

SUNSET EVALUATION REPORT
DENTAL HYGIENISTS
Chapter 447, Hawaii Revised Statutes

A Report to the Governor and the Legislature of the State of Hawaii

Submitted by the
Legislative Auditor of the State of Hawaii

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FOREWORD

Under the "Sunset Law," licensing boards and commissions and regulated programs are terminated at specified times unless they are reestablished by the Legislature. Hawaii's Sunset Law scheduled for termination 38 occupational licensing programs over a six-year period. These programs are repealed unless they are specifically reestablished by the Legislature. In 1979, the Legislature assigned the Office of the Legislative Auditor responsibility for evaluating each program prior to its repeal.

This report evaluates the regulation of dental hygienists under Chapter 447, Hawaii Revised Statutes. It presents our findings as to whether the program complies with the Sunset Law and whether there is a reasonable need to regulate dental hygienists to protect public health, safety, or welfare. It includes our recommendation on whether the program should be continued, modified, or repealed.

We acknowledge the cooperation and assistance extended to our staff by the Board of Dental Examiners, the Department of Commerce and Consumer Affairs, and other officials contacted during the course of our examination.

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Chapter 1

INTRODUCTION

The Hawaii Regulatory Licensing Reform Act of 1977, or Sunset Law, repeals statutes concerning 38 state licensing boards and commissions over a six-year period. Each year, six to eight licensing statutes are scheduled to be repealed unless specifically reenacted by the Legislature.

In 1979, the Legislature amended the law to make the Legislative Auditor responsible for evaluating each licensing program prior to its repeal and to recommend to the Legislature whether the statute should be reenacted, modified, or permitted to expire as scheduled. In 1980, the Legislature further amended the law to require the Legislative Auditor to evaluate the effectiveness and efficiency of the licensing program, even if he determines that the program should not be reenacted.

Objective of the Evaluation

The objective of the evaluation is: To determine whether, in light of the policies set forth in the Sunset Law, the public interest is best served by reenactment, modification, or repeal of Chapter 447, Hawaii Revised Statutes.

Scope of the Evaluation

This report examines the history of the statute on the licensing of dental hygienists and the public health, safety, or welfare that the statute was designed to protect. It then assesses the effectiveness of the statute in preventing public injury and the continuing need for the statute.

Organization of the Report

This report consists of three chapters: Chapter 1, this introduction and the framework developed for evaluating the licensing program; Chapter 2, background information on the regulated industry and the enabling legislation; and Chapter 3, our evaluation and recommendation.

Framework for Evaluation

Hawaii's Regulatory Licensing Reform Act of 1977, or Sunset Law, reflects rising public antipathy toward what is seen as unwarranted government interference in citizens' lives. The Sunset Law sets up a timetable terminating various occupational licensing boards. Unless reestablished, the boards disappear or "sunset" at a prescribed moment in time.

In the Sunset Law, the Legislature established policies on the regulation of professions and vocations. The law requires that each occupational licensing program be assessed against these policies in determining whether the program should be reestablished or permitted to expire as scheduled. These policies, as amended in 1980, are:

1. The regulation and licensing of professions and vocations by the State shall be undertaken only where reasonably necessary to protect the health, safety, or welfare of consumers of the services; the purpose of regulation shall be the protection of the public welfare and not that of the regulated profession or vocation.

2. Where regulation of professions and vocations is reasonably necessary to protect consumers, government regulation in the form of full licensure or other restrictions on the professions or vocations should be retained or adopted.

3. Professional and vocational regulation shall be imposed where necessary to protect consumers who, because of a variety of circumstances, may be at a disadvantage in choosing or relying on the provider of the services.

4. Evidence of abuses by providers of the services shall be accorded great weight in determining whether government regulation is desirable.

5. Professional and vocational regulation which artificially increases the costs of goods and services to the consumer should be avoided.

6. Professional and vocational regulation should be eliminated where its benefits to consumers are outweighed by its costs to taxpayers.

7. Regulation shall not unreasonably restrict entry into professions and vocations by all qualified persons.

We translated these policy statements into the following framework for evaluating the continuing need for the various occupational licensing statutes.

Licensing of an occupation or profession is warranted if:

1. There exists an identifiable potential danger to public health, safety, or welfare arising from the operation or conduct of the occupation or profession.
2. The public that is likely to be harmed is the consuming public.
3. The potential harm is not one against which the public can reasonably be expected to protect itself.
4. There is a reasonable relationship between licensing and protection of the public from potential harm.
5. Licensing is superior to other optional ways of restricting the profession or vocation to protect the public from the potential harm.
6. The benefits of licensing outweigh its costs.

The potential harm. For each regulatory program under review, the initial task is to identify the purpose of regulation and the dangers from which the public is intended to be protected.

Not all potential dangers warrant the exercise of the State's licensing powers. The exercise of such powers is justified only when the potential harm is to public health, safety, or welfare. "Health" and "safety" are fairly well understood. "Welfare" means well-being in any respect and includes physical, social, and economic well-being.

This policy that the potential danger be to the public health, safety, or welfare is a restatement of general case law. As a general rule, a state may exercise its police power and impose occupational licensing requirements only if such requirements tend to promote the public health, safety, or welfare. Under particular fact situations and statutory enactments, courts have held that licensing requirements for paperhangers, housepainters, operators of public dancing schools, florists, and private land surveyors could not be justified.¹ In Hawaii, the State Supreme Court in 1935 ruled that legislation requiring photographers to be licensed bore no reasonable relationship to public health, safety, or welfare and constituted an unconstitutional

1. See discussion in 51 *American Jurisprudence*, 2d., "Licenses and Permits," Sec. 14.

encroachment on the right of individuals to pursue an innocent profession.² The court held that mere interest in the practice of photography or in ensuring quality in professional photography did not justify the use of the State's licensing powers.

The public. The Sunset Law states that for the exercise of the State's licensing powers to be justified, not only must there be some potential harm to public health, safety, or welfare, but also the potential harm must be to the health, safety, or welfare of that segment of the public consisting mainly of consumers of the services rendered by the regulated occupation or profession. The law makes it clear that the focus of protection should be the consuming public and not the regulated occupation or profession itself.

Consumers are all those who may be affected by the services rendered by the regulated occupation or profession. Consumers are not restricted to those who purchase the services directly. The provider of services may have a direct contractual relationship with a third party and not with the consumer, but the criterion set forth here may be met if the provider's services ultimately flow to and adversely affect the consumer. For example, the services of an automobile mechanic working for a garage or for a U-drive establishment flow directly to the employer, but the mechanic's workmanship ultimately affects the consumer who brings a car in for repairs or who rents a car from the employer. If all other criteria set forth in the framework are met, the potential danger of poor workmanship to the consuming public *may* qualify an auto mechanic licensing statute for reenactment or continuance.

Consumer disadvantage. The consuming public does not require the protection afforded by the exercise of the State's licensing powers if the potential harm is one from which the consumers can reasonably be expected to adequately protect themselves. Consumers are expected to be able to protect themselves unless they are at a disadvantage in selecting or dealing with the provider of services.

Consumer disadvantage can arise from a variety of circumstances. It may result from a characteristic of the consumer or from the nature of the occupation or profession being regulated. Age is an example of a consumer characteristic which may cause the consumer to be at a disadvantage. The highly technical and complex

2. *Terr. v. Fritz Kraft*, 33 Haw. 397.

nature of the occupation is an illustration of occupational character that may result in the consumer being at a disadvantage. Medicine and law fit into the latter illustration. Medicine and law were the first occupations to be licensed on the theory that the general public lacked sufficient knowledge about medicine and law to enable them to make judgments about the relative competencies of doctors and lawyers and about the quality of services provided them by the doctors and lawyers of their choice.

However, unless otherwise indicated, consumers are generally assumed to be knowledgeable and able to make rational choices and to assess the quality of services being provided them.

Relationship between licensing and protection. Occupational licensing cannot be justified unless it reasonably protects the consumers from the identified potential harm. If the potential harm to the consumer is physical injury arising from possible lack of competence on the part of the provider of service, the licensing requirement must ensure the competence of the provider. If, on the other hand, the potential harm is the likelihood of fraud, the licensing requirements must be such as to minimize the opportunities for fraud.

Alternatives. Depending on the harm to be protected against, licensing may not be the most suitable form of protection for the consumers. Rather than licensing, the prohibition of certain business practices, governmental inspection, or the inclusion of the occupation within some other existing business regulatory statute may be preferable, appropriate, or more effective in providing protection to the consumers. Increasing the powers, duties, or role of the consumer protector is another possibility. For some programs, a nonregulatory approach may be appropriate, such as consumer education.

Benefit-costs. Even when all other criteria set forth in this framework are met, the exercise of the State's licensing powers may not be justified if the costs of doing so outweigh the benefits to be gained from such exercise of power. The term, "costs," in this regard means more than direct money outlays or expenditure for a licensing program. "Costs" includes opportunity costs or all real resources used up by the licensing program; it includes indirect, spillover, and secondary costs. Thus, the Sunset Law asserts that regulation which artificially increases the costs of goods and services to the consumer should be avoided; and regulation should not unreasonably restrict entry into professions and vocations by all qualified persons.

Chapter 2

BACKGROUND

Chapter 447, Hawaii Revised Statutes, regulates the practice of clinical dental hygiene in the State. Under the law, any person providing clinical dental hygiene services must be licensed by the Board of Dental Examiners. Dental hygienists have been regulated by the State since 1920.

Occupational Characteristics

According to data provided by the Department of Commerce and Consumer Affairs (DCCA), there are 509 licensed dental hygienists in the State.¹ The following paragraphs provide a brief history and description of the profession.

History. The prevention of oral disease through education and treatment is the primary function of dental hygienists. Dental hygienists help to administer dental treatment, provide instruction on tooth care, and generally provide appropriate and needed assistance to dentists.

The first dental hygienists were trained by dentists themselves. Prior to the late 1800s, most dentists provided dental care without any assistance. It was not until 1885 that the first dental assistant was hired. Eventually, the duties of dental assistants grew to include such functions as performing laboratory work and providing chairside assistance to the dentist. In the early 1900s, a new type of dental auxiliary, dental hygienists, evolved to assist dentists primarily by cleaning teeth. Connecticut was the first state to train and license hygienists.²

Hawaii's first organized dental hygiene program is associated with Mrs. George R. Carter who, in 1920, founded the Honolulu Dental Infirmary (now known as the Strong-Carter Dental Clinic) to provide dental care for Honolulu children whose parents were unable to afford private dental services.

1. State of Hawaii, Department of Commerce and Consumer Affairs. *Geographic Report*, August 22, 1983.

2. U.S. General Accounting Office, *Increased Use of Expanded Function Dental Auxiliaries Would Benefit Consumers, Dentists, and Taxpayers*, A Report to the Congress of the United States by the Comptroller General, Washington, D.C., March 7, 1980, p. 2.

In 1921, Mrs. Carter sponsored and financed a school for training dental hygienists at the Honolulu Dental Infirmary. That year also marked the beginning of Hawaii's first public school dental hygiene program. For the first time, dental hygienists were hired to provide dental hygiene services to students in Hawaii's public schools, and \$20,000 was appropriated by the Territory to implement this innovative health program.

Late in 1926, the dental hygiene school was transferred to the Territorial Normal and Training School, and in 1931, the school was combined with the University of Hawaii Teachers College. In 1961, the dental hygiene school was moved to its present affiliation with the School of Nursing at the University of Hawaii.

The dental hygiene program at the university remains the only program of its kind offered in the State. Students elect to complete one of two program options: (1) the 75 credit, three-year program which leads to a Certificate in Dental Hygiene; or (2) the 125 credit, four-year program which leads to a Bachelor of Science in Dental Hygiene. Students completing the program qualify for a certificate in dental hygiene and admission to the national and state board dental hygiene examinations.

Description of profession. Dental hygienists normally work under the direction of a dentist. Although the specific functions of dental hygienists vary according to the laws of the states where they are employed, their duties often include: providing oral prophylaxis services (cleaning teeth by removing stains and calcium deposits, polishing teeth, and massaging gums); applying topical fluoride to prevent tooth decay; mixing compounds for filling cavities; sterilizing instruments; assisting in surgical work; taking and developing X-rays; taking medical and dental histories; and carrying out clerical tasks.

According to the U.S. Public Health Service, about 36,000 persons worked as dental hygienists in 1980.³ Most work in private dental offices and many are employed part-time. Some contract their services to several dentists or dental offices. Dental hygienists are also employed by public health agencies, school systems, industrial plants, clinics, hospitals, dental hygiene schools, and the state, federal, and local governments.

3. U.S. Bureau of Labor Statistics, *Occupational Outlook Handbook, 1982-83*, Washington, D.C., April 1982, p. 16.

All 50 states and the District of Columbia require dental hygienists to be licensed.⁴ To obtain a license, an applicant must normally graduate from an accredited dental hygiene school and pass both a written and clinical examination.

In 1980, there were 210 schools of dental hygiene in this country accredited by the Commission on Dental Accreditation of the American Dental Association. Most schools offer a two-year program leading to an associate degree or certificate in dental hygiene. Other schools provide a four-year college program leading to a bachelor's degree. Some schools offer both types of programs. Currently, six schools offer master's degree programs in dental hygiene.

The major professional organization for dental hygienists is the American Dental Hygienists' Association which was founded in 1923. Total membership in the association numbers around 30,000. The objectives of the association include improving the oral health of the country and representing and protecting the interests of the dental hygiene profession. The Hawaii affiliate, the Hawaii Dental Hygienists' Association, was founded in 1926 and has approximately 180 members.⁵

Statutory History

Dental hygienists have been regulated by the State for over 60 years. Act 7, SLH 1920, the Hawaiian Dental Hygienist Act, prohibited any person from practicing dental hygiene in the Territory of Hawaii, "either gratuitously or for pay, or shall offer or attempt so to practice, or shall advertise or announce himself publicly or privately as prepared or qualified so to practice, without having a license as in this Act provided."⁶

The legislative intent of Act 7 was "to legalize the practice of dental hygiene here by persons trained for this work."⁷ Additionally, the Senate Committee on Public Health noted in its report that "the enactment of this Bill into law will result

4. *Ibid.*

5. Interview with Claudia Fujinaka, President, Hawaii Dental Hygienists' Association, April 19, 1983.

6. Section 1, Act 7, SLH 1920, Special Session.

7. Senate Standing Committee Report No. 27 on House Bill 7, Special Session of 1920.

in great benefit to the children of the Territory in that it will enable the Dental Clinic endowed by Mrs. George R. Carter . . . to function.”⁸

Since 1920, the Hawaiian Dental Hygienist Act has been amended more than a dozen times. In general, the Act has been amended to further protect the public, improve the professional quality of dental hygiene practice, and to clarify and improve the administration of the law. Some of the more significant amendments are summarized below.

In 1925, Act 33 amended the law by requiring that all practicing dental hygienists must work “under the direct or general supervision of a legally licensed dentist in the Territory of Hawaii.”⁹

Act 158, SLH 1931, clarified the licensing requirements for applicants. The Act also provided for the revocation of a dentist’s license should the dentist permit a dental hygienist employed under the dentist’s supervision to perform any dental work not allowed by the law.¹⁰

Act 30, SLH 1970, expanded the functions of dental hygienists by updating and redefining the term “practice of clinical dental hygiene.”

The House Judiciary Committee reported: “Existing law permits dental hygienists to clean teeth, apply chemical agents on the coronal surfaces of teeth and use mouth washes. This description is outmoded and prevents a dental hygienist from treating his patients in the manner he has been taught under the latest techniques. This bill corrects this situation by increasing a dental hygienist’s duties. . . . Flexibility of the law is provided by allowing the dental hygienist to practice other procedures delegated by the dentist in accordance with rules and regulations of the board of dental examiners.”¹¹

Act 30 also amended the law by requiring that dental hygienists employed by dentists in private practice “shall be under the direct and continuous supervision and

8. *Ibid.*

9. Section 1, Act 33, SLH 1925.

10. Section 2, Act 158, SLH 1931.

11. House Standing Committee Report No. 546-70 on House Bill 1224, Regular Session of 1970.

inspection of a licensed dentist.”¹² The amendment did not affect hygienists employed and practicing in an eleemosynary dental clinic, private school, welfare center, or a state or county office. Under the law, these hygienists were still allowed to practice under the direct or general supervision of a licensed dentist.

According to the House Judiciary Committee, this distinction in supervision was “prompted by an overriding and compelling state need.”¹³ In justifying its decision to allow publicly-employed hygienists to continue to work under a dentist’s general or direct supervision, the committee reported: “. . . the provision requiring that the work of dental hygienists be under the ‘direct and continuous supervision and inspection by a licensed dentist’ would inadvertently prevent the continuation of the Department of Health’s Dental Hygiene Program, which, because of its extensive nature, can only be conducted subject to general—not direct and continuous—supervision.”¹⁴

Act 53, SLH 1971, amended the revisions of the previous year by deleting the requirement that dental hygienists employed by dentists in private practice be under the continuous supervision and inspection of a licensed dentist. Under Act 53, such hygienists were only required to be under the direct supervision of a licensed dentist.

In its report, the Senate Judiciary Committee noted that the Act would allow more flexibility in the working conditions of dental hygienists in private practice. Additionally, if the law were not amended, dentists would be burdened by having to be present at all times in the same room while the dental hygienist worked.¹⁵

Nature of Regulation

The statutory provisions relating to dental hygienists are found in Chapters 447 and 448, Hawaii Revised Statutes. Chapter 447 pertains directly to dental hygienists while Chapter 448, the Dental Practice Act, regulates all dental operations in the

12. Section 1, Act 30, SLH 1970.

13. House Standing Committee Report No. 546-70 on House Bill 1224, Regular Session of 1970.

14. *Ibid.*

15. Senate Standing Committee Report No. 489 on Senate Bill 465, Regular Session of 1971.

State and establishes the Board of Dental Examiners. The board is responsible for regulating and issuing licenses to both dental hygienists and dentists.

Duties and supervision. Unless licensed under Chapter 447, a person is prohibited from practicing clinical dental hygiene or using the title, "dental hygienist." Although a dentist may employ other auxiliary personnel, the dental hygienist is the only person, other than the dentist, who may provide clinical dental hygiene services.

The practice of clinical dental hygiene is defined under the chapter as the removal of hard and soft deposits and stains from the teeth, the polishing of teeth, the application of approved preventive chemical agents, such as fluoride, to the surfaces of teeth, and the use of approved mouthwashes.

Dentists may delegate other duties to dental hygienists if these duties are permitted by the board's rules. However, dental hygienists are prohibited from performing any repair or operation work on teeth or tissues of the mouth and are also prohibited from performing any preparation for such work. The board may revoke the license of any dentist who permits a dental hygienist to perform any dental work not allowed under the chapter.

Under Chapter 447, dental hygienists are required to practice under the supervision of a licensed dentist. Either direct or general supervision is required for dental hygienists employed by legally incorporated eleemosynary dental clinics, private schools, welfare centers, or the state or county government. However, dental hygienists employed by dentists in private practice are required to be under the direct supervision of a licensed dentist.

Every practicing dental hygienist is required to inform the board of the hygienist's place of employment and the name of the employing dentist or institution.

Licensing requirements. The law requires that to be licensed as a dental hygienist a person must be at least 18 years old, a graduate of an accredited high school, a graduate of an American dental hygiene school approved by the board, and pass a national board written examination, a state written examination, and a practical examination on the removal of deposits or stains from teeth. Licenses must

be renewed biennially, on or before December 31 of each odd-numbered year. Failure to do this may result in forfeiture of the license.

Temporary license. A temporary license to practice as a dental hygienist may be issued by the board to any person qualified to take the examination and employed by the State or county, any legally incorporated eleemosynary dental clinic, private school, or welfare center. The temporary license remains valid only while the hygienist is in such employment and is automatically cancelled when the hygienist has been examined by the board. The board may revoke the temporary license at any time.

Dental hygiene schools. Under Chapter 447, any legal eleemosynary dental clinic may establish a school of dental hygiene to train students. The law stipulates that students accepted for such a school must be high school graduates, that the dental hygiene program last at least two years, and that the graduates of the training program be prohibited from practice until licensed under the chapter.

Under the rules of the board, the board retains the authority to approve training schools for dental hygienists. The rules also specify the minimum standards for these schools, e.g., the nature of the physical plant, enrollment, admission, instruction, faculty, and curriculum. In actual practice, the board normally approves those training programs accredited by the Commission of Dental Accreditation of the American Dental Association. The dental hygiene program at the University of Hawaii was given the full approval of the commission in 1982.¹⁶

Violations; license suspension or revocation. Under the law, persons who violate or fail to comply with any of the requirements or provisions of Chapter 447 are subject to a fine of up to \$100. After proper hearing and notice, the board also has the authority to suspend or revoke, with power to reinstate, the license of any dental hygienist who, in the board's opinion, violated the chapter, is guilty of professional misbehavior, or is not of good moral character.

Board of Dental Examiners. Chapter 448 prescribes the composition, organization, operation, and powers of the Board of Dental Examiners. Regarding dental hygienists, the board retains the statutory authority to examine and license

16. "U.H. Dental Program Gets OK." *Honolulu Advertiser*. January 23, 1982.

applicants, to issue temporary licenses, to conduct disciplinary hearings to revoke or suspend licenses, and to formulate and adopt necessary board rules.

The 11-member board is appointed by the Governor and is placed for administrative purposes in the Department of Commerce and Consumer Affairs. As required by law, board membership consists of eight practicing dentists, one of whom must be appointed from each of the counties of Hawaii, Maui, and Kauai and five from the City and County of Honolulu; two public members; and one practicing dental hygienist. The board members serve without pay but are reimbursed for expenses incurred during the performance of their duties.

Prior Sunset Evaluation

In 1980, the Legislative Auditor completed a sunset evaluation of Chapter 447, Hawaii Revised Statutes (see Legislative Auditor, *Sunset Evaluation Report, Dental Hygienists*, Report No. 80-7, February 1980). In the report, it was recommended that: (1) the Legislature reenact Chapter 447; (2) the Board of Dental Examiners discontinue the state theory examination since it duplicated the national board examination; and (3) the board evaluate the appropriateness of requiring different levels of supervision for dental hygienists employed by dentists in private practice and hygienists employed by private or public institutions.

During the Regular Session of 1980, the Legislature acted to continue regulation of dental hygienists by reenacting Chapter 447 and establishing a repeal date of December 31, 1986 for the chapter. Act 110, SLH 1982, further amended the statute by establishing a new repeal date of December 31, 1984.

Chapter 3

EVALUATION OF THE REGULATION OF DENTAL HYGIENISTS

This chapter contains our evaluation of the regulation of dental hygienists under Chapter 447, Hawaii Revised Statutes, including our evaluation of the need for regulation and existing regulatory operations. We conclude this report with our recommendations.

Summary of Findings

Our findings are as follows:

1. A clear potential for public harm exists with the practice of clinical dental hygiene. The absence of regulation would unnecessarily expose the public to threat of harm.
2. The integrity of the dental hygiene practical examination is threatened by the use of dental hygiene students as paid helpers during the examination.
3. Requiring candidates to pass the state written examination in addition to the national examination is an unnecessary duplication.
4. Current licensing provisions preventing licensure by credentials for qualified and licensed out-of-state hygienists are unreasonable and restrictive.
5. The distinction in supervision requirements for publicly and privately employed hygienists is unfair, restrictive, and unwarranted.
6. Present restrictions preventing properly trained, qualified, and supervised hygienists from performing such expanded functions as taking dental impressions, administering local anesthetics, and completing restorations are unreasonable.

The Need for Regulation

We find that the clinical practice of dental hygiene poses a clear potential for public harm, and the absence of regulation would unnecessarily endanger the health and safety of the public.

Any intra-oral procedure can be potentially harmful for the dental patient. A routine prophylaxis, for example, can be the mechanism for transmitting hepatitis, venereal disease, or other infections and diseases.

Other potentially harmful results of clinical dental hygiene include: serious health problems and possibly death resulting from inadequate attention and care to such high-risk patients as diabetics, persons with heart problems, and hemophiliacs; unnecessary and dangerous radiation exposure to patients and other dental personnel resulting from the incompetent and inappropriate use of radiographs (X-rays); laceration of gum tissue due to excessive roughness in removing deposits from teeth; and the aggravation of gum disease resulting from the incomplete removal of calculus from patients with the disease.

Our examination of complaints filed with the Regulated Industries Complaints Office (RICO) of the Department of Commerce and Consumer Affairs (DCCA) indicates that no complaints have been filed against dental hygienists in the last four years. However, the absence of formal complaints may not necessarily be a valid indicator of the actual potential for harm posed by the profession.

The absence of complaints may attest to the success of training/educational programs and licensing requirements in ensuring the competence of practitioners. Additionally, the lack of formal complaints may be attributable to the supervision requirements for hygienists. The dental hygienist is normally employed and supervised by the dentist who is ultimately responsible for the hygienist's work. If a patient has a complaint, it will often be made directly to the dentist. It remains in the dentist's best interest, then, to monitor the hygienist's work and ensure that it is satisfactory to both the dentist and the patient.

Without state regulation, there would be no formal restrictions or requirements regarding the training, education, qualifications, or competence of dental hygienists. Because of the technical nature of the profession, the public would be at a distinct disadvantage in trying to ascertain the competence of hygienists and would be subject to unnecessary risk of harm from unsafe and incompetent practitioners.

Finally, given the complex nature of the profession and the threat of harm posed by incompetent or negligent practitioners, we believe that dental hygienists warrant regulation through licensure as opposed to any less stringent forms of regulation.

A compelling argument for continued licensure is the fact that regulation in the form of licensure is required for dental hygienists in all 50 states and the District of Columbia.¹ The use of licensure by all of the states indicates that less restrictive forms of regulation are generally considered to be inadequate in providing protection for the public.

Regulatory Operations

Our evaluation of the board's existing regulatory practices indicates that improvements could be achieved by implementing changes in several key areas. This portion of the report will focus on suggested improvements in the following areas: (1) examinations; (2) licensing; and (3) scope of practice.

Examinations. Dental hygienist candidates are required to pass the national board dental hygiene examination, a nationally standardized examination prepared by the Council of National Board of Dental Examiners of the American Dental Association (ADA); a state written examination on clinical practice and the dental hygiene law and rules; and a practical clinical and laboratory examination.

1. *Practical examination.* As a result of a 1976 federal lawsuit in which two dentists alleged that the state dental board discriminated against applicants on the basis of race and residency, the State agreed to modify significantly the dental practical examination.² These new examination procedures are also being utilized for the dental hygiene practical examination.

These procedures include: (1) training and calibration sessions for graders; (2) "blind" or anonymous testing and grading procedures; (3) comprehensive and objective written criteria by which all clinical skills can be measured and graded; (4) individual grading of examinees in which graders are prohibited from comparing grades or consulting with other graders; (5) availability of grading and score sheets to candidates; and (6) an appeals procedure.

These new procedures appear to have greatly improved the practical examination. One dental hygienist states that the examination has become more

1. American Dental Hygienists' Association, *Legislative Action Packet No. 3*, Chicago, Illinois, June 1982.

2. "State to Change Dentist-Licensing Procedures." *Honolulu Star-Bulletin*, July 14, 1979.

objective and fairer with the blind grading and the training of graders. Another hygienist believes the examination is now more thorough, the instructions are clearer, and the examination is currently a more valid test of a candidate's ability.

During the practical examination, usually six or seven dentists from the board, the dental hygienist board member, and a deputized, nonpaid, licensed hygienist serve as graders. It is also normal practice for the board to utilize paid dental hygiene school students to serve as messengers and to provide chairside assistance during the grading of the candidates' work.

We believe this practice threatens the integrity of the examination and should be eliminated. Having hygienist students assist during the examination provides these students (potential future candidates) with an unfair advantage over other candidates, permits them to become acquainted with the graders, potentially jeopardizes the anonymity of candidates, and provides these student helpers with an opportunity to observe and familiarize themselves with the examination site, procedures, and grading techniques.

This practice is justified on the grounds that the dentists need technically knowledgeable assistants to help them record the clinical work of the candidates. If this is the case, volunteer licensed hygienists should be solicited to assist or funds should be made available to pay for the assistance and services of licensed hygienists.

2. *Written examination.* There are two portions to the state written examination, Part A, a clinical portion, and Part B, a test on state dental hygiene laws and rules. While there are good reasons for retaining Part B, the state written clinical examination is an unnecessary duplication of the national board dental hygiene examination. The state written clinical examination is a 50-question, 50-minute, multiple-choice examination dealing primarily with clinical procedures, oral inspection, and oral pathology. The examination is developed and administered by the DCCA, and the results are valid only in Hawaii.

The national board examination is a nationally standardized, 350 multiple-choice examination covering such subjects as oral inspection, exposing and processing radiographs, obtaining diagnostic data, performing prophylaxis, applying topical agents, providing oral health instruction, and assisting in emergencies. As a

nationally standardized examination, it undergoes rigorous scrutiny to ensure appropriate selection of test items and high levels of validity and reliability.

The national board examination results are accepted as fulfilling or partially fulfilling the state written examination requirements in 51 licensing jurisdictions, including 48 states, the District of Columbia, Puerto Rico, and the Virgin Islands. The examination is offered three times yearly, and locally, is administered by the Counseling and Testing Service at the University of Hawaii.

In comparison to the state written clinical examination, the national board examination appears to be a more comprehensive, thorough, and technically superior instrument to test the knowledge and competence of candidates. It also appears that the content of both examinations is similar. Consequently, we believe that requiring candidates to pass both examinations is unnecessary and unwarranted. The dental board should eliminate the requirement that candidates pass both the state written clinical and the national board examinations. Passing the latter examination should be sufficient.

Licensure by credentials. Under current licensing requirements, a licensed dental hygienist from another state cannot obtain a license to practice in Hawaii through reciprocity or through licensure by credentials. Licensure by credentials would permit the licensing of out-of-state dental hygienists based on their records and performance in other states. Instead, licensed out-of-state hygienists are required, like any other unlicensed candidates, to take and pass the state written and practical examinations.

These licensing restrictions are usually justified on the grounds that Hawaii hygienists are generally more qualified and competent than out-of-state hygienists because they passed Hawaii's more demanding and stringent state examinations. By not allowing reciprocity, it is argued that the public is provided with a necessary safeguard against incompetent out-of-state practitioners.

However, evidence indicates that these restraints tend to limit the entry rate of new hygienists into local markets, reduce market competition, and consequently, increase prices. Two empirical studies have analyzed price effects. One found that, other things being equal, dental fees were nearly 15 percent higher in nonreciprocity states. The second study, using data from the ADA's Survey of Dental Practice,

estimated that dental fees were at least 7 percent higher in states without reciprocity.³

Both the ADA and the Council of State Governments' National Task Force on State Dental Policies have endorsed licensure by credentials.⁴ According to the ADA, an evaluation of a practitioner's theoretical knowledge and clinical skill based on his performance record "can provide as much protection to the public as would an evaluation based on examination."⁵

The ADA further states that dental boards should be encouraged to develop mechanisms which allow hygienists licensed in one state to be examined for licensure in another state by using previous education, licensure, and experience as a substitute for current requirements.

The Council of State Governments' dental task force reports that the admitting state's sole interests regarding licensure by credentials should be in determining whether the out-of-state applicant has practiced recently and safely and whether the out-of-state license was issued on similar or greater criteria than the in-state license. The task force concludes: "Once these criteria are met, the board must recognize the out-of-state license of any licensed practitioner and issue a license."⁶

Current licensing provisions preventing licensure by credentials for qualified and licensed out-of-state hygienists are unreasonable and restrictive. According to the American Dental Hygienists' Association (ADHA), there are currently 34 states that permit licensure by credentials.⁷ The necessary statutory changes should be made to allow licensure by credentials for qualified hygienists from other states whose licensing requirements are equivalent to or more stringent than Hawaii's. The board should only require out-of-state licensees to pass Part B of the written state examination on Hawaii dental hygiene law and regulations. This would ensure that

3. Douglas A. Conrad and Peter Milgrom, "The Probable Effects of Federal Trade Commission Actions on Dentistry and Dental Education," *Journal of Dental Education*, vol. 46, no. 3, 1982, p. 137.

4. The Council of State Governments is a research and service agency created, supported, and directed by the 50 states. With funding provided by the Kellogg Foundation, the council undertook a review of state dental practice acts. In 1979, the task force issued its recommendations in the form of a suggested dental practice act.

5. American Dental Association, *American Dental Association—Policies, 1976-77*, Chicago, Illinois, p. 100.

6. The Council of State Governments, *State Regulatory Policies: Dentistry and the Health Professions*, Lexington, Kentucky, February 1979, p. 16.

7. American Dental Hygienists' Association, *Legislative Action Packet No. 3*.

the dental hygienists are familiar with the law and conditions under which they will be working.

Temporary licenses. The law permits the Board of Dental Examiners to issue a temporary dental hygienist license to any person who is employed by the State or county, any legally incorporated eleemosynary dispensary, private school, or welfare center and who is qualified to be examined but who has not yet taken the state examinations.

As currently written, however, the law provides no time limitations for temporary licensees. They may retain the license so long as they remain in the designated employment. Hypothetically, a temporary licensee could practice for an unlimited period without ever having to take or pass the dental hygienist examinations. To avoid possible abuses, this loophole in the statute should be eliminated by stipulating in the law how long a temporary license can remain in effect. A reasonable time period would be six months or no later than the first scheduled examination after the end of the six-month period. This should give the hygienist sufficient time to prepare for the examination.

Scope of Practice

Supervision. Under present statutes, all dental hygienists are required to practice under the supervision of a licensed dentist. The law prohibits the independent practice of dental hygiene. The law also stipulates that a hygienist employed by a dentist in private practice must be under the dentist's direct supervision. However, a hygienist employed by the State or county, an eleemosynary dental clinic, private school, or welfare center is required to be under either a dentist's direct or general supervision.

In its rules, the board defines "supervision" as follows: "...means prescribing work methods and objectives and assigning work, provided that the person supervising shall be a licensed dentist in Hawaii."⁸ The terms "direct supervision" and "general supervision" are not defined.

8. State of Hawaii, Title 16, Department of Commerce and Consumer Affairs, Chapter 79. Dentists and Dental Hygienists, Section 16-79-2.

The common understanding of "direct supervision" is the supervision of procedures which require the presence of a licensed dentist on the premises and the availability of the dentist for prompt consultation and treatment. "General supervision" is understood to mean supervision of those procedures which do not require the presence of a dentist on the premises but are performed with the knowledge of a dentist.

This distinction in supervision is justified on the grounds that it would be senseless, cumbersome, and inefficient to require the limited number of dentists employed in the public sector to provide direct supervision for hygienists who normally provide only routine prophylaxis and oral health services. On the other hand, given the number of dentists in private employment and the nature of their practice, it does not pose any kind of hardship for them to provide direct supervision for their hygienists. Additionally, these hygienists are likely to utilize more complex and potentially harmful hygiene procedures.

Dental hygienists argue that direct supervision is unwarranted because hygienists are already licensed professionals who have met stringent educational and training requirements and have demonstrated their competence by passing a national examination and both written and practical state examinations. Additionally, they believe that direct, on-site supervision limits their accessibility and prevents them from providing basic preventive services to such underserved populations as those residing in private institutions, care and nursing homes, urban poverty areas, or isolated rural districts.

In 1979, the Federal Trade Commission (FTC) sent a letter requesting comment from state and local governments and other interested parties regarding the FTC's intent to make recommendations designed to eliminate unnecessary restrictions on dental hygienists. One excerpt from that letter regarding appropriate levels of supervision reads as follows: "The staff also believes that in light of rigorous educational training and testing requirements which all hygienists must meet for licensure, there is no health or safety objective not realizeable by less restrictive means. . . ."⁹

9. Mary A. Fitch, "Deregulation or Delicensure: What's in the Future for Dental Hygiene?," *Dental Hygiene*, December 1980, p. 568.

In its background paper regarding the supervision of dental auxiliaries, the Council of State Governments' dental task force suggests that unnecessarily restrictive supervision requirements thwart the optimum use of auxiliaries. The paper states: "Realistically, delicensure of auxiliaries is not about to occur, nor should it. However, serious consideration should be given to relaxing supervision requirements in the hygienists' unique sphere of competence—preventive care. Controlled remote-site practice of preventive care raises only marginal questions of public safety."¹⁰

We concur with both the FTC and the Council of State Governments and find that the distinction in supervision for publicly and privately employed hygienists is unfair, restrictive, and unwarranted. All hygienists, regardless of their place of employment, should be allowed to perform such routine and traditional hygiene services as cleaning and polishing teeth, applying topical fluoride treatments, and giving oral health instruction under general supervision only.

Additionally, the definition for the term "general supervision" should be provided in the board rules to eliminate any confusion or misinterpretation that may exist regarding the appropriate level of supervision required for dental auxiliaries.

We suggest the following definition: under general supervision, the licensed dentist authorizes the service or procedure to be performed by a dental auxiliary but the dentist does not have to be physically on the premises where or when such a service or procedure is being performed.

Independent practice. As previously mentioned, independent practice by dental hygienists is prohibited in the State. In recent years, there have been some scattered attempts among mainland hygienists to gain independent practice status. These attempts, for the most part, have been unsuccessful; currently, no state allows the independent practice of dental hygiene.

In its suggested dental practice act, the Council on State Governments' dental task force made a deliberate decision not to sanction independent auxiliary practice. The task force was concerned about further fragmenting the dental delivery system

10. Special Issue, "Licensing and Regulation," *Journal of Dental Education*, vol. 43, no. 11, October 1979, p. 61.

and concluded that it would be best for dentists to maintain supervision and overall responsibility for all services provided by both dentists and their auxiliaries.¹¹

According to the ADA, independent practice by dental hygienists “would reduce the quality of oral health care and seriously increase risks to the patient. Any such attempts to fragment the delivery of dental services are contrary to the public interest.”¹²

Given these concerns and the apparent lack of interest among local hygienists for independent status, we believe that it would be premature at this time to consider eliminating all supervision requirements for hygienists and thereby allow the independent practice of dental hygiene in the State.

Expanded functions. Act 30, SLH 1970, amended Chapter 447 by expanding the legally allowable functions of dental hygienists. Additionally, the Act sought to make the law flexible by allowing the board, through its rules, to determine those procedures which could be legally delegated by dentists to dental hygienists. This legislative action was justified on the grounds that the law was outmoded, inflexible, and prevented hygienists from utilizing up-to-date techniques in treating patients.¹³

Despite these amendments, the law remains outmoded and unreasonably restrictive regarding the scope of practice for hygienists. Local hygienists are prohibited by the dental practice act and the board’s rules from performing several procedures which are legally allowable in other states. These include: (1) taking dental impressions for study casts; (2) administering local anesthetics; and (3) completing restorations.

Taking dental impressions for study casts is a relatively routine and safe dental procedure in which a mold or cast is taken of the patient’s teeth. Basically, the cast is used for oral diagnosis and as an aid in consulting with the patient by providing a visual means to show the extent, nature, and location of a problem.

Applying local anesthetics typically involves applying a drug by topical application or regional injection to eliminate sensation or pain in one part of the

11. The Council of State Governments. *State Regulatory Policies: Dentistry and the Health Professions*, p. 6.

12. American Dental Association. *American Dental Association – Policies*, p. 51.

13. House Standing Committee Report No. 546-70 on House Bill 1224. Regular Session of 1970.

mouth. Completing restorations involves the placing of materials (usually amalgam, composite resin, and silicate cement) in cavities prepared by dentists and shaping the materials to reconstruct the original tooth structure. The completion of a restoration is often referred to as placing and carving amalgam restorations, or placing and finishing composite resin or silicate cement restorations.

Proponents for allowing hygienists to perform these expanded functions argue that permitting properly trained, qualified, and supervised hygienists to perform these routine and time-consuming procedures would free dentists to concentrate on more complex dental tasks and to treat additional patients. This increased productivity could result in greater accessibility of dental services and possibly help to contain dental costs. They argue that it is inefficient and costly to require highly-trained dentists to perform these routine functions when competent and lesser paid personnel are available.

A review of the literature on research in expanded functions for dental auxiliaries indicates that numerous functions currently performed by dentists could be delegated safely to trained auxiliaries. One journal article states: "Results from all studies indicate that dental auxiliaries can, with the proper training, perform selected reversible and irreversible dental procedure at an acceptable level of quality."¹⁴ The studies show that the difference in quality between the dentist's and the trained auxiliary's work is minimal. What is discernible, however, is a significant difference in costs and efficiency.¹⁵

In its report concerning the use of expanded function dental auxiliaries (EFDAs), the U.S. General Accounting Office states: "Research studies conducted in the U.S. concerning the impact of EFDAs on dental practices are numerous and impressive.... Study conclusions about the impact of the EFDAs have been remarkably consistent. With appropriate training and supervision, using EFDAs to complete restorations increases the dentist's productivity and net income and maintains patient satisfaction and the quality of services."¹⁶ The report recommends that state laws be revised to permit EFDAs to complete restorations.

14. Nancy L. Sisty et al., "Review of Training and Evaluation Studies in Expanded Functions for Dental Auxiliaries," *Journal of the American Dental Association*, vol. 98, February 1979, p. 233.

15. Special Issue, *Journal of Dental Education*, p. 61.

16. U.S. General Accounting Office, *Increased Use of Expanded Function Dental Auxiliaries Would Benefit Consumers, Dentists, and Taxpayers*, Washington, D.C., March 1980, p. 20.

The suggested dental practice act developed by the Council of State Governments' dental task force includes the taking of dental impressions, applying local anesthesia, and completing restorations as allowable duties for dental hygienists. Their commentary states: "The task force determined that the legislation should not prohibit the hygienist from carrying out any function which with proper training could be performed safely. . . . The task force concluded that if dental hygienists could safely, for example, apply local anesthesia in one state, it should logically follow that this service, upon proper training, could be safely performed elsewhere. The task force having concluded that the procedure was safe, felt there was no state interest to be served by prohibiting hygienists from delivering the service."¹⁷

Those who believe that hygienists should be prohibited from performing these expanded functions state that present restrictions are necessary to protect the public from poor quality dental care. Additionally, they believe that hygienists do not possess the necessary training, competence, and judgment to perform these functions safely.

The ADA, for example, believes that these functions should not be delegated to dental auxiliaries "because effective and safe performance is dependent upon making judgments that require synthesis and application of knowledge acquired in professional dental education."¹⁸

Another argument suggests that factors unrelated to protecting the public's health or safety may be at the basis of present legal restrictions. This argument is grounded on the belief that the State already has enough dentists which makes productivity increases through the use of EFDAs unnecessary.

The General Accounting Office responds to this argument as follows: "Such a rationale appears to be related more to protecting the economic interests of dentists . . . than to the board's responsibility of protecting the public from poor quality dental services provided by unqualified practitioners."¹⁹

17. The Council of State Governments, *State Regulatory Policies: Dentistry and the Health Professions*, pp. 20-22.

18. American Dental Association, *American Dental Association—Policies*, p. 53.

19. U.S. General Accounting Office, *Increased Use of Expanded Function Dental Auxiliaries Would Benefit Consumers, Dentists, and Taxpayers*, pp. 48-49.

According to data provided by the ADHA, 45 states currently allow dental hygienists to take impressions for study casts; 12 states permit hygienists to administer local anesthetics; and 12 states allow hygienists to complete restorations by either placing or carving amalgam restorations or by placing and finishing composite resin or silicate cement restorations.²⁰

Based on available evidence, the qualified support of a majority of the dental board members, and the expressed interest and support of other dentists and dental hygienists, we find that present restrictions regarding these expanded functions are restrictive and should be eliminated. We find no compelling state need to prohibit properly trained, qualified, and supervised dental hygienists from taking dental impressions for study casts, administering local anesthetics, and completing restorations.

Since these will be functions new to dental hygienists now practicing in Hawaii, it may be desirable to specify that these expanded functions must be done under direct supervision, i.e., the dentist must be physically present on the premises and approve the work done before dismissal of the patient. Should the board deem this desirable, the expanded scope of practice and the level of supervision required should be specified in its rules.

Conclusion

We find that a clear potential for public harm exists with the practice of dental hygiene and that continued regulation through licensure is warranted.

We also find that the regulatory operations of the board could be significantly improved by implementing statutory, rule, or operational changes in several key areas. *First*, the practical examination could be improved by prohibiting dental hygiene students from assisting with the examination and by eliminating the requirement that candidates pass a written clinical examination in addition to a national board examination. *Second*, provision should be made for the Hawaii licensing of out-of-state licensed dental hygienists through reciprocity or credentialing. *Third*, certain supervisory requirements and practice restrictions are unreasonable and should be eliminated. Our specific recommendations follow.

20. American Dental Hygienists' Association, *Legislative Action Packet No. 3*.

Recommendations

We recommend that:

1. Chapter 447, Hawaii Revised Statutes, be reenacted to allow for the continued regulation of dental hygienists. In reenacting the chapter, consideration be given to the following changes:

- . Allowing all dental hygienists, regardless of their place of employment, to perform routine and traditional hygiene services under the general supervision of a dentist.
- . Establishing a specified time limit for the issuance of a temporary license.
- . Developing necessary provisions to allow licensure by credentials for qualified dental hygienists from other states whose licensing requirements are equivalent to or more stringent than Hawaii's.
- . Permitting properly trained, qualified, and supervised dental hygienists to perform such expanded functions as taking dental impressions for study casts, administering local anesthetics, and completing restorations.

2. The board's rules be amended by eliminating the requirement that candidates pass the state written clinical examination in addition to the national board dental hygiene examination.

3. The board improve its administration of the state practical examination by eliminating the use of dental hygiene student helpers.

APPENDIX

RESPONSES OF AFFECTED AGENCIES

COMMENTS ON AGENCY RESPONSES

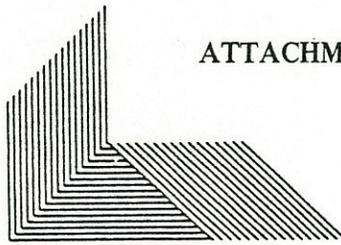
A preliminary draft of this Sunset Evaluation Report was transmitted on October 26, 1983 to the Board of Dental Examiners and the Department of Commerce and Consumer Affairs for their review and comments. A copy of the transmittal letter to the board is included as Attachment 1 of this Appendix. A similar letter was sent to the department. The responses from the board and the department are included as Attachments 2 and 3.

The board responded that it found the report to be comprehensive and a welcome supplement to the previous sunset evaluation report on dental hygienists. The board also states that it will be meeting in January 1984 to discuss the issues raised by our report and will provide a full report on our recommendations to the Legislature.

The department responded that it agrees with our report that it is premature to consider allowing dental hygienists to establish independent practice, that a limitation be placed on temporary licenses, and that the practice of using dental hygienist students at practical examinations be discontinued.

ATTACHMENT 1

THE OFFICE OF THE AUDITOR
STATE OF HAWAII
465 S. KING STREET, RM. 500
HONOLULU, HAWAII 96813



CLINTON T. TANIMURA
AUDITOR

October 26, 1983

COPY

Dr. George Uesato, President
Board of Dental Examiners
Department of Commerce and Consumer Affairs
State of Hawaii
Honolulu, Hawaii 96813

Dear Dr. Uesato:

Enclosed are 12 preliminary copies, numbered 4 through 15, of our *Sunset Evaluation Report, Dental Hygienists*. These copies are for review by you, other members of the board, and your executive secretary. This preliminary report has also been transmitted to Dr. Mary G. F. Bitterman, Director, Department of Commerce and Consumer Affairs.

The report contains our recommendations relating to the regulation of dental hygienists. If you have any comments on our recommendations, we would appreciate receiving them by November 25, 1983. Any comments we receive will be included as part of the final report which will be submitted to the Legislature.

Since the report is not in final form and changes may possibly be made to it, access to this report should be restricted solely to those officials whom you might wish to call upon to assist you in your response. We request that you exercise controls over access to the report and ensure that the report will not be reproduced. Should you require additional copies, please contact our office. Public release of the report will be made solely by our office and only after the report is published in its final form.

We appreciate the assistance and cooperation extended to us.

Sincerely,

Clinton T. Tanimura
Legislative Auditor

Enclosure

ATTACHMENT 2



GEORGE R. ARIYOSHI
GOVERNOR

MARY G. F. BITTERM
DIRECTOR

DICK H. OKAJI
LICENSING ADMINISTRATOR

BOARD OF DENTAL EXAMINERS
STATE OF HAWAII
PROFESSIONAL & VOCATIONAL LICENSING DIVISION
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS
P. O. BOX 3469
HONOLULU, HAWAII 96801

November 21, 1983

RECEIVED

Nov 23 10 56 AM '83

OFFICE OF THE AUDITOR
STATE OF HAWAII

Honorable Clinton T. Tanimura
Legislative Auditor
The Office of the Auditor
465 So. King St., Room 500
Honolulu, Hawaii 96813

Dear Mr. Tanimura:

Thank you for the opportunity to comment on your sunset evaluation report on dental hygienists. We found the report comprehensive and a welcome supplement to your previous evaluation in 1980.

Since the report contains recommendations involving major issues, we will discuss them at our next meeting scheduled for January 9, 1984. Input from all members will be evaluated and consolidated and a full report on your recommendations will be presented to the 1984 Legislature.

Very truly yours,

GEORGE UESATO, D.D.S.
President of the Board

GU:pl

ATTACHMENT 3



GEORGE R. ARIYOSHI
GOVERNOR

MARY G. F. BITTERMAN
DIRECTOR
Commissioner of Securities

STATE OF HAWAII
OFFICE OF THE DIRECTOR
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS
1010 RICHARDS STREET
P. O. BOX 541
HONOLULU, HAWAII 96809

DONALD D.H. CHING
DEPUTY DIRECTOR

November 22, 1983

RECEIVED

Nov 25 9 37 AM '83

OFF. OF THE AUDITOR
STATE OF HAWAII

Honorable Clinton T. Tanimura
Legislative Auditor
The Office of the Auditor
465 So. King St., Room 500
Honolulu, Hawaii 96813

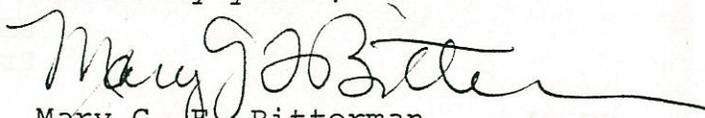
Dear Mr. Tanimura:

Thank you for the opportunity to comment on your sunset evaluation report on dental hygienists.

The Department of Commerce and Consumer Affairs is in agreement with the Legislative Auditor's report which states that it is premature to consider allowing dental hygienists to establish independent practice; that a limitation be placed on temporary license; and that the practice of using dental hygienist students at the practical examination be discontinued.

The department in the administration of the exams will replace the dental hygienist student "runners" with regular proctors and will explore how it may obtain the help of dental hygienists to provide the examiners with chairside assistance.

Sincerely yours,


Mary G. F. Bitterman
Director