

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**STATE DENTAL BOARDS AND
DENTAL DISCIPLINE**



AUGUST 1993

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AUGUST 1993 OEI-01-92-00821

EXECUTIVE SUMMARY

PURPOSE

To examine the capacity of State dental boards to carry out their disciplinary responsibilities.

BACKGROUND

In a recent inspection, "The Licensure of Out-of-State Dentists (OEI-01-92-00820)," we found that many State dental board officials had serious concerns about the capacity of the boards to identify and respond to incompetent and/or unprofessional dentists. They cited these concerns as a major basis for requiring out-of-State dentists to pass a clinical licensure exam before granting them a license.

In this follow-up report, we identify and review indicators of boards' capacity to carry out their disciplinary responsibilities. We draw on data collected from a survey of the boards as part of the above-noted inspection and on data available from published sources.

FINDINGS

THERE ARE STRONG BASES FOR QUESTIONING THE CAPACITY OF STATE DENTAL BOARDS TO CARRY OUT THEIR DISCIPLINARY RESPONSIBILITIES.

They lack comprehensive reporting laws which can help them identify dentists warranting investigation.

- . Twenty-nine of 48 reporting boards indicate that their States do not have laws mandating other parties to report to the board a dentist who may have violated the State dental practice act. In contrast, 47 States have mandated reporting laws for physicians.
- . Only 14 of the 48 boards indicate that their States require dentists to report to the board another dentist who may have violated the State practice act. Thirty-one States have such laws applying to physicians.

They make limited use of disciplinary action clearinghouses.

- . In 1992, only 23 of 48 reporting boards requested information from the clearinghouse maintained by the American Association of Dental Examiners and only 19 from the one maintained by the National Practitioner Data Bank. Failure to obtain such information can

deprive boards of knowledge about prior actions involving dentists under investigation.

They discipline dentists to widely varying degrees and at a level somewhat less than that of State medical boards.

- . During the September 1, 1990 to August 31, 1992 period, dental board disciplinary actions per 1,000 active dentists ranged from lows of 0 in Connecticut, Delaware, Kentucky, Hawaii, and Wyoming to highs of 23.2 in Oregon, 15.0 in Alaska, 19.2 in Missouri, 13.5 in Maine, and 12.0 in Iowa.
- . The median and average rates of disciplinary actions per 1,000 active dentists taken by dental boards during this period was 6.41 and 7.0. The comparable figures for medical boards were 6.65 and 8.94. Although this differential is not extensive, it is important to recognize that dental boards may be more vital quality assurance bodies for dentists than medical boards are for physicians. This is because dentists are much more likely to practice alone and much less likely to be subject to oversight by other external bodies, such as hospitals or health maintenance organizations.

They have insufficient resources to devote to investigations, particularly of complex cases involving the quality of dental care rendered.

- . The American Association of Dental Examiners, the association of State dental boards, cites "the lack of sufficient funding as the principle reason for enforcement difficulties."
- . Eighteen of 24 boards reporting that they have their own investigators indicate that caseloads have increased since 1989, but only 5 state that staffing levels have increased during the same period.
- . Twenty-three of 48 reporting boards indicate that they do not maintain an in-house computerized file incorporating data on prior complaints against a dentist. Thirty-one of them state the same in regard to data on settled malpractice claims.

CONCLUSION

The information presented in this report reinforces the concerns of many State dental board officials about the capacity of the boards to carry out their disciplinary responsibilities. But the significance of the information goes beyond whether or not out-of-State dentists should be licensed by any given board. It suggests that many boards may not be providing adequate protection to the consumers of dental services

and that they and the State governments of which they are a part would find it constructive to focus on ways in which they could improve the capacity of the boards.

The PHS, through the Agency for Health Care Policy and Research or the Bureau of Health Professions, could facilitate State efforts to improve the capacity of their dental boards by extending financial support for the development of a self-assessment instrument for the boards. The PHS has supported a similar effort for State medical boards, with notable success.

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INTRODUCTION

PURPOSE

To examine the capacity of State dental boards to carry out their disciplinary responsibilities.

BACKGROUND

Prior Reports

In an August 1988 report, "State Licensure and Discipline of Dentists" (OAI-01-88-00580), we raised concerns about how well State dental boards were carrying out their disciplinary responsibilities. In an August 1993 report, "The Licensure of Out-of-State Dentists" (OEI-01-92-00820), we reported that many board officials themselves were raising such concerns and citing them as a major basis for requiring out-of-State dentists to pass a clinical examination as a condition of licensure. These board officials expressed serious reservations about the capacity and readiness of many boards to identify and then respond to incompetent and/or unprofessional dentists.

Federal Interest

Given the primacy of the State role in licensing and disciplining dentists, it is important to establish the bases for the Federal interest in the capacity of State dental boards. The most direct basis is the Medicaid program, under which the Federal government now contributes about \$1 billion a year for dental services.¹ It looks to the boards to provide a vital front line of protection for the recipients of those services. It relies upon them to see that dentists meet the minimum necessary qualifications to practice dentistry and to take disciplinary action against them when their conduct and/or practice warrant it.

But the Federal interest in boards also rests on the protection they provide to all consumers of dental services, who, from various payment sources, are generating annual expenditures of close to \$40 billion² for services performed by about 145,00 dentists.³ To the extent that dental boards carry out their responsibilities effectively, they contribute to the capacity of the dental profession to respond effectively to oral diseases. The U.S. Public Health Service (PHS) has identified oral diseases as being "among the most prominent in the United States"⁴ and has set forth many specific objectives to reduce their incidence by the year 2000.⁵ These objectives could become of even greater concern to the Federal government if some dental coverage is included as a core benefit under a reformed national health care system.

Over the years, the PHS, through the Bureau of Health Professions, has taken a number of actions to contribute to the development of dental (and other health care) boards. In 1984, it funded the Council on Licensure, Enforcement and Regulation of

the Council of State Governments to prepare a composite State-by-State information system on dental and other health care boards. In 1989, it funded the American Association of Dental Examiners (AADE), the association of State dental boards, to help it convert its disciplinary action clearinghouse from a manual to a computerized system. And, just recently, in 1993, it once again funded AADE, this time to facilitate its efforts to develop criteria and mechanisms that State dental boards can use when assessing the continued competency of dentists.

Finally, it is also important to recognize that PHS has an ongoing interest in State dental boards because of its responsibilities for managing the National Practitioner Data Bank (NPDB) established by the Health Care Quality Improvement Act of 1986. Intended by Congress to facilitate improved credentialing activities by health care institutions and licensing bodies, the NPDP serves as a clearinghouse of information on disciplinary and adverse actions taken against health care practitioners. Among health care licensing boards, only medical and dental boards are required to report all their disciplinary actions to the NPDP.

METHODOLOGY

In this report, we draw on data collected from our 1992 survey of State dental boards. That survey was conducted primarily for our inspection on out-of-State dentists and focused on questions addressing that topic. It included, however, a number of questions addressing the disciplinary capacities of the State boards. In addition to these data elements, we draw on data available in many published reports of the American Association of Dental Examiners (AADE), the American Dental Association (ADA), The Federation of State Medical Boards (FSMB), the American Medical Association (AMA), and the National Practitioner Data Bank (NPDB).

We organize the report around seven key indicators of boards' capacity to carry out their disciplinary responsibilities. These are not the only such indicators, but they are ones which we have found pertinent in our work over the past seven years⁶ and in our review of the literature on the licensure and discipline of the health care occupations.⁷ They are also indicators for which we can present current and reliable data. In each case, we present a brief statement indicating why the indicator is pertinent to a board's capacity to carry out its disciplinary responsibilities, a figure revealing the key data, and brief explanatory text. Data was provided for the 50 States and the District of Columbia, hereafter referred to as States.

To facilitate interpretations of the data, we present them, where possible, in a manner that allows for comparative assessments. We do this primarily by presenting trend data for recent years. The actual time periods we use vary because of inconsistencies in the data available.

We also allow for some comparative assessment by presenting parallel data, where available, for State medical boards. Such boards have the same basic responsibilities as dental boards. It is important to take into account, however, that dental boards

may well be a more vital quality assurance overseer for dentists than medical boards are for physicians. This is because dentists are less likely to be subject to oversight by other bodies, such as hospitals, health maintenance organizations, Medicare-funded Peer Review Organizations, and insurers.⁸

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

FINDINGS

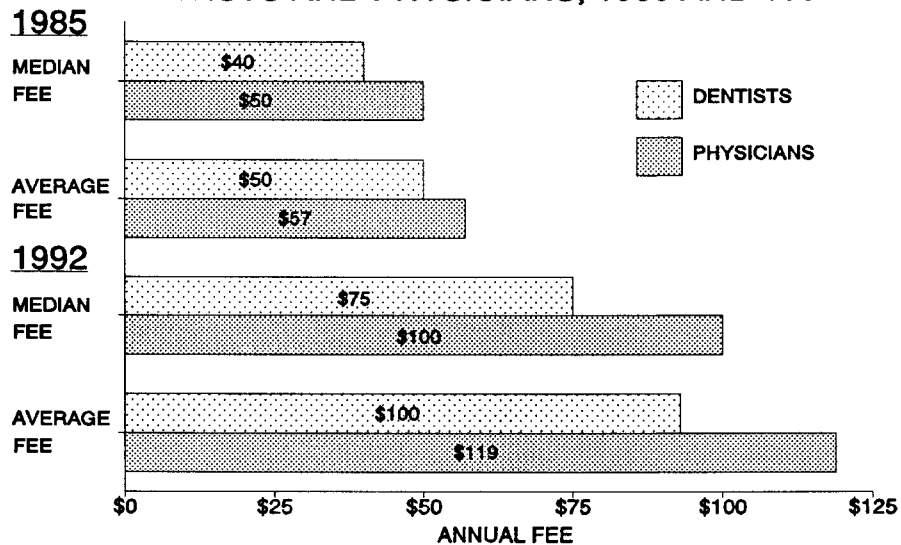
THERE ARE STRONG BASES FOR QUESTIONING THE CAPACITY OF STATE DENTAL BOARDS TO CARRY OUT THEIR DISCIPLINARY RESPONSIBILITIES.

There may be individual boards that have adequate capacity to carry out their disciplinary responsibilities and that are performing effectively in this regard. But the information we present on the following seven indicators raises serious questions about the disciplinary capacity of most boards. These data support the reservations that many State board officials themselves expressed to us during our inquiry on the licensure of out-of-State dentists.

Renewal Fee Income

Dental license renewal fees represent a major portion of the operating budget of State dental boards. In calls to five of the more heavily populated States in the country, we found that renewal fee income ranged from 44 percent to 88 percent of the their annual budget. Sufficient income is vital to boards having the staff, computer, and other resources needed to conduct effective investigations.

FIGURE 1: ANNUAL LICENSE RENEWAL FEES FOR DENTISTS AND PHYSICIANS, 1985 AND 1992



Sources: For dentists - Council of State Governments, *State Regulation of the Health Occupations and Professions*; 1985-86, March 1987 and OIG telephone survey, April 1993. For physicians - American Medical Association, *U.S. Medical Licensure Requirements*, 1985/1986 and 1993 editions. N = 51 States.

The median renewal fee of dental boards has increased from \$40 to \$75 between 1985 and 1992, but it still lags that of medical boards, which increased from \$50 to \$100 during the same period (figure 1). In California, the State with the largest number of licensed dentists, the 1992 dental board renewal fee was \$120, compared with \$250 for the medical board. In New York, the State with the second largest number of licensed dentists, the comparable fees were \$70 and \$165.

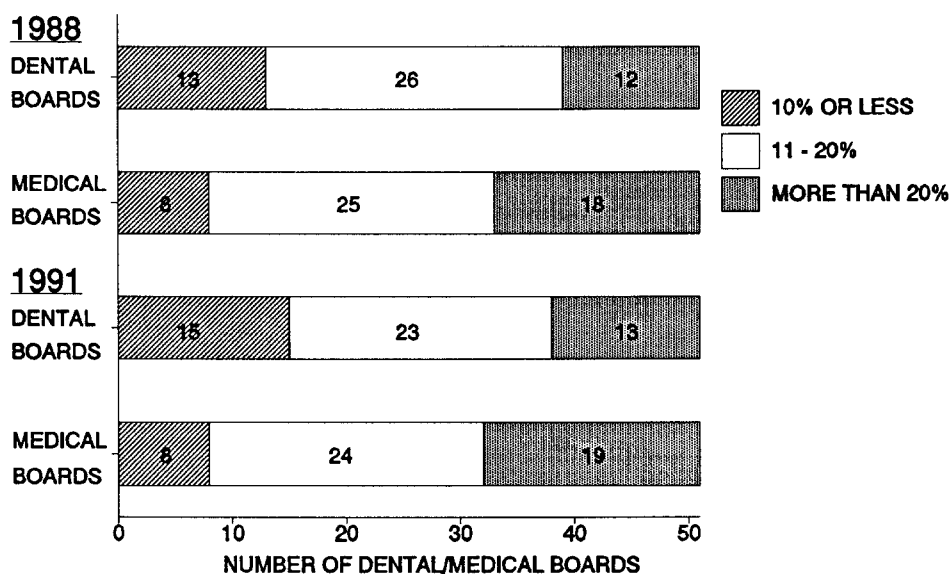
Aside from the level of the fees, it is important to recognize that the fee income often is not reserved exclusively for the use of the dental board. This was the case for 17 of the 48 States responding to the relevant question in our survey.

Thus, it appears quite possible that many boards are left with insufficient resources to do their investigatory work. The American Association of Dental Examiners, the association of State dental boards, acknowledged that such a deficiency does, in fact, exist when in response to our prior report on out-of-State dentists, it commented that "the lack of sufficient funding is the principle reason for enforcement difficulties."

Consumer Membership on Dental Boards

Dental boards are governmental bodies responsible to the general public, not to the dental profession. Consumer, that is nondental, membership on boards can help to reinforce that public accountability and to add public credibility. In some cases, it may also contribute to the boards' readiness to investigate and, when necessary, discipline dentists who present a danger to the public.

FIGURE 2: PUBLIC MEMBERSHIP OF STATE DENTAL AND MEDICAL BOARDS, 1988 AND 1991



Sources: For dentists - American Association of Dental Examiners, *Composite*, 1989 and 1992 editions. For physicians - Federation of State Medical Boards, *Exchange*, 1989 - 1990 and 1992 - 1993 editions. N = 51 States. Note - we include only public members with full voting privileges.

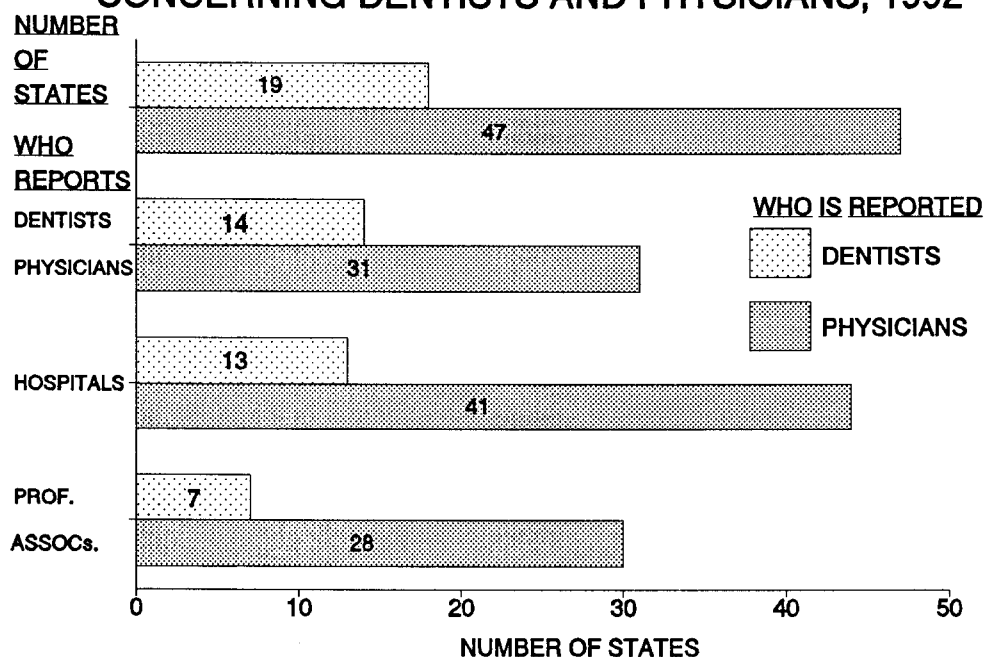
In 1989, a broadly based task force of The Federation of State Medical Boards issued an important report entitled "Elements of a Modern State Medical Board: A Proposal." Although it focuses on medical boards, it offers many suggestions concerning board membership, structure, and operation that can also be highly instructive to dental boards. One of those suggestions is that public or consumer members should constitute 25 percent of a board's membership.⁹

Even this modest benchmark is one which most medical and dental boards fall short of meeting (figure 2). In fact, 15 dental boards have 10 percent or fewer consumer members and 38 have 20 percent or fewer; the comparable numbers for medical boards are 8 and 32.

State Mandatory Reporting Laws

Mandatory reporting laws can facilitate the identification of dentists whose performance or behavior has been deficient in some important way. They call for individual dentists, professional associations, hospitals, and/or others to inform the boards of dentists who may warrant investigation. Such referrals, coming from professionals in the field, can be particularly helpful in identifying quality-of-care problems.

FIGURE 3: STATES WITH MANDATORY REPORTING LAWS CONCERNING DENTISTS AND PHYSICIANS, 1992



Sources: For dentists - OIG mail survey, Fall 1992. For physicians - The Federation of State Medical Boards, Exchange, 1992 -1993 edition. N = 48 States.

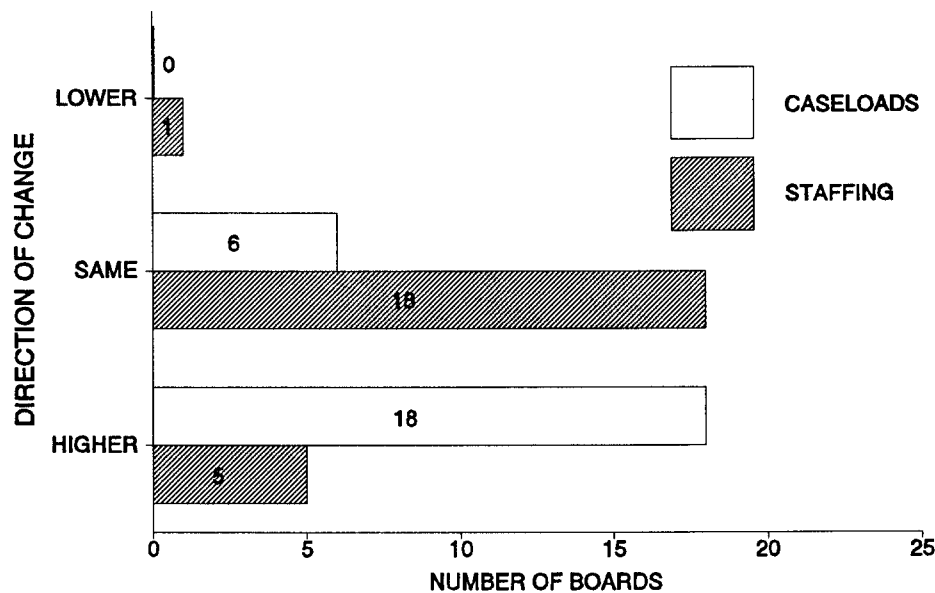
Among 48 States for which we have comparative information, 47 have mandated reporting laws for physicians, but only 19 have them for dentists (figure 3). Only 14 of these States require individual dentists to report to the board other dentists who they believe may be acting in an unprofessional manner or delivering substandard dental care. Even fewer States require hospitals (13) or professional associations (7) to report.

Given the relative lack of reporting laws and the fact that the great majority of dentists practice alone, it can be quite difficult for State dental boards to identify dentists responsible for poor practice or some wrongdoing. More so than State medical boards, they are dependent on referrals made by individual consumers.

Investigative Staffing Levels

Case investigations can be time consuming and costly. This is especially so for quality-of-care cases, where appropriate standards of care are often unclear and where pertinent evidence can be difficult to obtain. It is vital therefore that investigative staffing levels be sufficient to enable boards to make fully informed decisions on how to proceed with cases and when they do proceed to a hearing stage to be able to present evidence that holds up to careful scrutiny.

FIGURE 4: CHANGES IN INVESTIGATIVE CASELOADS AND INVESTIGATOR STAFFING LEVELS AT STATE DENTAL BOARDS, FROM 1989 TO 1992



Source: OIG mail survey, Fall 1992. N = 24 State dental boards reporting they have investigators on their own staffs.

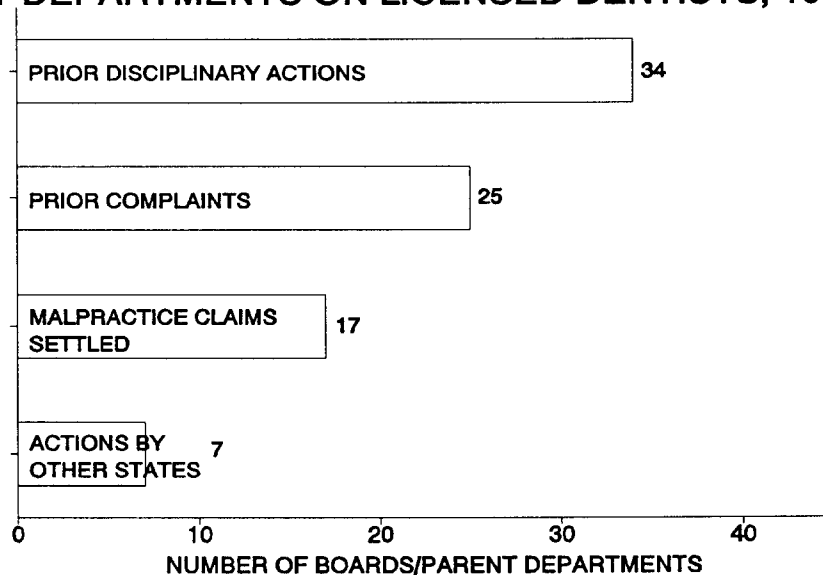
In response to our survey of the State dental boards, 24 reported that they have their own investigators to follow up on complaints or referrals received by the board (figure 4). Among these 24, 18 indicated that their caseload increased during the prior three years, but only 5 stated that their investigative staffing level had also increased. Such a disparity contributes to higher caseloads per investigator and more constricted investigatory efforts.

Whether the boards that rely on investigators in a parent department are experiencing a similar strain in staffing support is not clear from our survey. It is more difficult to assess investigative staffing trends for these boards because the investigators often serve boards besides the dental board.

Computerized Information Systems

One of the most important considerations facing board investigators is whether a particular act of a dentist is an isolated one or part of a larger pattern suggesting ongoing deficiencies. The latter is particularly important if an investigation is to result in convincing evidence concerning the quality of dental care. In this context, it is extremely helpful to board investigators to have access to an in-house computerized file that presents pertinent information on matters such as prior disciplinary actions, settled malpractice claims, and prior complaints.

FIGURE 5: TYPES OF COMPUTERIZED INFORMATION MAINTAINED BY STATE DENTAL BOARDS OR THEIR PARENT DEPARTMENTS ON LICENSED DENTISTS, 1992



Source: OIG mail survey, Fall 1992. N = 44 States report having computerized information on licensed dentists; 48 States responded to the survey question.

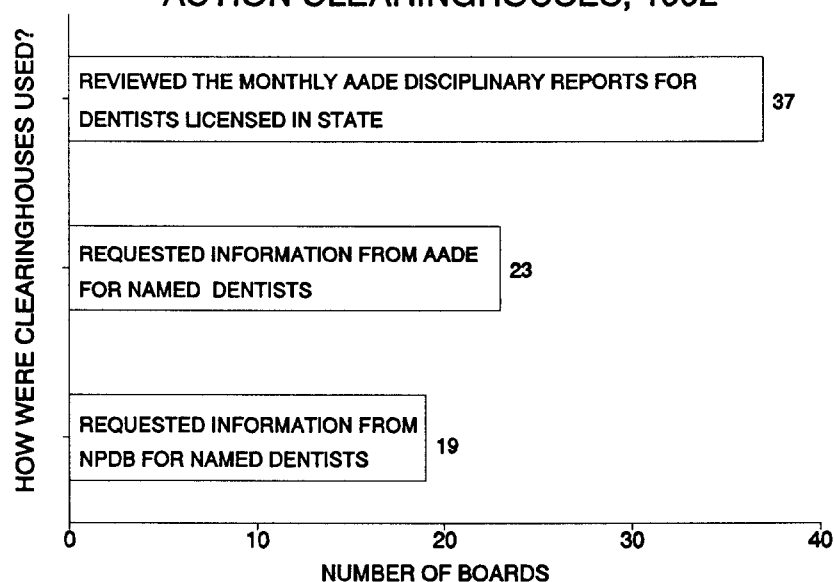
Most dental boards (34 of 48 reporting) can turn to a computerized file that they or their parent department maintains to determine if they have taken prior disciplinary action against that dentist (figure 5). But for other types of information pertinent to an investigation, fewer boards are likely to have this opportunity. Twenty-five of the 48 can look to an in-house computerized file to determine if any prior complaints have been lodged against the dentist, 17 to learn if there have been settled malpractice claims involving the dentist, and only 7 to find out if any other State has taken disciplinary action against the dentist.

With some effort, such information can almost always be obtained by the inquiring board. But its lack of ready availability adds to the cost and time of an investigation and ultimately impedes the effectiveness of a board.

Disciplinary Action Clearinghouses

The American Association of Dental Examiners maintains a data bank on disciplinary actions taken by State dental boards. On a monthly basis, it distributes to member boards a report identifying dentists recently disciplined by the boards. Upon request, it also informs boards of any prior actions boards have reported for a named dentist. The National Practitioner Data Bank also maintains a data bank on board actions, but in addition includes information on malpractice payments and adverse action taken by hospitals, other health care entities, and professional associations. Boards making full use of these clearinghouses can enhance their case investigations, particularly in regard to dentists who hold or have held licenses in other States.

FIGURE 6: STATE DENTAL BOARDS' USE OF DISCIPLINARY ACTION CLEARINGHOUSES, 1992



Source: OIG mail survey, Fall 1992. N = 48 States. (Each State did not respond to each of the three questions posed.) AADE = American Association of Dental Examiners. NPDB = National Practitioner Data Bank.

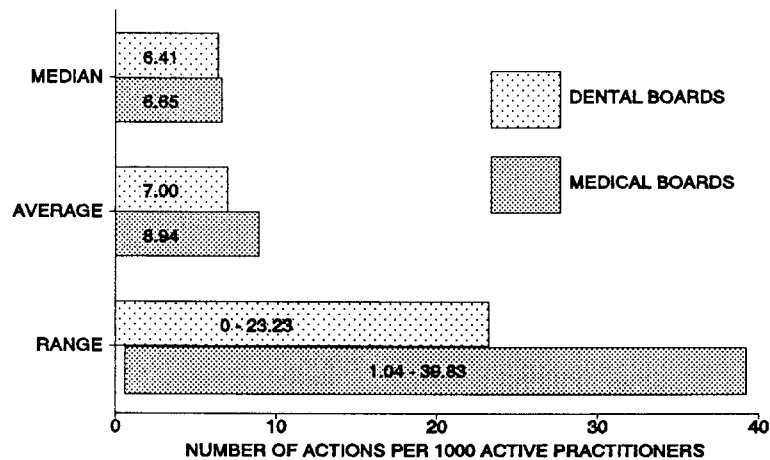
Nearly all of the dental boards that addressed the pertinent question in our survey (37 of 41), reported that they reviewed the monthly reports that the AADE sends them on dentists licensed in their States (figure 6). But during the past year, only 23 indicated that they made any name requests of the AADE and only 19 of the NPDP.

The \$6 (\$10 for paper queries) accessing fee charged by the NPDP may have some effect in limiting the boards' readiness to make name requests of it. Why they may also be disinclined to make such inquiry of the AADE clearinghouse, which is available free of cost for the first 100 queries in a year, is less clear.

Disciplinary Actions

Disciplinary actions such as licensure revocations, suspensions, or fines are an important indicator of board capacity and performance because they show a board's readiness to intervene to protect the public and to hold dentists accountable for their actions. This information is most useful if it is expressed in terms of a ratio that facilitates comparisons across States and if it is considered over a period of years.

**FIGURE 7: RATE OF DISCIPLINARY ACTIONS BY STATE
DENTAL AND MEDICAL BOARDS, 9/1/90 - 8/31/92**



Sources: For dentists - National Practitioner Data Bank, licensure actions reported by State dental boards for 9/1/90 - 8/31/92 and the American Dental Association, 1991 - 1992 *Distribution of Dentists in the United States by Region and State*. For physicians - National Practitioner Data Bank, licensure actions reported by State medical boards for 9/1/90 - 8/31/92 and The Federation of State Medical Boards, *Exchange*, 1992 - 1993 edition. N = 50 States.

The number of disciplinary actions taken by dental boards during the September 1, 1990 to August 31, 1992 period varied greatly; at one extreme five boards took no such actions and at the other 5 took 12 or more.¹⁰ Overall, the median was 6.41 and the average 7.0. This compares with 6.65 and 8.94 for medical boards (figure 7). Thus dentists were somewhat less likely to be disciplined by licensure boards than were physicians, even though, as we noted earlier, dental boards may be a more important front line of protection for consumers than are medical boards.

It would be inappropriate to suggest that there is any proper number of disciplinary actions for a board or to overemphasize their importance as an indicator of a board's capacity or effectiveness. Yet it would also be inappropriate to ignore this factor. In this context, it is well to note that in a report on medical boards, the American Association of Retired Persons advised that the simplest way to determine how well a board is performing is to determine how many disciplinary actions it is taking.¹¹

CONCLUSION

The stimulus for this report was our prior finding that State dental board officials were often reluctant to license out-of-State dentists because of concerns about the capacity and readiness of many of their counterpart boards to carry out their disciplinary responsibilities. The information presented in this report supports their concerns, but its significance goes beyond the licensure of out-of-State dentists to the more basic issue of providing adequate protection to the consumers of dental services in all the States.

Given that the licensure and discipline of dentists is essentially a State responsibility, it is the State boards and the State governments of which they are a part that must take the lead if the limitations identified in this report are to be addressed. Those limitations affect the boards' capacity to identify dentists warranting investigation, to conduct thorough investigations that will facilitate responsible decision making about how a board should proceed with a case, and, when, necessary to take disciplinary and corrective action that will protect the public and be fair to the dentist involved.

The Federal government, as indicated at the outset of this report, has a considerable interest in how the States address the limitations of their dental boards. In this context, one important way in which the Public Health Service (PHS) might help the State boards, but still respect the primacy of their role, is to extend some financial support for the development of a self-assessment instrument for the boards. Such an instrument, if developed by representatives of dental boards, could serve as an important stimulus for boards to develop consensus on key indicators of their performance, to collect data in accord those indicators, and then to compare the results over time and even across States.

The PHS, through the Agency for Health Care Policy and Research (AHCPR), has funded The Federation of State Medical Boards to develop a self assessment instrument for State medical boards, with notable success.¹² Similar support whether through AHCPR or the Bureau of Health Professions, oriented to dental boards, the only other State licensing boards mandated to report their disciplinary actions to the National Practitioner Data Bank, could build upon the prior project and have similar benefits.

APPENDIX A

NOTES

1. Suzanne W. Letsch, Helen C. Lazenby, Katherine R. Levit, and Cathy A. Cowan, "National Health Expenditures, 1991," *Health Care Financing Review* 14 (Winter 1992): 29. Federal Medicare expenditures for dental services are only a few million dollars a year as they are limited to surgery related to the jaw or facial bone.
2. See Letsch, et al., p. 29.
3. 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 the American Dental Association, Bureau of Economic and Behavioral Research.
4. U.S. Department of Health and Human Services, Public Health Service, *Healthy People: National Health Promotion and Disease Prevention Objectives*, DHHS Publication No. (PHS) 91-50212, 1991, p. 350.
5. *Ibid.*, pp. 352-61.
6. In particular, see "State Medical Boards and Quality-of-Care Cases: Promising Approaches," OEI-01-92-00050, February 1993; "Performance Indicators, Annual Reports, and State Medical Discipline: A State-by-State Review," OEI-01-89-00563, July 1991; "State Licensure and Discipline of Dentists," OAI-01-88-00580, August 1988; and "Medical Licensure and Discipline: An Overview," P-01-86-00064, June 1986.
7. See, for examples, American Medical Association, *Physician Competence: Whose Responsibility: Conference Proceedings, April 7 - 9, 1988*; U.S. Department of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research, *Issues in Medical Liability: A Working Conference*, Mary L. Grady and Randie A. Siegel, eds., 1991; and U.S. Congress, Office of Technology Assessment, *The Quality of Medical Care: Information for Consumers*, OTA-H-386 (Washington, DC: U.S. Government Printing Office, June 1988).
8. See EH O'Neil, *Health Professions Education for the Future: Schools in Service to the Nation* (San Francisco: Pew Health Professions Commission, 1993), 51. A major reason for dentists being subject to lesser oversight is that about 69 percent of them conduct solo practices. See American Dental Association, *The*

1991 Survey of Dental Practice: General Characteristics of Dentists, April 1992, p. 2.

9. See Federation of State Medical Boards, *Elements of a Modern State Medical Board: A Proposal*, 1989, p. 3.
10. In a recent article, Damiano et al. also reported significant variations among the States in disciplinary actions and among State professional associations in peer review actions. Such variations, they concluded "suggest the need for modifications to improve the licensure and disciplinary process to ensure performance in accord with accepted professional standards." See Peter C. Damiano, Daniel A. Shugass, 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.
11. See American Association of Retired Persons, *Effective Physician Oversight: Prescription for Medical Licensing Board Reform*, 1987.
12. A task force of the Federation of State Medical Boards developed a lengthy self-assessment instrument which it sent to all State medical boards for comment and then, upon revision, for their own use. Many State boards have completed the assessment instrument and have sent in their results to the Federation. The Federation, upon the receipt of such results, enters the data into a common data base incorporating the information submitted by all boards. It then returns information back to the State boards in a manner which allows them to compare their results with those of other States. At the annual meeting of the Federation, held in April 1993, many board representatives reported that the self-assessment instrument and process associated with completing it were helping in identifying ways of improving their boards' capacity.