many State dental boards in carrying out their enforcement and discipline responsibilities."

As regards the "questionable performance of many State dental boards" it is clear that the lack of sufficient funding is the principle reason for enforcement difficulties.

In addition the report states "If State governments and dental organizations, such as the American Association of Dental Examiners, the American Dental Association, the American Association of Dental Schools, and the Association of State and Territorial Dental Directors, focus constructively on these issues, support for licensure by credentials could broaden considerably." This is likely to follow closely on the heels of continuing competency programs.

The AADE agrees that continued competency should be addressed. AADE established a Continuing Competency Committee in 1992, the goal of which is



to develop criteria and mechanisms for states to use in assessing the continued competency of their licensed dentists. The AADE is currently seeking support for the Committee's activities from the Bureau of Health Professions of the Department of Health and Human Services, the American Dental Association, the Academy of General Dentistry, and the American Association of Dental Schools.

The AADE would like to officially request that, if possible, any information obtained during the Office of Inspector General's study on the subject of continued competency be shared with the AADE Continuing Competency Committee. Also, the AADE Continuing Competency Committee would appreciate any information that the IG's office has with respect to other health organizations' activities in the area of continued competency.

Sincerely,



Molly Nadler  
Executive Director

cc: Members, AADE Executive Council  
Members, AADE Continuing Competency Committee

Mr. Mitchell  
May 28, 1993  
Page 2

view that licensure by credential states do not include any of the retirement areas in the sunbelt region.

#### Continued Competency

We agree with your assessment that it is important for state governments and dental organizations, such as the American Dental Association, the American Association of Dental Schools and others, to focus constructively on the issue of continued competency of practicing dentists. At present, the American Association of Dental Examiners has an ongoing task force to study this issue, with participation by the American Dental Association, the American Association of Dental Schools and other dental organizations.

We note on this issue that you may wish to mention in the report the importance of continuing education as one mechanism to address clinical competency. We believe continuing education is a very important aspect of this issue. The American Dental Association, through existing policy, urges states to develop mechanisms to foster continuing education. In fact, to date 29 states plus the District of Columbia believe it is sufficiently important that they have made continuing education mandatory. There is a growing trend in states to adopt mandatory continuing education legislation.

#### American Dental Association Activities

Your report quite accurately states the American Dental Association's position on licensure by credentials. We support licensure by credentials. However, we also firmly support the notion that this is an issue to be addressed on a state by state basis. Professional licensure has been a traditional area of state regulation, and we support the rights of the states to make their own decisions in this area.

The Association believes that it has contributed proactively to state acceptance of licensure by credentials through its many activities in support of credentialing. These include most significantly a national conference on licensure hosted by the ADA in July 1992. This conference, which was attended by representatives of the educational community, state regulatory agencies, and other interested groups and individuals, provided a forum for the communities of interest to discuss progress toward appropriate opportunities for licensure by credentials. The conference included presentations and workshops that provided the participants with a forum in

Mr. Mitchell  
May 28, 1993  
Page 3

which to develop their own strategies for implementation of licensure by credentials in their states. The conference also sparked a momentum for several new and important resolutions that were adopted by the ADA's House of Delegates in October 1992. These resolutions provided direction on specialty licensure by credentials; supported ADA efforts to encourage state regulatory agencies to accept a common core of requirements and guidelines for clinical examinations; and directed the appropriate agencies of the ADA to urge all dental licensing jurisdictions to utilize the ADA guidelines for licensure by credentials. In short, ADA's policy on licensure by credentials is not simply a statement of position. It is a core policy that is actively supported by the Association.

#### Conclusion

In conclusion, new data for the first five months of 1993 supports the overall trend noted in your report: more and more states are adopting licensure by credentials legislation and regulations. While the trend may not be as rapid as credentialing proponents would like, change is coming in a well-reasoned manner.

The American Dental Association supports licensure by credentials but just as firmly supports the right of states to make their own determination about whether more licensing laws and regulations should permit credentialing. At the same time, we have taken a number of active steps, particularly in the past two years, to assist states in moving toward licensing by credentials, and will continue our efforts in this regard.

Thank you again for the opportunity to comment on your excellent report.

Sincerely,



John S. Zapp, D.D.S.  
Executive Director

JSZ/MKL



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June 7, 1993

**Bryan B. Mitchell**  
**Principal Deputy Inspector General**  
**Office of Inspector General**  
**Washington, D.C. 21201**

**Dear Mr. Mitchell:**

**Thank you for the opportunity to respond to the Office of Inspector General draft report, "The Licensure of Out-of-State Dentists." The Association of State and Territorial Dental Directors (ASTDD) is an affiliate of the Association of State and Territorial Health Officials (ASTHO). Membership is composed of the Chief Dental Officer of the Department of Health, or equivalent public health agency of the states, territories, or possessions of the United States. ASTDD considers policies or recommendations of private or public agencies pertaining to oral and dental health, and adopts policies for guidance of its members. This response represents my opinion and experience as ASTDD President and diplomate of dental public health, one of the eight American Dental Association dental specialties. This report is not necessarily the official position of ASTDD, but the Executive Committee of ASTDD has reviewed the report.**

**State dental programs should aid in the licensing and credentialing of dentists. For example, the State Dental Director in the Rhode Island Department of Health serves as the Chairperson of the Rhode Island Board of Examiners in Dentistry. This allows for coordination of the two state entities, and increased public accountability. It brings access to care and public health to the forefront of discussions that might be considered self-serving to private practicing dentists or other special interest groups. Most Board appointments are made by the Governor from dentists recommended by state dental associations. However, state dental programs are having major problems. A December 1992 ASTDD Survey indicated: a. 10 (20%) states have no state dental program; b. 3 (6%) states have dental programs, but no director; c. 32 (64%) states have a full time director; and d. 5 (10%) states have a part time director. All state oral health programs must be able to perform the core functions of assessment, policy development, and assurance.**

*ASTDD continues to be concerned about the lack of access to oral health services, and would support methods to increase access to care while ensuring quality of care. Access to care is a complex issue. Maldistribution of dental health care workers is a problem in many states including Georgia. A public health license by credentials has helped bring public health dentists to Georgia. This has helped in underserved areas and institutions. The Georgia Board of Dentistry now requires dentists with a public health license to take the next available Board, and this has inhibited recruitment of public health dentists. Fortunately Georgia has started to accept the Southern Regional Boards which should help with the decreased numbers of licensed dentists in our State.*

*Specialty Board licensure by credentials should help, (e.g. Board qualified or certified specialists in good standing with their Specialty Boards). However the present method in many states of requiring the clinical board and then the Specialty Board does not help recruit competent dentists for the public sector, or various specialties. Specialty licensure must not be used to restrict competent primary care dentists (i.e. general dentists) from providing specialty services. Although the majority of dentists and the American Dental Association support licensure by credentials many of the "decision makers" both on State Boards of Dentistry and State Dental Associations remain opposed.*

*Even though you state "most applicants pass the examinations" (page 6), individuals who attempt the examinations are a select group, and do not include many experienced dentists who do not want to go through the trauma of another Board.*

*There may be some variations in the quality of graduates, but in my opinion a national clinical board should be explored. If the National Practitioner Data Bank does not include necessary information about disciplined dentists, the individual state boards could be contacted prior to licensure by credentials. The example of "one" dental school dean who failed the clinical examination three times (page 8) does not significantly strengthen opposition to licensure by credentials. Several examples of the most "clinically" competent graduates failing the examinations can also be found.*

*A major influx of out-of-state applicants for the population growth states should eventually be solved by supply and demand, not by examinations restrictions.*

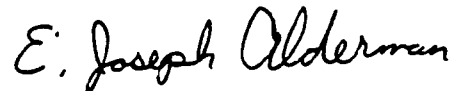
*If dentistry is concerned about quality of dentists, some periodic assessment of competency should be established. It might be helpful to compare how the physicians handle licensure by credentials and quality of care issues, especially in isolated practices (e.g. rural). It is interesting that once licensed, one can practice "forever." Monitoring all physical and mental disabilities (e.g. impaired vision) cannot be expected to be handled by overworked Examining Boards as they are currently configured. Licensure by credentials, in conjunction with a national clinical exam, would allow state boards to focus on more important issues like investigating complaints against and appropriately discipline licensees, or continued credentialing past initial licensure.*

*Continuing education does not ensure quality care. Many practitioners take courses they like, rather than courses they need. Assessment of what a dentist actually learned from a course (e.g. knowledge), does not necessarily translate into changes in practice or attitude.*

*Although the present growth and acceptance of regional boards is to be commended, a true licensure by credentials could ensure quality of care, and help provide access to care in underserved areas. Regional Boards could begin to form a national clinical exam by uniting existing regional boards. However, licensure by credentials or financing through public or private insurance does not guarantee access to oral health care. Other barriers to access include economic, geographic (rural, transients, migrants), cultural, and educational, as well as individuals who are institutionalized, homebound, or have handicapping conditions.*

*I hope this information is helpful in your deliberations concerning licensure of dentists. The licensure and shortage of dental hygienists is another issue that should be addressed. ASTDD and ASTHO are working to establish a National Oral Health Agenda. ASTDD is an active member of the Coalition for Oral Health and strongly supports the inclusion of oral health in health care reform. We believe that ASTDD cooperation and collaboration with federal, state, and local agencies, the private sectors of dentistry and dental hygiene, and oral health advocates is the key to ensuring that everyone can enjoy good oral health and an enhanced quality of life. If I or this organization can be of any further assistance, please let me know.*

*Sincerely,*



*E. Joseph Alderman, DDS, MPH  
President, Association of State  
& Territorial Dental Directors*

*EJA/ja*

*cc: ASTDD Executive Committee  
ASTHO Executive Director*

# APPENDIX D

---

## ENDNOTES

1. American Dental Association, *Report of the Division of Education: Dental Licensure*, April 1992.
2. The American Association of Dental Schools (AADS) has also addressed the licensure by credentials issue. Of particular note is a 10-part 1991 policy statement (presented in appendix C of this report). It calls for AADS to cooperate in efforts "to develop uniform standards for licensure and credentialing that would permit freedom in geographic mobility for dentists and dental hygienists."
3. Charles R. E. Koch, ed., *History of Dental Surgery*, Vol. 1, (Chicago: The National Art Publishing Co., 1909), p. 691.
4. According to the American Dental Association, during the years between 1987 and 1993, 16 States authorized their dental boards to grant licensure by credentials: AK, AR, CT, GA, IL, KY, LA, NJ, OH, SC, SD, TX, VA, WA, WI, and WY. One State board which did not exercise its authority in 1987 did so by 1993: ND.

Three States, the ADA reports, moved in the opposite direction by removing the authority to grant licensure by credentials: RI, TN, and VT. And three of the State boards with newly acquired authority have yet to exercise it: GA, SC, and VA.

On balance, the number of State boards that grant licensure by credentials increased by eleven between 1987 and 1993. See appendix A.

5. See American Dental Association, *Report of the Division of Education: Dental Licensure*, April 1992, pp. 436-41.
6. Indeed, in a number of States that do not grant licensure by credentials, most of their licensees are graduates of out-of-State dental schools.
7. An American Dental Association report describes the process as follows: "Location of patients for examination in another state or distant city is one of the most difficult parts of the examination process. The patients have to have the required oral problems, and they have to be willing to undergo a long and demanding series of procedures. They have to be cooperative, patient and

neutral. They have to be prepared to receive treatment that may not be at an acceptable level." See American Dental Association, *Report of the Division of Education: Dental Licensure*, April 1992, p. 429.

8. A recent article reporting "significant variation within and among state and regional dental board clinical examinations" seems to support the point, as the authors suggest, "that factors other than the ability of the candidates influence exam outcomes." See Peter S. Damiano, Daniel Shugars, and James Freed, "Clinical Board Examinations: Variations Found in Pass Rates," *Journal of the American Dental Association* 128 (June 1992): 72.
9. See Susan E. Lovelace, "States Divided," *Journal of the California Dental Association* 16 (February 2, 1992): 21.
10. The States were California, Florida, North Carolina, Texas, and Washington. See American Dental Association, "Report of the Special Committee to Study Freedom of Movement and Licensure Issues," *ADA Annual Reports*, 1989.
11. Such doubts were expressed by representatives of State dental boards that grant licensure by credentials as well as those from States that do not. In fact, many in the former group of representatives were quite sympathetic to the reasons advanced by the latter for not granting licensure by credentials.
12. In our survey of the State dental boards we asked for information on the number of licensure applications and the number of licenses granted in calendar year 1991 or the fiscal year ending in 1992. The great majority of the boards provided this information. However, few provided information in response to our questions concerning whether or not those applying for a license and those receiving one held a dental license in another State.  
  
For example, among the seven States leading the nation in population growth in the 1980's, only the North Carolina board answered these questions. It indicated that 34 percent of its 144 licensure applicants in 1991 already held a license in another State and that 17 percent had done so for more than 5 years. Among the 121 individuals granted a dental license in 1991, 35 percent already held a license in another State--16 percent for more than 5 years.
13. Here again, many among the dental board members we spoke with who came from States granting licensure by credentials were sympathetic to this point of view.
14. See Preston A. Littleton, Jr., "Educating Dentists for the Future," in *Human Resources for Health: Defining the Future*, C. McCollister Evarts, Peter P. Bosomworth, and Marion Osterweis, eds., (Washington, D.C.: Association of Academic Health Centers, 1992), p. 142.



15. American Dental Association, *The 1991 Survey of Dental Practice: General Characteristics of Dentists*, April 1992, p. 2.
16. See Littleton, p. 142.
17. The American Dental Association, American Association of Dental Examiners, American Association of Dental Schools, and other major dental organizations provide support for this contention. In making the case for the funding of a proposal to develop interactive computer-based patient simulations, they point out the following:

"Dental practices generally are not reviewed by external organizations, nor are they required to participate in systematic quality assurance activities. Assessments of provider competency are limited to a one-time state or regional examination prior to being granted a license to practice general dentistry."
- See Dental Interactive Simulations Corporation, *Computer-Based Simulations in Dentistry*, a grant application developed and submitted by the Dental Interactive Simulations Corporation, undated, p. 14.
18. In recognition of this situation, the W. K. Kellogg Foundation in 1982 funded Alvin Morris and other researchers at the University of Pennsylvania "to develop new methods and technologies that can be used by individual dentists and the dental profession to assess the effectiveness and efficiency of the full scope of dental practice." This ambitious effort resulted in the development of an assessment instrument which a trained team of evaluators used to conduct 1-day on-site assessments of a national sample of 300 dentists who volunteered to participate. The project generated many articles, but to this point little sustained follow-up. See Alvin L. Morris, J. Marvin Bentley, Anthony A. Vito, and Marguerite R. Bomba, "Assessment of Private Dental Practice: Report of Study," *Journal of the American Dental Association* 117 (July 1988): 153-162.
19. American Dental Association, "State Dental Board Continuing Education Requirements for Dentists," August 1992.
20. We sought data from the regional testing agencies and from the States that conduct their own clinical examinations to determine the proportion of applicants passing the examination--distinguishing out-of-State applicants who had been practicing for more than five years from other applicants. However, the data we obtained were extremely limited and insufficient to offer any generalizations on the proportions passing the examinations. Such data could add some valuable information to discussions of the pros and cons of licensure by credentials.
21. American Dental Association, "State Dental Board Continuing Education Requirements for Dentists," August 1992.

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**THE LICENSURE OF OUT-OF-STATE  
DENTISTS**



AUGUST 1993

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This report was prepared under the direction of Mark R. Yessian, Ph.D., Regional Inspector General, and Martha B. Kvaal, Deputy Regional Inspector General, Boston Region, Office of Evaluation and Inspections. Participating in this project were the following people:

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For additional copies of this report, please contact the Boston regional office at 617/565-1050.

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**THE LICENSURE OF OUT-OF-STATE  
DENTISTS**



AUGUST 1993    OEI-01-92-00820

# EXECUTIVE SUMMARY

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## PURPOSE

To describe and assess State dental board policies for licensing dentists already licensed in another State.

## BACKGROUND

Dentists who have a license in one State and wish to obtain one in another face two different paths to licensure. In one group of States, they can get a license through a process called "licensure by credentials." It allows for the granting of a license on the basis of established credentials, with no further examination requirement. In the other group of States, the out-of-State dentists must pass a clinical examination, regardless of their experience and credentials. The examination is the same one given to those seeking an initial dental license. It involves the use of a live patient and calls for the applicant to find a willing patient with the necessary oral problems.

The chairman of the Subcommittee on Small Business Opportunities and Energy of the House Committee on Small Business asked the Office of Inspector General to conduct an inspection. He was concerned that the failure of many States to provide licensure by credentials might be detrimental to consumers and might impede access to dental services for those living in underserved rural or inner-city areas.

This report responds to his request. It draws on a survey of the dental boards for 50 States and the District of Columbia (hereafter referred to as a State), a review of the professional literature and existing data on State licensure policies, and interviews with representatives of State dental boards and national dental organizations.

## FINDINGS

**Twenty-nine States grant licensure by credentials, an increase of 11 since 1987.**

- The 29 States are concentrated in the Northeast and Midwest.
- The core argument in favor of licensure by credentials is that it facilitates freedom of movement by practicing dentists.

**Twenty-two States do not grant licensure by credentials.**

- They are concentrated in the South and West and include six of the seven States leading the nation in population growth between 1980 and 1990.

- The core argument in opposition to licensure by credentials is that it fails to offer adequate assurance of the competency of the out-of-State dentists seeking licensure.

The clinical examination which 22 States require of out-of-State dentists seeking licensure provides a check on the continued competency of practicing dentists. But these States do not apply the requirement or any similar assessment of competency to dentists already practicing within their borders.

The examination requirement can impede efforts to recruit individual dentists willing to locate in underserved areas within the States. Yet we found no data, nor any studies, to support a contention that it has much overall bearing on access to dental care in these areas.

## CONCLUSION

Since 1987 dentists have come to enjoy somewhat greater freedom of movement as more States have established licensure-by-credentials policies. Yet, within the profession, controversy over the issue remains and may even have intensified.

Our inquiry has not provided a basis for supporting or opposing licensure by credentials. It has, however, identified two closely related issues that are of considerable significance to dentists and the general public. These are:

- the minimal degree to which States currently assess the continued competency of practicing dentists, and
- the questionable performance of many State dental boards in carrying out their enforcement and discipline responsibilities.

If State governments and dental organizations, such as the American Association of Dental Examiners, the American Dental Association, the American Association of Dental Schools, and the Association of State and Territorial Dental Directors, focus constructively on these issues, support for licensure by credentials could broaden considerably. More importantly, the public could receive increased protection for the close to \$40 billion a year it is spending on services provided by about 145,000 dentists across the United States.

## COMMENTS ON THE DRAFT REPORT

We received comments on the draft report from the American Association of Dental Examiners, the American Dental Association, the American Association of Dental Schools, and The Association of State and Territorial Dental Directors. In appendix C, we present each set of comments in full. In response to the comments, we have made some technical corrections and some updates in our data on States' practices concerning licensure by credentials.

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**TABLE 1**  
**THE AMERICAN DENTAL ASSOCIATION AND LICENSURE BY CREDENTIALS:**  
**AN HISTORICAL SKETCH**

YEAR	SIGNIFICANT ACTIONS
1972	American Dental Association (ADA) survey of membership indicates that 62 percent favor licensure by credentials.
1973	ADA House of Delegates passes a resolution calling for States to "consider including in their practice acts" provisions for waiving the written and clinical licensure examination requirements for candidates who are licensed in another State.
1976	ADA House passes a resolution setting forth guidelines for licensure by credentials. The resolution notes that the ADA "believes that an evaluation of a practicing dentist's theoretical knowledge and clinical skill based upon his performance record can provide as much protection to the public as would an evaluation based upon examination."
1986	ADA survey of its membership shows that 77 percent favor licensure by credentials.
1988	ADA House adopts a resolution calling for ADA "to appoint a committee to study the freedom of movement and licensure issues" and to report back to the House in 1989. It also calls for ADA in cooperation with the American Association for Dental Examiners (AADE) to study "(1) the comparability of clinical examinations in use for dental licensure and (2) the feasibility of identifying reliable standards for evaluating clinical competency."
1989	The committee to study freedom of movement and licensure issues surveys States with and without licensure by credentials. Drawing on the committee report, the ADA House passes resolutions extending the ADA's licensure-by-credentials guidelines for the States, calling for ADA and AADE to study the development of mutually acceptable continuing competence criteria, and urging State boards of dentistry to grant mutual acceptance to State or regional clinical licensure examinations found to be comparable.
1990	ADA/AADE study produces "Guidelines for Developing Dental Licensure Clinical Examinations." It identifies the minimum common core for a clinical licensure examination.  Congressman Bob Livingston (LA) introduces in the U.S. House of Representatives H.R. 5444 to require State dental boards to grant licensure by credentials. No action taken on bill.
1991	Congressman William Jefferson (LA) introduces in the U.S. House H.R. 2691, a bill "to prohibit discrimination by the states on the basis of nonresidency in the licensing of dental health care professionals." ADA House of Delegates narrowly votes down a resolution calling for the ADA to "actively support H.R. 2691."
1992	ADA/AADE committee produces "Guidelines for Valid and Reliable Dental Licensure Examinations" in order "to further inform dental testing agencies concerning test procedures that will comply with professional testing standards." The ADA and AADE convene a national conference to address the document. Examination committee chairs of 20 of the 22 regional and State testing agencies make up the primary audience.  ADA convenes a national conference on licensure by credentials. It draws together more than 230 participants in an effort "to find common ground."  ADA House passes resolutions on licensure by credentials. Among them are ones calling for "all dental jurisdictions to follow the recommendations of the Joint ADA/AADE Guidelines for Valid and Reliable Dental Licensure Clinical Examinations," offering further elaboration of ADA's Guidelines for Licensure by Credentials, and urging State dental boards "to implement specialty licensure by credentials and/or specialty licensure examination as a top priority."  ADA House of Delegates, by a considerable margin, votes down a resolution in support of H.R. 2691. H.R. 2691 dies with the close of the 102nd U.S. Congress in 1992.
1993	Congressman Michael McNulty (NY) introduces H.R. 729, parallel to H.R. 2691 of 1991.



In 1992, Congressman Ron Wyden, Chairman, Subcommittee on Small Business Opportunities and Energy, House Committee on Small Business, began his own investigation of the matter. He was concerned that the reluctance of many States to grant licensure by credentials might be detrimental to consumers and might be countering efforts to improve access to dental services in underserved rural or inner-city areas. As a result, he asked the Office of Inspector General to conduct an inspection on the nature and implications of State dental board policies in licensing out-of-State dentists. This report responds to his request and follows up on a report concerning State dental boards that we issued in 1988 ("State Licensure and Discipline of Dentists," OAI-01-88-00580). It describes the current situation concerning the licensure of out-of-State dentists. It explains the primary rationales for and against licensure by credentials. And it identifies some key factors relevant to an understanding of the consequences associated with the practice of granting licensure by credentials.

## **METHODOLOGY**

In the report we drew on five major sources of information. Each is identified briefly below.

- **A survey of all State dental boards.** We conducted a mail survey of all State dental boards. We sought information concerning board resources and authorities and board actions involving licensure, enforcement, and discipline.
- **The professional literature.** We reviewed articles identified through a search of the National Library of Medicine's on-line data base.
- **Existing data and materials available from the ADA and the American Association of Dental Examiners (AADE).** We reviewed existing data on State licensure policies, reports on existing policy positions of the organizations, task force reports, and other internal documents.
- **Personal interviews.** We interviewed representatives of national dental organizations, regional testing agencies and State boards, and individual dentists. Our attendance at the August 1992 ADA conference on licensure by credentials offered a good opportunity to conduct many such interviews.
- **Focus group sessions.** During the ADA and the AADE annual meetings in October 1992, we conducted focus group sessions addressing the rationales and consequences of licensure-by-credentials policies. One group was composed of representatives of States granting licensure by credentials; the other of representatives of States that do not.

We conducted our review in accordance with the **Quality Standards for Inspections** issued by the President's Council on Integrity and Efficiency.

# FINDINGS

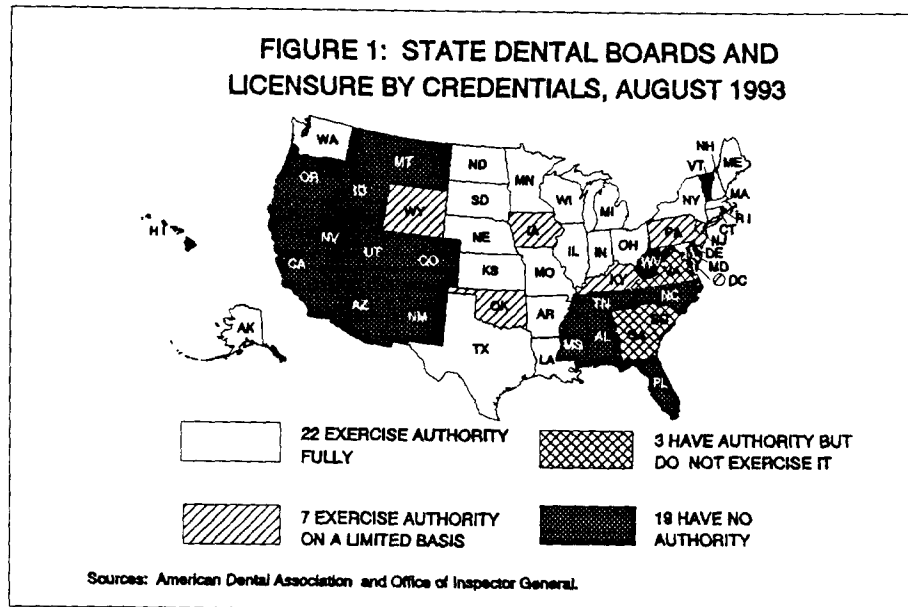
## CURRENT PRACTICES

Twenty-nine States grant licensure by credentials, an increase of 11 since 1987.

- The 29 States are concentrated in the Northeast and Midwest.
- Twenty-two of them grant licensure by credentials to applicants from all States; 7 do so only for applicants from States with similar practices.
- States that provide licensure by credentials still impose various requirements on applicants. Most common are those calling for applicants to be in active practice, receive a favorable report from the dental board in their former State, and agree to a personal interview.

In 1909, in a book on the history of dental surgery, the author noted that eight States had a system for granting licensure by credentials and that in time such practice "will become general throughout the country."<sup>3</sup> Eighty-four years later, the practice has increased but is still far from general. About half of the States will grant a dental license on the basis of a licensed dentist's credentials; about half will not (see appendix A).

Since our review of dental licensure practices in 1987, the number of States that exercise licensure-by-credentials authority (on either a complete or restricted basis) has increased by one-half.<sup>4</sup> The growth, however, has reinforced a long-existing geographic concentration of such States. They remain heavily concentrated in the middle and northeastern portions of the country (see figure 1).



In the 29 States that offer licensure by credentials, out-of-State dentists seeking a license do not automatically receive one. Their credentials are still subject to review. This review varies widely among the States in terms of both the type and extent of requirements (see appendix B). One State has a particularly exacting review process that calls for applicant dentists to submit a sample of patient records for board review. It reports denying licensure to 5 to 10 percent of its licensure-by-credentials applicants.

**Twenty-two States do not grant licensure by credentials.**

- **They are concentrated in the South and West and include six of the seven States leading the nation in population growth between 1980 and 1990.**
- **In 19 of these States, the dental board has no authority to provide licensure by credentials; in 3 it has the authority but does not exercise it.**

The 22 States that do not grant licensure by credentials represented the major growth areas of the country in the 1980's. Collectively, their population grew by 19 percent from 1980 to 1990 while that of the other 29 States grew by 5 percent. Included among the 22 are 6 of the 7 States with the largest population increases during the decade: California, Florida, Georgia, Arizona, Virginia, and North Carolina.

Among the States that do not grant licensure by credentials, there are some signs of change. Whereas in 1987 only one had the authority to engage in such practice (see appendix A), by 1993 three had such authority. In others there is active inquiry into the matter that could well result in some liberalizing changes.

Yet in these 22 States, the entry-level clinical examination remains as a major gateway to licensure, even for dentists who have specialty practices and/or have many years of experience. Eleven of these States devise and conduct their own examinations; the other 11 typically rely upon 1 of the 4 regional dental testing services.<sup>5</sup>

## **RATIONALES**

**The core argument in favor of licensure by credentials is that it facilitates freedom of movement by practicing dentists. Supporting arguments are that it:**

- **presents minimal risk because of the disciplinary action clearinghouses run by the National Practitioner Data Bank (NPDB) and AADE, and**
- **rests on a base of positive experiences in States granting licensure by credentials.**

To practicing dentists living in a highly mobile American society, licensure by credentials makes good sense. It facilitates their freedom of movement from one State to another. Whatever their motives for moving--be it to live in a better climate, establish a more lucrative practice, accommodate a spouse who has an attractive

employment opportunity, accept a teaching position at a university, or work in a clinic in an underserved area--the availability of licensure by credentials makes it easier and more possible for them to move than if they had to pass an entry-level examination in general dentistry.

Dentists recognize that the examination requirement is not an impenetrable barrier to licensure and that most applicants pass the examination.<sup>6</sup> Yet they raise concerns about it. Most prominent among them is the cost and inconvenience associated with taking the examination and finding patients who will be part of the examination.<sup>7</sup> Another concern is the relevance of the examination for experienced dentists who are specialists in fields such as periodontics or orthodontics. Still another is that the examination requirement might have more to do with reducing competition to dentists already practicing in highly desirable States than with assuring appropriate qualifications of out-of-State dentists.<sup>8</sup>

In response to those who argue that licensure-by-credentials States will be vulnerable to "bad apples" who move from State to State, proponents point to the establishment and operation of the national clearinghouses on disciplinary actions run by NPDB and AADE. Between them the clearinghouses provide all State boards with access to the names of dentists disciplined by other State boards, professional associations, or hospitals.

For example, in a letter to Congressman John Dingell (MI), one dentist stressed the significance of the NPDB and concluded: "There is no longer a need to restrict the movement of all dental health care professionals because this national clearinghouse of information detects the few who try to move around for unprofessional reasons."<sup>9</sup>

To further their case, proponents also point to the experiences of those States that have granted licensure by credentials for a number of years. If the practice were harmful to the public, would these States continue to practice it, they ask. Before 1987, one State did rescind its licensure-by-credentials practice, largely because of concerns about a few dentists who had been licensed by this route and who it later found had been disciplined in another State. But it has since reestablished the practice and reports no subsequent problems. Similarly, representatives from other States that engage in the practice reported to us that they have had no bad experiences and expressed confidence in their own credentials review process as a way of weeding out problem cases.

Two States we contacted had actually reviewed the number of disciplinary actions they had taken against dentists to whom they had granted licensure by credentials. One State found that of 59 dentists issued a license in this way since 1974, only 1 was subsequently disciplined. The other reported that of 171 dentists licensed by credentials in the last 10 years, only 1 had a complaint lodged against him. This represented less than one-half of 1 percent of all complaints lodged during this period.

The core argument in opposition to licensure by credentials is that it fails to offer adequate assurance of the competency of out-of-State dentists seeking licensure. Supporting arguments are that:

- the NPDB and AADE clearinghouses have limited information and can not compensate for the inadequate enforcement efforts of some State dental boards; and
- the clinical licensure examination requirement is a vital safety valve, especially for States to which large numbers of dentists seek to move.

From the opponents' camp comes the message that what licensure-by-credentials advocates are seeking is "licensure by convenience," without regard for a board's obligations to protect the residents of its State. In that context, they cite two fundamental bases for their contention that licensure by credentials fails to provide adequate protection.

One is that some of the out-of-State applicants may not be sufficiently competent. This reservation rests largely on perceived variations in the quality of dental schools and their graduates. Indeed, a committee formed by the ADA to study freedom of movement and licensure issues reported in 1989 that these perceived variations were a primary reason why five States surveyed opposed licensure by credentials.<sup>10</sup> The reservation about out-of-State dentists, however, involves more than dental schools; it also extends to dental boards and to their capacity and readiness to identify and then respond to incompetent and/or unprofessional dentists. Dental board officials we met with doubted the adequacy of the enforcement efforts of many State boards and even the willingness of some boards to strengthen these efforts.<sup>11</sup>

The other fundamental basis offered for opposing licensure by credentials is that, in itself, it is not a credible basis for granting licensure. The argument is that the credentials available for review, the lack of any disciplinary action, the receipt of a supportive letter from a board or character witness, the conduct of a personal interview, and the like simply fail to offer adequate assurance of the competency of a dentist. A dental board owes the residents of its State greater assurance than such factors provide.

In this context, the fact that the NPDB and AADE clearinghouses offer a source of information about disciplined dentists presents little assurance. The latter, they point out, does not receive reports from a number of States and the former does not include any disciplinary actions taken prior to October 1990. Even more significant, they add, is that both of these clearinghouses identify only those individuals who have had formal action taken against them. That a dentist's name does not appear in either clearinghouse is no assurance that he or she is competent; nor does it preclude the possibility that the dentist is under investigation.

Thus, the opponents of licensure by credentials hold to the argument that a clinical examination provides a minimum necessary check to impose on any dentist wishing to practice in a State. Many of them will grant that the examination itself is not a sure measure of competence and that better mechanisms can probably be developed. Yet, even as it is, they assert it provides better protection than that offered through licensure-by-credentials reviews. For example, one dental board member told of a dental school dean who on paper had excellent credentials and would have easily passed a licensure-by-credentials review, but failed the board's clinical examination three times.

Further, representatives from States facing a major influx of out-of-State applicants for licensure say that they have a particularly compelling need to go beyond a case-by-case review of a candidate's qualifications and rely upon a standardized examination to help them assess a candidate's capacity to practice dentistry. For dental board officials from California, which had 1,294 dental licensure applicants in 1991 or from Florida, which had 631, the positive experiences of Iowa (70 applicants), Minnesota (93), or other States which have much smaller number of applicants (and can more readily give each candidate individual attention) seem of little relevance.<sup>12</sup> It is not, they note, a matter of keeping out the competition, but giving their residents the assurance that licensed dentists are sufficiently competent to practice.<sup>13</sup>

## CONSEQUENCES

It is reasonable to ask what if any notable consequences are associated with the practice of granting licensure by credentials. We addressed that question as part of the rationale offered by those favoring licensure by credentials. They cite the results as positive, with no particular dangers presented to their States' residents.

We gave more attention, however, to any consequences associated with the practice of not granting licensure by credentials--that is, of requiring all out-of-State applicants to take a clinical examination. We did that because the controversy concerning licensure by credentials has focused on the possibly negative effects caused by the 22 States falling in the latter category. Our inquiry in this regard was not a comprehensive assessment of the many possible consequences. At a general level, however, it surfaced two central findings that are pertinent to further discussions of the pros and cons of licensure by credentials.

**The clinical examination which 22 States require of out-of-State dentists seeking licensure provides a check on the continued competency of practicing dentists. But these States do not apply the requirement or any similar assessment of competency to dentists already practicing within their borders.**

Dentistry is often referred to as one of the last "cottage industries."<sup>14</sup> The relevance of this analogy is indicated by the fact that 69 percent of dentists practice alone and that 89 percent practice alone or with 1 other dentist.<sup>15</sup> Thus, dentists tend to have

relatively little day-to-day contact with colleagues, other health care professionals, or with hospitals.<sup>16</sup>

Dentists also tend to have little if any exposure to quality assurance reviews once they receive their initial dental license.<sup>17</sup> Few, for instance, are exposed to the kind of ongoing oversight which hospitals and the Medicare-funded Peer Review Organizations conduct on the hospital-based medical practice of physicians.<sup>18</sup> Among the 51 States, 30 require some continuing education courses as a condition of dental licensure, but none calls for any assessment of what a dentist actually learned from a course.<sup>19</sup>

Thus, the clinical examination that 22 States require of out-of-State dentists seeking licensure represents the most significant quality assurance check that licensed dentists are likely to face in their entire career. Whatever the examination's limitations as a competency assessment tool, it affords some basis for determining a dentist's current clinical knowledge and skill.<sup>20</sup>

Notwithstanding the quality assurance benefits associated with the clinical examination requirement, the fact remains that the 22 States imposing it on licensed out-of-State dentists seeking licensure apply it selectively. They require these out-of-State applicants to take it regardless of their credentials or the nature of their practice, but they impose no similar requirement on the much larger number of dentists already practicing in their own States. As in all other States, licensed dentists practicing in these States are not subject to any ongoing State-imposed assessment of their competency. In 11 of the 22 States that do not grant licensure by credentials, dentists do not even have the minimal State-imposed obligation of attending continuing education courses.<sup>21</sup>

Some representatives of these States defend this inequity on the grounds that their own licensees have already passed the clinical examination they require out-of-State applicants to take. Yet, when questioned, they acknowledge that could have been as many as 30 to 40 years ago and offers insufficient basis for assuming current competency.

Thus, however much a clinical examination may help ensure a certain minimum level of competency, the selective manner in which these States use it makes them vulnerable to the charge that it is intended to reduce competition more than to protect patients. One educator who has studied this issue described this situation as imposing a "secondary burden" on out-of-State "competitors" that does not exist for in-State "commercial interests". He adds:

"State licensing bodies would be hard pressed to maintain that they are ensuring the safety and health of in-state residents and not establishing a barrier to commercial interests when in-state practitioners may maintain licensure for a lifetime without some system of retesting and/or continuing education."<sup>22</sup>

**The examination which 22 States require of out-of-State dentists seeking licensure can impede efforts to recruit individual dentists willing to locate in underserved areas within the States. Yet we found no data, nor any studies, to support a contention that it has much overall bearing on access to dental care in these areas.**

Another concern associated with the clinical examination requirement for out-of-State dentists is that it might serve to hinder efforts to improve access to dental services in underserved areas. There are data that lend some support to this concern. Among the 22 States, 16 have dentist-to-population ratios below the national average of 57.5 per 100,000 population. Further, while the 22 States account for 36 percent of the licensed dentists in the United States, they account for 54 percent of the 771 dental shortage areas and 55 percent of the 423 shortage areas with 20 percent or more of the population below the poverty level.<sup>23</sup>

A State requirement that licensed out-of-State dentists take and pass a clinical examination as a condition of licensure clearly does not facilitate the movement of such dentists to shortage areas in these States, nor does it encourage the retention of National Health Services Corps dentists who work in underserved areas in these States and do not have a State license. Indeed, we have been informed of individual cases of these kinds.

Yet we found no data, nor any studies, to indicate that licensure-by-credentials policies have much overall bearing on the access to dental services in underserved areas. If dentists enjoyed complete freedom of movement, it is not at all clear that many more would work in underserved areas than is now the case. Representatives from most of the States we covered in our focus groups--whether or not they grant licensure by credentials--reported significant difficulties in having dentists work in underserved areas, even in those underserved areas where they have the opportunity to make a substantial income.



## CONCLUSION

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Since 1987 dentists have come to enjoy somewhat easier freedom of movement across the United States as more States have established licensure-by-credentials policies. Yet within the profession, the controversy has continued and perhaps even intensified. The core of that controversy focuses on the restrictive practices of a few large sunbelt States and perhaps three to five others to which significant numbers of dentists might wish to move.

The ongoing operation of the NPDB and AADE clearinghouses, the slow but clear movement toward a standardized clinical licensure examination acceptable to all States,<sup>24</sup> and the continuing pressure exerted by many dentists could lead to wider adoption of licensure by credentials in the years ahead. Such direction would obviously contribute to the interstate mobility of dentists; its consequence for the public at large is less clear.

Our inquiry has not provided a basis for supporting one side or the other in the controversy concerning licensure by credentials. In examining the arguments for and against it, however, we have identified two closely related issues that are of major significance to dentists and the general public. These are:

- the minimal degree to which States currently assess the continued competency of practicing dentists, and
- the questionable performance of many State dental boards in carrying out their enforcement and discipline responsibilities.

If State governments and dental organizations, such as the American Association of Dental Examiners, the American Dental Association, the American Association of Dental Schools, and The Association of State and Territorial Dental Directors, focus constructively on these issues, the support for licensure by credentials could broaden considerably. More importantly, the public could receive increased protection for the close to \$40 billion a year<sup>25</sup> it is spending on services provided by about 145,000 dentists across the United States.<sup>26</sup>

## COMMENTS ON THE DRAFT REPORT

We received comments on the draft report from the American Association of Dental Examiners (AADE), the American Dental Association (ADA), the American Association of Dental Schools (AADS), and The Association of State and Territorial Dental Directors (ASTDD). In appendix C, we present each set of comments in full.

The AADE agrees with our concluding observations about the minimal attention given to continued competency and the questionable performance of boards' in carrying out their enforcement responsibilities. It asked for any additional information we could provide on continued competency to facilitate its own efforts in that area. We have followed up with AADE to provide such information.

The ADA provided some updated information on licensure by credentials policies of the States and indicated it would alter some of our observations on which States engage in the practice. It agreed with our conclusion about continued competency, but suggested we report the importance of continuing education as a mechanism to address such competency. Finally, it reviewed its position and actions concerning licensure by credentials.

On the basis of ADA's information and follow up conversations with representatives from Texas and Arkansas, we have added them to the group of States that is now fully exercising the authority. But, as figure 1 indicates, it remains that this group is concentrated in the middle and northeastern portions of the country and still does not include 6 of the 7 States with the largest population increases during the 1980's (California, Florida, Georgia, Arizona, Virginia, and North Carolina).

In regard to continuing education (CE), we agree, as ADA suggests, that mandated CE is important to consider among the array of approaches that are relevant to continued competency. Yet, we also point out that, its overall value in this regard remains questionable.<sup>27</sup> In a proposal seeking funding for computer-based patient simulations, the major national dental organizations, including ADA, note: "It is widely agreed that a major weakness in mandatory continuing education requirements is that frequently there is little relationship between the continuing education activity and the professional development needs of the individual."<sup>28</sup> The ASTDD, in its comments on this report, reinforces this point by noting: "Many practitioners take courses they like, rather than courses they need. Assessment of what a dentist actually learned from a course (e.g. knowledge), does not necessarily translate into changes in practice or attitude."

The AADS offered some technical suggestions, cited two recent articles in the *Journal of the American Dental Association* (JADA) that were relevant to our discussion, and urged that we more fully address antitrust issues. We made corrections that addressed their technical suggestions, referenced one of the articles at an appropriate point in

our text, and did not address the antitrust implications - mainly because they would call for judgments by the Federal Trade Commission.

The ASTDD's president urged that State public health dental programs be more closely tied in with State licensing and credentialing efforts, emphasized its concern about insufficient access to oral health services, expressed its support for periodic assessment of the competency of dentists, and suggested that it is time to move toward a national clinical licensure examination for dentists. He did not call for any changes in our draft report.

# APPENDIX A

## STATE DENTAL BOARD AUTHORITIES AND PRACTICES IN GRANTING LICENSURE BY CREDENTIALS TO OUT-OF-STATE CANDIDATES: 1987 AND 1993

	BOARD <b>HAS</b> AUTHORITY TO GRANT LICENSURE BY CREDENTIALS						BOARD HAS <b>NO</b> AUTHORITY TO GRANT LICENSURE BY CREDENTIALS	
	BOARD EXERCISES* ITS AUTHORITY				BOARD HAS NOT EXERCISED ITS AUTHORITY			
	BOARD AUTHORITY EXTENDS TO CANDIDATES FROM ALL STATES		BOARD AUTHORITY LIMITED TO CANDIDATES FROM STATES WITH SIMILAR PRACTICES					
STATE	1987	1993	1987	1993	1987	1993	1987	1993
AL							X	X
AK		X					X	
AZ							X	X
AR		X					X	
CA							X	X
CO							X	X
CT		X					X	
DE							X	X
DC			X	X				
FL							X	X
GA						X	X	
HI							X	X
ID							X	X
IL		X					X	
IN	X	X						
IA	X			X				
KS	X	X						
KY				X			X	
LA		X					X	
ME	X	X						

**STATE DENTAL BOARD AUTHORITIES AND PRACTICES IN GRANTING  
LICENSURE BY CREDENTIALS TO OUT-OF-STATE CANDIDATES: 1987 AND 1993**

	BOARD <u>HAS</u> AUTHORITY TO GRANT LICENSURE BY CREDENTIALS						BOARD HAS <u>NO</u> AUTHORITY TO GRANT LICENSURE BY CREDENTIALS	
	BOARD EXERCISES* ITS AUTHORITY				BOARD HAS NOT EXERCISED ITS AUTHORITY			
	BOARD AUTHORITY EXTENDS TO CANDIDATES FROM ALL STATES		BOARD AUTHORITY LIMITED TO CANDIDATES FROM STATES WITH SIMILAR PRACTICES					
STATE	1987	1993	1987	1993	1987	1993	1987	1993
MD	X	X						
MA	X	X						
MI		X	X					
MN	X	X						
MS							X	X
MO	X	X						
MT							X	X
NE	X	X						
NV							X	X
NH	X	X						
NJ				X			X	
NM							X	X
NY	X	X						
NC							X	X
ND		X			X			
OH		X					X	
OK			X	X				
OR							X	X
PA			X	X				
RI			X					X
SC						X	X	
SD		X					X	
TN			X					X

**STATE DENTAL BOARD AUTHORITIES AND PRACTICES IN GRANTING  
LICENSURE BY CREDENTIALS TO OUT-OF-STATE CANDIDATES: 1987 AND 1993**

	BOARD <u>HAS</u> AUTHORITY TO GRANT LICENSURE BY CREDENTIALS						BOARD HAS <u>NO</u> AUTHORITY TO GRANT LICENSURE BY CREDENTIALS		
	BOARD EXERCISES* ITS AUTHORITY				BOARD HAS NOT EXERCISED ITS AUTHORITY				
	BOARD AUTHORITY EXTENDS TO CANDIDATES FROM ALL STATES		BOARD AUTHORITY LIMITED TO CANDIDATES FROM STATES WITH SIMILAR PRACTICES						
STATE	1987	1993	1987	1993	1987	1993	1987	1993	
TX		X					X		
UT							X	X	
VT			X					X	
VA						X	X		
WA		X					X		
WV							X	X	
WI		X					X		
WY				X			X		
<b>TOTALS</b>	11	22	7	7	1	3	32	19	
		<b>29 BOARDS GRANT LICENSURE BY CREDENTIALS</b>					<b>22 BOARDS DO NOT GRANT LICENSURE BY CREDENTIALS</b>		
<p><i>Sources: American Dental Association, ADA News, July 8, 1987 and October 5, 1992. Updated through August 1993 by Office of Inspector General telephone contacts with ADA and State boards.</i></p> <p><i>* We sought data from the individual States on how often they actually exercised their licensure-by-credentials authority in Fiscal Year 1991. However, most of the States were unable to provide us with the data.</i></p>									

## APPENDIX B

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### CREDENTIALING REQUIREMENTS IMPOSED BY STATES THAT GRANT LICENSURE BY CREDENTIALS, 1993

REQUIREMENT	NUMBER OF STATES REQUIRING
Active practice within former State immediately preceding application	24
Board in former State must attest that the subject was in legal and reputable practice (no unresolved complaint, review procedure, or disciplinary proceeding, and license has not been revoked)	20
Must be personally interviewed	14
Affidavits or letters from practicing dentists regarding moral character	8
Good moral character	6
Physician's statement of physical and mental health	3
Intends to establish practice	2

Source: American Dental Association, *Report of the Division of Education: Dental Licensure, April 1992.*

# APPENDIX C

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## DETAILED COMMENTS ON THE DRAFT REPORT

In this appendix, we present the complete comments on the draft report received from the American Association of Dental Examiners (AADE), the American Dental Association (ADA), the American Association of Dental Schools (AADS), and The Association of State and Territorial Dental Directors (ASTDD).



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Dear Mr. Mitchell:

Thank you for giving the American Association of Dental Examiners an opportunity to comment on the draft report "The Licensure of Out-Of-State Dentists".

The report concludes that "Our inquiry has not provided a basis for supporting or opposing licensure by credentials. It has, however, identified two closely related issues that are of considerable significance to dentists and the general public. These are:

- the minimal degree to which States currently assess the continued competency of practicing dentists, and
- the questionable performance of many State dental boards in carrying out their enforcement and discipline responsibilities."

As regards the "questionable performance of many State dental boards" it is clear that the lack of sufficient funding is the principle reason for enforcement difficulties.

In addition the report states "If State governments and dental organizations, such as the American Association of Dental Examiners, the American Dental Association, the American Association of Dental Schools, and the Association of State and Territorial Dental Directors, focus constructively on these issues, support for licensure by credentials could broaden considerably." This is likely to follow closely on the heels of continuing competency programs.

The AADE agrees that continued competency should be addressed. AADE established a Continuing Competency Committee in 1992, the goal of which is

to develop criteria and mechanisms for states to use in assessing the continued competency of their licensed dentists. The AADE is currently seeking support for the Committee's activities from the Bureau of Health Professions of the Department of Health and Human Services, the American Dental Association, the Academy of General Dentistry, and the American Association of Dental Schools.

The AADE would like to officially request that, if possible, any information obtained during the Office of Inspector General's study on the subject of continued competency be shared with the AADE Continuing Competency Committee. Also, the AADE Continuing Competency Committee would appreciate any information that the IG's office has with respect to other health organizations' activities in the area of continued competency.

Sincerely,



Molly Nadler  
Executive Director

cc: Members, AADE Executive Council  
Members, AADE Continuing Competency Committee

American  
Dental  
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(312) 440-2500

May 28, 1993

Mr. Bryan B. Mitchell  
Principal Deputy Inspector General  
U.S. Department of Health & Human Services  
Office of Inspector General  
Washington, D.C. 20201

RE: Draft Inspection Report,  
"The Licensure of Out-of-State Dentists"

Dear Mr. Mitchell:

Thank you for your recent letter inviting the American Dental Association's comments on your draft inspection report, "The Licensure of Out-of-State Dentists." We greatly appreciate this opportunity to provide comments and your offer to include them in your final report. We would like to begin by stating quite simply that the report is excellent. We also commend the thoroughness of the report, as well as the accuracy of the data on the licensing requirements of each state, which we are pleased is based on reports from the American Dental Association. The remainder of this letter will provide our specific comments.

#### Update on Data

This year, the State of Arkansas enacted legislation in support of licensure by credentials. It is our understanding that the legislation will now go to the state dental board for implementation. As of this date you may wish to report that implementation is pending with the state board.

Licensure by credentials also is currently under consideration in the State of Texas. A bill is progressing through the Texas legislature that, if adopted, will require the dental board to implement licensure by credentials. This bill is supported by the Texas Dental Association. Licensure by credentials also is being considered at the present time at the regulatory level by the dental board in Texas.

The addition of two sunbelt states this year would alter your report's analysis that the states with licensure by credentials: (1) are concentrated heavily in the middle and northeastern portions of the country, and (2) do not represent the fastest growing states in the country. Moreover, the addition of Texas runs counter to the sometimes cited

Mr. Mitchell  
May 28, 1993  
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view that licensure by credential states do not include any of the retirement areas in the sunbelt region.

#### Continued Competency

We agree with your assessment that it is important for state governments and dental organizations, such as the American Dental Association, the American Association of Dental Schools and others, to focus constructively on the issue of continued competency of practicing dentists. At present, the American Association of Dental Examiners has an ongoing task force to study this issue, with participation by the American Dental Association, the American Association of Dental Schools and other dental organizations.

We note on this issue that you may wish to mention in the report the importance of continuing education as one mechanism to address clinical competency. We believe continuing education is a very important aspect of this issue. The American Dental Association, through existing policy, urges states to develop mechanisms to foster continuing education. In fact, to date 29 states plus the District of Columbia believe it is sufficiently important that they have made continuing education mandatory. There is a growing trend in states to adopt mandatory continuing education legislation.

#### American Dental Association Activities

Your report quite accurately states the American Dental Association's position on licensure by credentials. We support licensure by credentials. However, we also firmly support the notion that this is an issue to be addressed on a state by state basis. Professional licensure has been a traditional area of state regulation, and we support the rights of the states to make their own decisions in this area.

The Association believes that it has contributed proactively to state acceptance of licensure by credentials through its many activities in support of credentialing. These include most significantly a national conference on licensure hosted by the ADA in July 1992. This conference, which was attended by representatives of the educational community, state regulatory agencies, and other interested groups and individuals, provided a forum for the communities of interest to discuss progress toward appropriate opportunities for licensure by credentials. The conference included presentations and workshops that provided the participants with a forum in

Mr. Mitchell  
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which to develop their own strategies for implementation of licensure by credentials in their states. The conference also sparked a momentum for several new and important resolutions that were adopted by the ADA's House of Delegates in October 1992. These resolutions provided direction on specialty licensure by credentials; supported ADA efforts to encourage state regulatory agencies to accept a common core of requirements and guidelines for clinical examinations; and directed the appropriate agencies of the ADA to urge all dental licensing jurisdictions to utilize the ADA guidelines for licensure by credentials. In short, ADA's policy on licensure by credentials is not simply a statement of position. It is a core policy that is actively supported by the Association.

#### Conclusion

In conclusion, new data for the first five months of 1993 supports the overall trend noted in your report: more and more states are adopting licensure by credentials legislation and regulations. While the trend may not be as rapid as credentialing proponents would like, change is coming in a well-reasoned manner.

The American Dental Association supports licensure by credentials but just as firmly supports the right of states to make their own determination about whether more licensing laws and regulations should permit credentialing. At the same time, we have taken a number of active steps, particularly in the past two years, to assist states in moving toward licensing by credentials, and will continue our efforts in this regard.

Thank you again for the opportunity to comment on your excellent report.

Sincerely,



John S. Zapp, D.D.S.  
Executive Director

JSZ/MKL



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June 17, 1993

Mr. Bryan B. Mitchell  
Principal Deputy Inspector General  
Office of the Inspector General  
Department of Health and Human  
Services  
Washington, D.C. 20201

Dear Mr. Mitchell:

On behalf of the American Association of Dental Schools (AADS), we appreciate the opportunity to review the draft Inspector General's Report, "The Licensure of Out-of-State Dentists."

First, we compliment you, Dr. Mark Yessian, Martha Kvaal, and other staff from the Boston regional office on the development of this report. Indeed, the Association was pleased to have been contacted by these individuals during the course of the study.

We offer the following comments and suggestions:

1. Page 1, first paragraph of the Background section, line 7: We suggest this line be edited as follows ".... responsibility of finding cooperative patients with the necessary oral problems."
2. Page 6, line 4 of the first full paragraph: This line should be edited to read as follows: ".... taking the examination and finding patients who will be part of the examination."

The rationale for recommendations numbers 1 and 2 can be found in the Appendix C endnotes, number 6 (page C-1) which states the need to find patients for the examination.

3. Page 2, Table 1, Significant Actions: We suggest that the action taken by the AADS House of Delegates in 1991 to update and revise the Association's policy on dental licensure be cited in this Table. A copy of the AADS policy statement is enclosed.

The inclusion of the AADS policy will give further understanding and justification to the report's recommendation found in the conclusion (page 11) and elsewhere that calls for the American Association of Dental Schools, among other organizations, to work for the continued improvement in the dental licensure process.

4. Fully cognizant of the report's heavy emphasis on issues of access, we suggest that the report's discussion on the issue of quality and the protection of the public could be strengthened. In particular, there are two recent articles, not cited in the report, which suggest that the current system has little relation to assuring quality (i.e., board passing rates are fairly arbitrary and everyone eventually passes). The articles are "Clinical Board Examinations: Variation Found in Pass Rates" by Damiano, Shugars, and Freed,

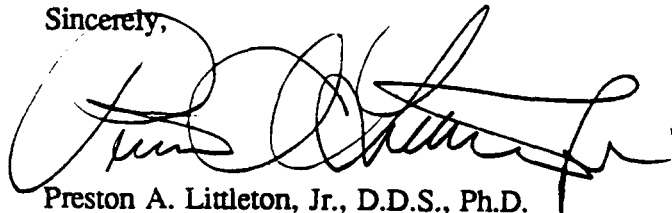
Mr. Bryan B. Mitchell  
June 17, 1993  
Page 2

in the June 1992 issue of the *Journal of the American Dental Association* (JADA). The finding was a significant variation in pass rates within and among state and regional dental board clinical exams during 1979-88. This suggests factors other than the abilities of candidates influence exam outcomes. "These inconsistencies should be of considerable concern to the public and the profession alike as they undermine the perceived effectiveness of the boards to protect the public." The second article is in the May 1993 JADA by the same authors, "Assessing Quality in Dentistry: Dental Boards, Peer Review Vary on Disciplinary Actions." "This study raises questions about the ability of the peer review system and the state dental boards to function as a consistent national system of quality assurance."

5. We recommend that the report address more fully the potential anti-trust implications for a requirement that serves to restrict the competition, but does little to ensure the quality of practitioners who are eventually licensed or their continued competency (pages 9-10).

The Association appreciates this opportunity to provide these comments. Please call me or Mr. Scott Litch, AADS Legislative Counsel, should you have any questions.

Sincerely,



Preston A. Littleton, Jr., D.D.S., Ph.D.  
Executive Director

Enclosure

cc: AADS Executive Committee

**American Association of Dental Schools  
Policy Statement on Licensure and Certification**

1. The American Association of Dental Schools should cooperate with the American Dental Association, the American Dental Hygienists' Association, and the American Association of Dental Examiners to develop uniform standards for licensure and credentialing that would permit freedom in geographic mobility for dentists and dental hygienists.
2. The Association should explore the medical-legal and infection-control liabilities and the ethical issues associated with the delivery of care in clinical entry-level board examinations.
3. The Association, in cooperation with appropriate organizations and agencies, should identify the minimum competencies needed by dental personnel to participate effectively in the delivery of health care.
4. The Association, both through cooperative ventures and on its own initiatives, should support the development of valid and reliable methods that can be used nationally to measure minimum competencies of dental personnel.
5. The Association, in cooperation with appropriate organizations and agencies, should explore the development of alternative testing methods, and support the development of appropriate demonstration projects and pilot programs.
6. As a long-term goal, the Association recommends elimination of state and regional entry-level clinical licensure examinations for dentists and dental hygienists who are graduates of programs accredited by the Commission on Dental Accreditation, and have successfully completed the National Board Dental Examinations or the National Board Dental Hygiene Examinations.
7. The Association supports the continual evaluation of the competencies of dentists and dental hygienists throughout their professional lifetimes.
8. The AADS supports the appointment of qualified dental hygienists to all state boards of dentistry to participate in the examination of candidates for dental hygiene licensure and to serve as full voting and policy-making members in all matters relating to dental hygiene.
9. Successful completion of a program approved by the Commission on Dental Accreditation or the Canadian Dental Association, through its Council on Education, should be a prerequisite for eligibility for the certification examination of the Dental Assisting National Board.
10. Dental laboratory technicians should be eligible for certification immediately following successful completion of a program approved by the Commission on Dental Accreditation and the passing of the National Board of Certification Examination.





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June 7, 1993

**Bryan B. Mitchell**  
**Principal Deputy Inspector General**  
**Office of Inspector General**  
**Washington, D.C. 21201**

**Dear Mr. Mitchell:**

**Thank you for the opportunity to respond to the Office of Inspector General draft report, "The Licensure of Out-of-State Dentists." The Association of State and Territorial Dental Directors (ASTDD) is an affiliate of the Association of State and Territorial Health Officials (ASTHO). Membership is composed of the Chief Dental Officer of the Department of Health, or equivalent public health agency of the states, territories, or possessions of the United States. ASTDD considers policies or recommendations of private or public agencies pertaining to oral and dental health, and adopts policies for guidance of its members. This response represents my opinion and experience as ASTDD President and diplomate of dental public health, one of the eight American Dental Association dental specialties. This report is not necessarily the official position of ASTDD, but the Executive Committee of ASTDD has reviewed the report.**

**State dental programs should aid in the licensing and credentialing of dentists. For example, the State Dental Director in the Rhode Island Department of Health serves as the Chairperson of the Rhode Island Board of Examiners in Dentistry. This allows for coordination of the two state entities, and increased public accountability. It brings access to care and public health to the forefront of discussions that might be considered self-serving to private practicing dentists or other special interest groups. Most Board appointments are made by the Governor from dentists recommended by state dental associations. However, state dental programs are having major problems. A December 1992 ASTDD Survey indicated: a. 10 (20%) states have no state dental program; b. 3 (6%) states have dental programs, but no director; c. 32 (64%) states have a full time director; and d. 5 (10%) states have a part time director. All state oral health programs must be able to perform the core functions of assessment, policy development, and assurance.**

*ASTDD continues to be concerned about the lack of access to oral health services, and would support methods to increase access to care while ensuring quality of care. Access to care is a complex issue. Maldistribution of dental health care workers is a problem in many states including Georgia. A public health license by credentials has helped bring public health dentists to Georgia. This has helped in underserved areas and institutions. The Georgia Board of Dentistry now requires dentists with a public health license to take the next available Board, and this has inhibited recruitment of public health dentists. Fortunately Georgia has started to accept the Southern Regional Boards which should help with the decreased numbers of licensed dentists in our State.*

*Specialty Board licensure by credentials should help, (e.g. Board qualified or certified specialists in good standing with their Specialty Boards). However the present method in many states of requiring the clinical board and then the Specialty Board does not help recruit competent dentists for the public sector, or various specialties. Specialty licensure must not be used to restrict competent primary care dentists (i.e. general dentists) from providing specialty services. Although the majority of dentists and the American Dental Association support licensure by credentials many of the "decision makers" both on State Boards of Dentistry and State Dental Associations remain opposed.*

*Even though you state "most applicants pass the examinations" (page 6), individuals who attempt the examinations are a select group, and do not include many experienced dentists who do not want to go through the trauma of another Board.*

*There may be some variations in the quality of graduates, but in my opinion a national clinical board should be explored. If the National Practitioner Data Bank does not include necessary information about disciplined dentists, the individual state boards could be contacted prior to licensure by credentials. The example of "one" dental school dean who failed the clinical examination three times (page 8) does not significantly strengthen opposition to licensure by credentials. Several examples of the most "clinically" competent graduates failing the examinations can also be found.*

*A major influx of out-of-state applicants for the population growth states should eventually be solved by supply and demand, not by examinations restrictions.*

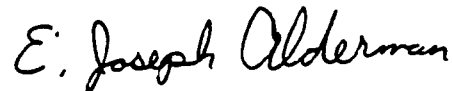
*If dentistry is concerned about quality of dentists, some periodic assessment of competency should be established. It might be helpful to compare how the physicians handle licensure by credentials and quality of care issues, especially in isolated practices (e.g. rural). It is interesting that once licensed, one can practice "forever." Monitoring all physical and mental disabilities (e.g. impaired vision) cannot be expected to be handled by overworked Examining Boards as they are currently configured. Licensure by credentials, in conjunction with a national clinical exam, would allow state boards to focus on more important issues like investigating complaints against and appropriately discipline licensees, or continued credentialing past initial licensure.*

*Continuing education does not ensure quality care. Many practitioners take courses they like, rather than courses they need. Assessment of what a dentist actually learned from a course (e.g. knowledge), does not necessarily translate into changes in practice or attitude.*

*Although the present growth and acceptance of regional boards is to be commended, a true licensure by credentials could ensure quality of care, and help provide access to care in underserved areas. Regional Boards could begin to form a national clinical exam by uniting existing regional boards. However, licensure by credentials or financing through public or private insurance does not guarantee access to oral health care. Other barriers to access include economic, geographic (rural, transients, migrants), cultural, and educational, as well as individuals who are institutionalized, homebound, or have handicapping conditions.*

*I hope this information is helpful in your deliberations concerning licensure of dentists. The licensure and shortage of dental hygienists is another issue that should be addressed. ASTDD and ASTHO are working to establish a National Oral Health Agenda. ASTDD is an active member of the Coalition for Oral Health and strongly supports the inclusion of oral health in health care reform. We believe that ASTDD cooperation and collaboration with federal, state, and local agencies, the private sectors of dentistry and dental hygiene, and oral health advocates is the key to ensuring that everyone can enjoy good oral health and an enhanced quality of life. If I or this organization can be of any further assistance, please let me know.*

*Sincerely,*



*E. Joseph Alderman, DDS, MPH  
President, Association of State  
& Territorial Dental Directors*

*EJA/ja*

*cc: ASTDD Executive Committee  
ASTHO Executive Director*

# APPENDIX D

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## ENDNOTES

1. American Dental Association, *Report of the Division of Education: Dental Licensure*, April 1992.
2. The American Association of Dental Schools (AADS) has also addressed the licensure by credentials issue. Of particular note is a 10-part 1991 policy statement (presented in appendix C of this report). It calls for AADS to cooperate in efforts "to develop uniform standards for licensure and credentialing that would permit freedom in geographic mobility for dentists and dental hygienists."
3. Charles R. E. Koch, ed., *History of Dental Surgery*, Vol. 1, (Chicago: The National Art Publishing Co., 1909), p. 691.
4. According to the American Dental Association, during the years between 1987 and 1993, 16 States authorized their dental boards to grant licensure by credentials: AK, AR, CT, GA, IL, KY, LA, NJ, OH, SC, SD, TX, VA, WA, WI, and WY. One State board which did not exercise its authority in 1987 did so by 1993: ND.  
  
Three States, the ADA reports, moved in the opposite direction by removing the authority to grant licensure by credentials: RI, TN, and VT. And three of the State boards with newly acquired authority have yet to exercise it: GA, SC, and VA.  
  
On balance, the number of State boards that grant licensure by credentials increased by eleven between 1987 and 1993. See appendix A.
5. See American Dental Association, *Report of the Division of Education: Dental Licensure*, April 1992, pp. 436-41.
6. Indeed, in a number of States that do not grant licensure by credentials, most of their licensees are graduates of out-of-State dental schools.
7. An American Dental Association report describes the process as follows:  
"Location of patients for examination in another state or distant city is one of the most difficult parts of the examination process. The patients have to have the required oral problems, and they have to be willing to undergo a long and demanding series of procedures. They have to be cooperative, patient and

neutral. They have to be prepared to receive treatment that may not be at an acceptable level." See American Dental Association, *Report of the Division of Education: Dental Licensure*, April 1992, p. 429.

8. A recent article reporting "significant variation within and among state and regional dental board clinical examinations" seems to support the point, as the authors suggest, "that factors other than the ability of the candidates influence exam outcomes." See Peter S. Damiano, Daniel Shugars, and James Freed, "Clinical Board Examinations: Variations Found in Pass Rates," *Journal of the American Dental Association* 128 (June 1992): 72.
9. See Susan E. Lovelace, "States Divided," *Journal of the California Dental Association* 16 (February 2, 1992): 21.
10. The States were California, Florida, North Carolina, Texas, and Washington. See American Dental Association, "Report of the Special Committee to Study Freedom of Movement and Licensure Issues," *ADA Annual Reports*, 1989.
11. Such doubts were expressed by representatives of State dental boards that grant licensure by credentials as well as those from States that do not. In fact, many in the former group of representatives were quite sympathetic to the reasons advanced by the latter for not granting licensure by credentials.
12. In our survey of the State dental boards we asked for information on the number of licensure applications and the number of licenses granted in calendar year 1991 or the fiscal year ending in 1992. The great majority of the boards provided this information. However, few provided information in response to our questions concerning whether or not those applying for a license and those receiving one held a dental license in another State.  
  
For example, among the seven States leading the nation in population growth in the 1980's, only the North Carolina board answered these questions. It indicated that 34 percent of its 144 licensure applicants in 1991 already held a license in another State and that 17 percent had done so for more than 5 years. Among the 121 individuals granted a dental license in 1991, 35 percent already held a license in another State--16 percent for more than 5 years.
13. Here again, many among the dental board members we spoke with who came from States granting licensure by credentials were sympathetic to this point of view.
14. See Preston A. Littleton, Jr., "Educating Dentists for the Future," in *Human Resources for Health: Defining the Future*, C. McCollister Evarts, Peter P. Bosomworth, and Marion Osterweis, eds., (Washington, D.C.: Association of Academic Health Centers, 1992), p. 142.

15. American Dental Association, *The 1991 Survey of Dental Practice: General Characteristics of Dentists*, April 1992, p. 2.
16. See Littleton, p. 142.
17. The American Dental Association, American Association of Dental Examiners, American Association of Dental Schools, and other major dental organizations provide support for this contention. In making the case for the funding of a proposal to develop interactive computer-based patient simulations, they point out the following:

"Dental practices generally are not reviewed by external organizations, nor are they required to participate in systematic quality assurance activities. Assessments of provider competency are limited to a one-time state or regional examination prior to being granted a license to practice general dentistry."
- See Dental Interactive Simulations Corporation, *Computer-Based Simulations in Dentistry*, a grant application developed and submitted by the Dental Interactive Simulations Corporation, undated, p. 14.
18. In recognition of this situation, the W. K. Kellogg Foundation in 1982 funded Alvin Morris and other researchers at the University of Pennsylvania "to develop new methods and technologies that can be used by individual dentists and the dental profession to assess the effectiveness and efficiency of the full scope of dental practice." This ambitious effort resulted in the development of an assessment instrument which a trained team of evaluators used to conduct 1-day on-site assessments of a national sample of 300 dentists who volunteered to participate. The project generated many articles, but to this point little sustained follow-up. See Alvin L. Morris, J. Marvin Bentley, Anthony A. Vito, and Marguerite R. Bomba, "Assessment of Private Dental Practice: Report of Study," *Journal of the American Dental Association* 117 (July 1988): 153-162.
19. American Dental Association, "State Dental Board Continuing Education Requirements for Dentists," August 1992.
20. We sought data from the regional testing agencies and from the States that conduct their own clinical examinations to determine the proportion of applicants passing the examination--distinguishing out-of-State applicants who had been practicing for more than five years from other applicants. However, the data we obtained were extremely limited and insufficient to offer any generalizations on the proportions passing the examinations. Such data could add some valuable information to discussions of the pros and cons of licensure by credentials.
21. American Dental Association, "State Dental Board Continuing Education Requirements for Dentists," August 1992.

22. H. Barry Waldman, "Reciprocity: Why Doesn't Someone Try this Idea," *Compendium of Continuing Education in Dentistry* XII (November 1991): 86.
23. See U.S. Department of Health and Human Services, Public Health Service, *Sixth Report to the President and Congress on the Status of Health Personnel in the United States*, March 1988; U.S. Department of Health and Human Services, Public Health Service, *Health Professional Shortage Areas*, July 7, 1992; and American Association of Dental Examiners, *Composite*, 1991 edition.
24. Particularly notable in this regard is the publication by the American Dental Association and the American Association of Dental Examiners in May 1992 of the *Guidelines for Valid and Reliable Dental Licensure Clinical Examinations*.
25. Sally T. Sonnefeld, Daniel R. Waldo, Jeffrey A. Lemieux, and Daniel R. McKusik, "Projections of National Health Expenditures Through the Year 2000," *Health Care Financing Review* 13 (Fall 1991): 22.
26. U.S. Department of Commerce, Bureau of the Census, *Statistical Abstract of the United States, 1992*, Table 160, p. 109. Based on data supplied by American Dental Association, Bureau of Economic and Behavioral Research. Further, it is relevant to note that many who are in need of dental care are not receiving it, with the result that neglected oral diseases are widespread. See Myron Allukian, "The President's Column: The Neglected American Epidemic," *The Nation's Health*, (May-June 1990).
27. In a recent article addressing quality assurance in dentistry, Damiano et al. note, "The effectiveness of continuing education as it currently exists has never been adequately demonstrated." See Peter C. Damiano, Daniel A. Shugars, and James R. Freed, "Assessing Quality in Dentistry: Dental Boards, Peer Review Vary on Disciplinary Actions," *Journal of the American Dental Association* 124 (May 1993): 130.
28. Dental Interactive Simulations Corporation, *Computer-Based Patient Simulations in Dentistry*, a grant application submitted by the Dental Interactive Simulations Corporation, undated, p. 10.