

**SUNSET EVALUATION REPORT**  
**DENTISTRY**  
**Chapter 448, 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**

**Report No. 84-2**  
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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 These programs are repealed unless they are specifically reestablished by the Legislature.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 dentistry under Chapter 448, 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 dentistry 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 It includes our recommendation on whether the program should be continued, modified, or repealed.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 Each year, six to eight licensing statutes are scheduled to be repealed unless specifically reenacted by the Legislature.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 448, Hawaii Revised Statutes.

#### Scope of the Evaluation

This report examines the history of the statute on the licensing of dentists 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.<sup>1</sup> 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.<sup>2</sup> 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 448, Hawaii Revised Statutes, regulates the practice of dentistry in the State. Under the law, any person practicing dentistry must hold a valid license from the Board of Dental Examiners. Dentists have been regulated in Hawaii since 1892.

### Occupational Characteristics

According to data provided by the Department of Commerce and Consumer Affairs, there are 1256 licensed dentists in the State.<sup>1</sup> The following paragraphs provide a brief history and description of the profession.

**History.** Dentistry is that autonomous branch of medicine concerned with the prevention, diagnosis, and treatment of diseases and abnormalities of the teeth, jaws, oral cavity, and adjacent oral structures.

The practice of dentistry dates far back into history. As early as 2600 B.C., the Egyptians included “physicians of the teeth” and “toothmakers” among their medical specialists. An Egyptian lower jawbone, dating around 2900—2750 B.C., has been found and contains two holes drilled through the bone to drain an abscess under a first molar.<sup>2</sup>

In its early history, dentistry represented a primitive yet necessary health practice. For many centuries, the practice of dentistry consisted largely of curing toothaches by simple extraction or the use of herbs and other crude methods to alleviate pain. There was no conception of the sophisticated dental care, procedures, and techniques so commonly accepted and practiced today.

Locally, ancient Hawaiian dental care was simple. To clean their teeth, Hawaiians rubbed wood ash or charcoal on their teeth and then rinsed their mouths. The root of the “puakala” (poppy) was used to treat toothaches and periodontal

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

2. *Academic American Encyclopedia*, Arct Publishing Company: Princeton, New Jersey, 1981, vol. 6, p. 115.

disease, and decayed teeth were removed by extracting them with a strong "olona" cord (the olona is a native shrub; the durable fiber from the bark was also used for fish nets, etc.).<sup>3</sup>

Hawaii's first known professional dentist was Dr. M. B. Stevens who, in December 1847, advertised the availability of his dental practice. After five weeks he discontinued his advertisements and apparently left the Islands.<sup>4</sup> In 1851, Dr. John Mott-Smith, Hawaii's first resident professional dentist, arrived in Hawaii where he practiced dentistry until his death 44 years later.<sup>5</sup>

In Hawaii, census statistics on medical and health personnel were first compiled in 1884. The census of that year reported that four dentists were practicing in Hawaii. The early decades of the 20th century were marked by a rapid growth in the profession. In 1900, there were 21 dentists in Hawaii; by 1970, this number jumped to 401.<sup>6</sup> Today, a little more than a decade later, the number of dentists practicing in Hawaii has more than tripled.

**Description of profession.** Dentists seek to maintain healthy teeth through such preventive and restorative procedures as filling, extracting, or replacing teeth; performing corrective work such as straightening teeth; treating diseased gum tissue; performing corrective surgery on the jaw or mouth; and fitting and making artificial dentures. In addition, dentists may clean teeth and provide other preventive services.

Most dentists are general practitioners and provide many types of dental care. Only about 10 percent practice as specialists. Seven branches of specialists are recognized by the American Dental Association.<sup>7</sup> The largest group of specialists are orthodontists who correct irregularities in the development of teeth and jaws by

3. Robert C. Schmitt, "Dentistry in Hawaii During the 19th Century," *The Hawaiian Journal of History*, vol. 17, 1983, p. 1 (in process).

4. Robert C. Schmitt, "Health and Medical Firsts in Hawaii," *The Hawaii Medical Journal*, September 1981, p. 285.

5. Schmitt, "Dentistry in Hawaii During the 19th Century."

6. Robert C. Schmitt, "Health Personnel in Hawaii, 1820-1974," *The Hawaii Medical Journal*, vol. 34, no. 2, February 1975, p. 53.

7. *McGraw-Hill Encyclopedia of Science and Technology*, New York, McGraw-Hill Book Company, 1982, vol. 4, p. 98.

using braces and similar devices. The next largest group, oral surgeons, perform surgical operations on the mouth and jaws.

The remaining specialists include: periodontists who treat diseased tissues that support the teeth; prosthodontists who make artificial teeth or dentures; pedodontists who specialize in dentistry for children; oral pathologists who diagnose diseases of the mouth; and public health dentists who seek to educate the public on the importance of dental health and care.

In 1980, there were approximately 126,000 dentists in the United States.<sup>8</sup> About 90 percent of these dentists were in private practice. The remainder served as dentists in the military, were employed by dental schools, served as researchers or administrators of dental health programs, or were employed by the federal, state, or local government in hospitals, clinics, or public health agencies.

Dentists are required to be licensed in all 50 states and the District of Columbia.<sup>9</sup> To qualify for licensure, an applicant must normally graduate from a dental school approved by the American Dental Association and pass written and practical examinations. Graduates of most dental schools are usually awarded the degree of doctor of dental surgery (D.D.S.). An equivalent degree, doctor of dental medicine (D.M.D.), is awarded by 19 schools.

A licensed dentist wishing to practice in another state must usually pass that state's licensing examination. However, at least 21 states grant licenses to dentists from other states on the basis of their credentials. Dentists wishing to teach or do research must usually have an additional two to four years of advanced dental training from schools, hospitals, and other higher educational institutions.

The American Dental Association, whose membership consists of about 90 percent of the nation's 126,000 dentists, is the major national organization for dentists.<sup>10</sup> Its objectives are to represent members of the dental profession, to encourage improvement of the public health, and to promote the art and science of

8. U.S. Bureau of Labor Statistics, *Occupational Outlook Handbook, 1982-83*, Washington, D.C., April 1982, p. 149.

9. *Ibid.*

10. Paul I. Murphy and Rene C. Murphy, "The Perils and Pitfalls of Dentistry," *New York Times Magazine*, April 29, 1979, p. 110.

dentistry. The local affiliate, the Hawaii Dental Association, consists of approximately 700 members.<sup>11</sup>

## Statutory History

Dentists have been regulated in Hawaii for almost 100 years. With the enactment in 1892 of "An Act to Regulate the Practice of Dentistry in the Hawaiian Kingdom," it became "unlawful for any person or persons to practice dentistry in the Hawaiian Kingdom except upon a certificate issued from a Board of Dental Examiners."<sup>12</sup> The Act created a three-member Board of Dental Examiners (one physician and two dentists) and established standards for licensing. Unlicensed practitioners were subject to fines from \$100 to \$500.

Since 1892, the law has been amended more than three dozen times. In general, these changes were intended to further protect the public, improve the quality of dental practice, and clarify the administration of the law. A few of the more significant amendments are summarized below.

Act 159, SLH 1929, amended the law by requiring stringent penalties for persons practicing dentistry illegally. The Senate Committee on Public Health reported: "Your Committee feels that severe measures are needed to curb the continuous and flagrant violation of the Dentistry Act, and we believe that this Bill, if enacted into law, will have a salutary effect on those who practice dentistry without a license."<sup>13</sup>

In 1937, Act 220, among other amendments, clarified the definition of dentistry, strengthened the law regarding fraudulent advertising, prohibited corporations from practicing dentistry except to furnish free dental services for their employees, and clarified the law regarding the refusal or revocation of a license.

Act 69, SLH 1961, exempted dental service corporations from the provisions of the law prohibiting the corporate practice of dentistry. In its report, the Senate Judiciary Committee wrote: "This bill is designed to permit the creation of dental

11. Data provided by the Hawaii Dental Association, April 26, 1983.

12. Chapter LXXII, Session Laws of 1892, *Laws of Her Majesty Liliuokalani, Queen of the Hawaiian Islands, Passed by the Legislative Assembly of 1892*, p. 172.

13. Senate Standing Committee Report No. 241 on Senate Bill 143. Regular Session of 1929.

service corporations to provide for group dental care.... Although dental service corporations are considered a new innovation, more than ten states have such enabling legislation and the proposed bill is patterned after model law."<sup>14</sup>

In 1971, Act 96 amended the law by permitting dentists to employ, in addition to dental hygienists, other auxiliary personnel to be known as dental assistants. The Act empowered the Board of Dental Examiners to regulate and expand their duties through relevant board rules and regulations.

The Senate Committee on Health reported: "The present law does not classify the dental assistant who performs a prominent role in assisting the dentist with his work. Your Committee finds this bill in keeping with the national practice to expand the duties of auxiliary personnel in the field of dentistry."<sup>15</sup>

Act 249, SLH 1980, required, for the first time, that a dental hygienist be represented on the Board of Dental Examiners. Board membership was also increased to its present size of 11 members. The House Conference Committee reported: "Your Committee feels that it is in the best interests of the dental hygiene profession and the dental health care system in general to provide for the representation of dental hygienists on the board that regulates them."<sup>16</sup>

Act 251, SLH 1980, eliminated the requirement that applicants for licensure be United States citizens and permitted the examination and licensure of qualified graduates of foreign dental colleges. The joint report of the Senate Committees on Health and Consumer Protection and Commerce stated: "Under current law an applicant is required to be a United States citizen in order to obtain a license to practice dentistry. In 1974 the Office of the Attorney General ruled that the Board of Dental Examiners could not require such citizenship as a prerequisite for licensure."<sup>17</sup>

Finally, in 1983, Act 220 amended the law by redefining the practice of dentistry; deleting the detailed provisions regarding fraudulent advertising; eliminating the "good character" requirements; clarifying examination

14. Senate Standing Committee Report No. 454 on Senate Bill 897, Regular Session of 1961.

15. Senate Standing Committee Report No. 411 on Senate Bill 1127, Regular Session of 1971.

16. House Conference Committee Report No. 5-80 on House Bill 159, Regular Session of 1980.

17. Senate Standing Committee Report No. 975-80 on House Bill 1655, Regular Session of 1980.

requirements for foreign dental applicants; providing for a vice president of the board and eliminating the secretary and treasurer positions; and deleting the requirement that the board submit an annual report to the Governor.<sup>18</sup>

### **Nature of Regulation**

**Dentistry defined.** Under Chapter 448, a person is prohibited from practicing dentistry unless that person holds a valid license from the Board of Dental Examiners.

The law defines a person who practices dentistry as one "who represents oneself as being able to diagnose, treat, operate or prescribe for any disease, pain, injury, deficiency, deformity, or physical condition of the human teeth, alveolar process, gums, or jaw, or who offers or undertakes by any means or methods to diagnose, treat, operate or prescribe for any disease, pain, injury, deficiency, deformity, or physical condition of the same, or to take impressions of the teeth or jaws; or who owns, maintains, or operates an office for the practice of dentistry; or who engages in any of the practices included in the curricula of recognized and approved dental schools or colleges. Dentistry includes that part of health care concerned with the diagnosis, prevention, and treatment of diseases of the teeth, oral cavity, and associated structures including the restoration of defective or missing teeth."<sup>19</sup>

Under the law, certain practices are exempt from the provisions of Chapter 448. These include: (1) the rendering of dental relief in emergency cases by a licensed physician or surgeon; (2) the practice of dentistry by dentists in the United States military, Public Health Service, or Veterans Administration; (3) the practice of dentistry by licensed dentists from other states or countries at official dental meetings; (4) the use of roentgen and other rays for making radiograms or similar records of dental or oral tissues; and (5) the making of prosthetic devices if such work is authorized by a licensed dentist.

**Board of Dental Examiners.** Under Chapter 448, the licensing of dentists is regulated by an 11-member Board of Dental Examiners appointed by the Governor

18. House Conference Committee Report No. 15 on House Bill 291, Regular Session of 1983.

19. Section 448-1, HRS.

and placed for administrative purposes in the Department of Commerce and Consumer Affairs. The department provides staff support to the board.

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.

All nine of the professional members of the board are required to have been engaged in professional practice in the State for at least five years preceding appointment to the board. None of the members must have any connection with or financial interest in any dental supply company. Board members serve without pay but are reimbursed for expenses incurred during the performance of their duties.

The board is required to elect from its membership a president and a vice president. Under the law, the board must meet to examine applicants and for other relevant purposes. It is also authorized to formulate and adopt necessary board rules.

**Licensing requirements.** To be licensed as a dentist, an applicant must meet the following requirements: (1) be at least 18 years old; (2) graduate from a dental college accredited by the Council of Dental Education of the American Dental Association; (3) pass Parts I and II of the examination sponsored by the National Board of Dental Examiners; and (4) pass the state board's written and practical examination on dentistry.

The board, at its discretion, may give an oral examination to make a final determination on the qualification of an applicant. Additionally, the board or its authorized representative is statutorily empowered to conduct investigations or hearings to obtain further information regarding an applicant's character, qualifications, or experience.

To qualify for licensure, a graduate of a dental school not accredited by the American Dental Association is required to be a permanent resident of the United States and must meet these additional requirements: (1) provide an authenticated and complete transcript of the applicant's academic and dental school record; (2) provide an authenticated copy of the applicant's dental diploma or degree; (3) provide certification that the applicant has been admitted to practice dentistry in the applicant's home country; (4) provide evidence of having passed Parts I and II of

the examination of the National Board of Dental Examiners; (5) provide other documents or credentials that may be required by the board; and (6) pass the state board's restorative technique examination.

**Temporary license; renewals.** Under the chapter, the board may issue without examination a temporary license to any otherwise qualified person employed and practicing dentistry with the State or county, a legally incorporated eleemosynary dental clinic, a private school, or a welfare center. The license remains valid only while the person remains in such employment, and the license is automatically cancelled when the person takes the board examination. No person who has failed the board examination is eligible for a temporary license. The board may revoke a temporary license at any time.

The board may also issue without examination a temporary license to any otherwise qualified person employed by the Department of Health to provide dental services to Hansen's disease patients. The license is valid for three years and only if the dentist remains in such employment. The license is not renewable, is subject to annual review by the board, and may be revoked at any time. While the temporary license is in effect, the licensee is ineligible to take the board examination.

The law stipulates that every licensed dentist, by December 31 of each odd-numbered year, must pay a fee to the board for the biennial renewal of the dentist's license. Failure to do so may result in forfeiture of the license. A person holding a license that has been expired for less than three years may have the license restored after proper application and payment of required fees. To restore a license that has been expired for more than three years, the holder must establish to the satisfaction of the board that the holder is still qualified to practice.

**Advertising.** Chapter 448 prohibits persons from advertising in any kind of false, misleading, or fraudulent manner. Persons violating these provisions may be subject to penalties contained in the chapter.

**Patient safety.** Under the law, a dentist is required to cover a patient's torso from the neck to the pelvis, including the genital area, with a lead apron while conducting X-ray procedures on the patient.

Any licensed dentist using proper dental procedures may administer drugs for local anesthesia. However, board rules stipulate that a dentist must meet certain

requirements before administering drugs for analgesia (defined by board rules as the elimination of pain in a conscious patient) or general anesthesia (the elimination of all sensation accompanied by a state of unconsciousness).

To administer drugs for sedation and analgesia, a dentist must present certified documents to the board that the dentist has successfully completed a course of study in those procedures. To administer drugs for general anesthesia, a dentist must meet even more stringent requirements and have written authorization from the board.

All licensed dentists are required to submit a report to the board within 30 days if there has been a death or an injury requiring hospitalization resulting directly from the administering of anesthesia to a patient.

**Corporations and associations.** The chapter prohibits any corporation from practicing dentistry. Exempt from this provision are: (1) corporations employing dentists to provide free dental services to their employees; (2) corporations or associations providing dental services on a purely charitable basis to the poor; (3) corporations or associations providing information or clerical services, which can be furnished by persons not licensed to practice dentistry, to a licensed dentist if the dentist assumes full responsibility for the information and services; (4) dental service corporations; and (5) professional corporations.

The law requires every association of persons engaged in the practice of dentistry to display at its place of business the names of all persons employed by the association as practicing dentists. The law also requires every person or association practicing dentistry in the State, upon request of the board, to provide within 15 days the name and address of each employee practicing dentistry or assisting in such work and a statement indicating under what license or authority the person or association is practicing.

**License refusal, revocation, suspension, restoration.** Under the law, the board may refuse to issue a license to any applicant who commits an act which, if committed by a licensed dentist, would result in the suspension or revocation of the license.

The board may suspend or revoke the license of any person found guilty of: (1) fraud in obtaining a license; (2) alcohol or drug addiction; (3) willful or repeated violations of Department of Health rules; (4) illegal acceptance of a fee for serving

as a witness of the court; (5) splitting fees with any person for referring a patient; (6) assisting in the care or treatment of a patient without the knowledge of the patient or the patient's legal representative; (7) aiding an unlicensed person to practice dentistry; (8) making misrepresentations or false promises to induce dental patronage; (9) professional association with any person or corporation involved in the illegal practice of dentistry; (10) seeking to obtain practice or money through false or fraudulent representations; (11) practicing under an assumed name; and (12) any other improper, unprofessional, or dishonorable conduct in the practice of dentistry.

The board has the authority to restore any revoked license if it determines that such an action will not endanger public health and safety or the reputation of the profession.

**Hearings; penalties.** If the board seeks to revoke, suspend, or refuse to issue a license, it is required to give the person concerned proper notice and a hearing in conformity with the Administrative Procedure Act. In all proceedings, the board has the same powers regarding the administering of oaths, compelling the attendance of witnesses and production of documentary evidence, and examination of witnesses as are possessed by circuit courts.

Persons violating any of the provisions of Chapter 448, if the penalty is not otherwise provided, are subject to a fine of up to \$500 or can be imprisoned for six months. Upon any subsequent convictions, persons are subject to a maximum fine of \$1,000 and can be imprisoned for one year. Persons convicted of practicing dentistry without a license are also subject to having their equipment, tools, etc., forfeited to the State by the court and ordered destroyed.

## Chapter 3

### EVALUATION OF THE REGULATION OF DENTISTS

This chapter contains our evaluation of the regulation of dentists under Chapter 448, 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 and significant potential for public harm exists with the practice of dentistry. The absence of regulation would unnecessarily expose the public to possible harm.
2. Although the practical examination generally appears to be fair and unbiased, the rationale for requiring candidates to complete gold foil restorations, a relatively infrequent and archaic procedure, is questionable.
3. Current licensing provisions preventing licensure through credentials for qualified and licensed out-of-state dentists are unreasonable and restrictive.
4. No time limits have been set for temporary licenses and licensees may retain these indefinitely, opening the practice up to potential harm.
5. Current statutory provisions that restrict ownership of a dental practice to licensed dentists and prohibit many corporations from providing dental services appear to be unreasonable and unnecessarily prohibitive.
6. Present rules are unclear and confusing regarding those duties which may be legally performed by dental assistants and the level of supervision required for their practice.
7. Because of the potential risks involved in denturism, the independent and unsupervised practice of dental laboratory technicians, it is premature at this time to seriously consider independent practice status for these technicians.

## The Need for Regulation

We find that the practice of dentistry poses a clear and significant potential for public harm, and the absence of regulation would unnecessarily threaten the health and safety of the public.

Included within a dentist's scope of practice are several irreversible procedures that can potentially result in costly corrective treatment, serious injury, and even loss of life. A significant public risk is involved when a dentist is allowed to diagnose or treat any injury of the mouth or teeth. This risk is increased when a dentist is allowed to perform oral surgery or to administer radiographs (X-rays), anesthesia, and other sedatives or drugs.

Common complaints against incompetent or negligent dentists include: misusing anesthetics, analgesics, sedatives, and antibiotics; failing to diagnose and treat oral cancers and cysts; exposing patients and other dental personnel to unnecessary radiation; failing to refer patients to specialists when necessary; not taking complete health histories before administering drugs; failing to diagnose and inform patients of gum diseases; doing unnecessary and costly dental work; mishandling injections; and drilling and extracting wrong teeth.

These practices have resulted in costly and extensive corrective work, serious injury and hospitalization, and loss of life. The Journal of Prosthetic Dentistry reports the tragic case involving a New Jersey dentist's irresponsibility in failing to take a patient's history and blood pressure before giving a local anesthetic. The patient, who was suffering from hypertension at the time, developed a cerebral hemorrhage and died.<sup>1</sup>

Another case, cited by the West Virginia Law Review, involved a patient who went to her dentist complaining only of a simple toothache. X-rays indicated a partial destruction of bone under the tooth, and the tooth was extracted. A follow-up examination indicated that the socket was not healing properly. The patient

1. Paul I. Murphy and Rene C. Murphy. "The Perils and Pitfalls of Dentistry," *New York Times Magazine*, April 29, 1979, pp. 110-111.

subsequently died of oral cancer partly as a result of the dentist's failure to make a correct diagnosis and to recommend a biopsy.<sup>2</sup>

The significant potential for harm posed by dentists is further illustrated by the dramatic increase in the number of malpractice suits against dentists and the substantial rise in court awards. In the past ten years, there has been a staggering 3,000 percent rise in malpractice suits against dentists nationally.

The Professional Regulation News reports: "... the average plaintiff's award in dental malpractice cases has more than tripled since 1975, although American Dental Association statistics show that the number of claims remains at roughly seven per 100 dentists. Most cases alleged the loss of healthy teeth, nerve damage to the mouth, oral infections, and jaw fractures through negligent dental practices, while a few wrongful death cases resulted from anesthesia complications."<sup>3</sup>

Our examination of formal complaints filed with the Regulated Industries Complaints Office (RICO) of the Department of Commerce and Consumer Affairs (DCCA) further supports the need to protect the public from possible harm involved in the practice of dentistry. Since 1980, for example, 53 complaints have been filed with the department. These complaints include incompetent or negligent dental work; billing problems; unauthorized or unnecessary dental work; unethical, improper, or unprofessional conduct; and false, misleading, or deceptive advertising.

Currently, no other state or federal agency is directly concerned with the overall regulation or quality of dentists. Without state regulation, then, there would be no formal requirements regarding the training, qualifications, or competence of dentists. Consumers would face a distinct disadvantage in trying to determine the competence of dentists and would be subject to an even greater risk of harm.

Finally, given the highly complex and technical nature of the profession and the significant and immediate potential for harm posed by incompetent or negligent practitioners, we believe that dentists warrant continued regulation through licensure as opposed to any less stringent forms of regulation. This is the consensus in all 50 states and the District of Columbia which continue to regulate dentists through licensure.

2. *Ibid.*, p. 111.

3. "Dental Malpractice," *Professional Regulation News*, December 1981, p. 7.

## 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 regulatory operations in the following areas: (1) examinations; (2) licensing; and (3) practice restrictions.

**Examinations.** Dental candidates are required to pass: (1) the national board dental examination [a nationally standardized examination prepared by the Council of National Board of Dental Examiners of the American Dental Association (ADA)]; (2) a state written examination on the dental law and rules; (3) a state written clinical examination; and (4) a state practical clinical and laboratory examination. Dental candidates who are graduates of foreign dental schools not accredited by the ADA are further required to pass a special restorative technique examination before they are permitted to take the state practical examination.

The written portion of the state examination is designed to assess the candidate's knowledge of oral diagnosis, treatment planning, operative dentistry, dental materials, and the dental practice act. The practical examination is used to determine the candidate's actual clinical competence. In the clinical or operative portion of the practical examination, the candidate, working with a volunteer patient, must complete a gold foil and amalgam restoration. In the laboratory component, the candidate is required to complete a crown and bridge procedure and to set up an upper and lower full denture.

The written, clinical, and laboratory components of the examination are weighted with each portion comprising a percentage of the overall grade. The written portion consists of 10 points, the clinical is worth 60 points, and the laboratory portion consists of 30 points. A candidate must obtain an overall grade of 75 to pass the dental examination. Examinations are usually administered twice a year in February and July and are normally conducted at the Pearl Harbor Dental Clinic. Generally, the dental examination is administered over a three-day period with varying time requirements for each specific portion of the examination.

Except for the written portion of the examination which is administered and graded by personnel from DCCA's examination branch, usually all the board members are involved in either helping to administer or grade the examination.

Grading is usually limited to those board members who practice general dentistry. Public members and the dental hygienist member help to administer the examinations but are not involved in the grading process. Because of the increasing number of dental candidates, the board often utilizes one or two deputized, nonpaid dentists to assist with the grading.

No waiting period is required for the candidate who fails the examination and wishes to be reexamined at the next scheduled examination. Candidates who are reexamined are not credited for any portion of the examination previously passed. A candidate who fails the dental examination three times is required to successfully complete a one semester postgraduate course in operative and prosthetic dentistry from an accredited dental college before being reexamined.

In December 1976, two dental candidates filed a federal suit against the Board of Dental Examiners, the Governor, the director of the Department of Regulatory Agencies, and the executive secretary of the board. The plaintiffs alleged that the dental board used the licensing examination to discriminate against applicants on the basis of race and residency.<sup>4</sup>

The contested issue in the suit was not the content of the board's examination, but the administration of the practical examination. Specifically, the plaintiffs argued that the examination was about 90 percent "subjective." The plaintiffs claimed that bias was introduced when board members personally, in face-to-face contact, graded the candidates.<sup>5</sup>

In an out-of-court settlement, the State agreed to significantly modify the dental practical examination. Several new examination procedures were implemented including: (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.

4. "Dentists' Suit Charges Racial Bias in Licensing," *Honolulu Star-Bulletin*, December 17, 1976.

5. "2 Dentists Sue State for Bias," *Honolulu Advertiser*, December 18, 1976.

These new procedures appear to have improved the practical examination significantly. Based on our review of various examination materials and data and our personal observation of the examination, it appears that the examination is generally fair and unbiased. According to data provided by DCCA's examination branch, the pass rates for dental candidates for the last five years are as follows: 1979—51 percent; 1980—52 percent; 1981—66 percent; 1982—80 percent; and 1983—70 percent.

**Gold foil restoration.** Our evaluation of the dental examination reveals one aspect of the practical examination which could be improved. Current statutes require that the State, in administering the dental examination, consider current trends in dental education. However, some have expressed concern regarding the relevance and fairness of requiring candidates to complete a gold foil restoration when such a procedure is relatively uncommon in routine dental practice today and is not taught in many dental schools.<sup>6</sup>

One dentist, for example, claims that the gold foil procedure has been outdated for years and that some states have eliminated the procedure from their examinations. According to the Council of State Governments' National Task Force on State Dental Policies, the fairness of certain practices and requirements in dental licensure testing is questionable.<sup>7</sup> These include the testing for some procedures "which are considered archaic by certain segments of the dental profession such as the gold foil restoration (a procedure no longer taught in many schools and rarely used in actual practice)."<sup>8</sup>

An article from the Journal of the American Dental Association (JADA) states: "In spite of many changes in dentistry, we are currently testing what we tested 70 years ago. Certainly teeth have not changed but the rationale for the various types of restorations has. . . . The use of gold foils (Class II, III, IV, and V) may be questioned

6. A gold foil restoration normally involves preparing a cavity by removing the decay and shaping the cavity to support the filling, restoring or filling the decayed space inside the tooth with gold foil, and carving off the excess material. Gold's soft working quality and resistance to corrosion permits a good seal and maintains cleanliness. Gold fillings are excellent but not very popular since manipulation of the material is often time-consuming and tricky.

7. 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.

8. Special Issue, "Licensing and Regulation," *Journal of Dental Education*, vol. 43, no. 11, October 1979, p. 62.

on the basis of data from research and the infrequency that practitioners do gold foil restorations.”<sup>9</sup>

Board members justify using the gold foil procedure on the grounds that it provides an excellent test of the candidate's manual dexterity and restorative skills. Some members acknowledge that the procedure is not a routine one, but believe nonetheless that all dentists should know how to complete the procedure.

The JADA article goes on to state: "Many boards will freely admit that the gold foil restoration is not done routinely in general practice, but it is included in the examination because the boards think that this procedure demonstrates the manual dexterity of the student. If this is true, and this is what the boards are trying to examine, then perhaps dexterity might be tested in endodontic treatment... a procedure that is more applicable and more routinely done in the practice of dentistry."<sup>10</sup>

The board should evaluate the necessity of retaining the gold foil restoration on the practical examination and seriously consider replacing that procedure with a more up-to-date, relevant, and fair testing procedure.

**Licensing. *Licensure by credentials.*** Under present licensing requirements, a licensed dentist from another state cannot obtain a license to practice in Hawaii through reciprocity or through licensure by credentials. Licensure by credentials would permit dentists previously licensed by another state to be licensed in Hawaii based on that dentist's qualifications. Instead these licensed out-of-state dentists are required, like other unlicensed candidates, to pass the state written and practical examinations.

This licensing restriction is defended on the grounds that it maintains the quality of dental care. Local dentists argue that our state dental examinations are generally more demanding than examinations in other states. Consequently, our licensing requirements provide better safeguards for the public. Eliminating the

9. Jerry F. Taintor et al., "The Necessity of Updating Dental Examining Boards," *Journal of the American Dental Association*, vol. 99, July 1979, p. 17.

10. *Ibid.*, p. 18. (Endodontic treatment, or root canal work, involves treating diseases of the inner tooth pulp and related tissues. Such treatment is often an exacting and difficult procedure especially when working with molars which are located in the hard-to-reach back part of the mouth.)

restriction would enable out-of-state dentists of questionable qualifications and skills to practice in the State.

Local dentists also believe that there is already a sufficient number of dentists in Hawaii. Removing the licensing restriction, they argue, would add to the problem and would encourage transient dentists with little commitment to the community to vacation and "practice" here for only a few months out of the year.

Evidence indicates, however, that restraints on reciprocity tend to limit unfairly the entry rate of new dentists into local markets, reduce market competition, and consequently, increase prices. Several empirical studies have analyzed dental prices in nonreciprocity states. Shepard found, for example, "that where regulatory authorities have constructed competition barriers, dentists systematically raise fees augmenting their earnings. It is estimated that the price of dental services and mean dentist income are between 12 and 15 percent higher in nonreciprocity jurisdictions when other factors are accounted for."<sup>11</sup>

Both the ADA and the Council of State Governments' dental task force have endorsed licensure by credentials. According to the ADA, an evaluation of a practitioner's theoretical knowledge and clinical skill based on the dentist's performance record "can provide as much protection to the public as would an evaluation based on examination."<sup>12</sup>

Also, the ADA House of Delegates adopted a resolution in 1975 stating that the ADA, through its constituent societies, "strongly encourages state boards of dentistry to establish criteria by which dentists could be licensed by credentials to permit the freedom of interstate movement while retaining those controls necessary to fulfill the responsibilities of the respective state boards."<sup>13</sup>

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

11. Lawrence Shepard, "Licensing Restrictions and the Cost of Dental Care," *The Journal of Law and Economics*, vol. 21, no. 1, April 1978, p. 200.

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

13. Bryan L. Boulier, "An Empirical Examination of the Influence of Licensure and Licensure Reform on the Geographical Distribution of Dentists," *Occupation Licensure and Regulation—A Conference Sponsored by the American Enterprise Institute for Public Policy Research*, 1980, Washington, D.C., p. 74.

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."<sup>14</sup>

There are currently 21 states that permit licensure by credentials. We find that local licensing provisions preventing licensure by credentials for qualified and licensed out-of-state dentists are unreasonable and restrictive. While we believe that the board should continue to maintain its high licensing standards, we also believe that it would be in the public's best interest to allow licensure by credentials when these standards are met.

*Temporary licenses.* Under certain circumstances, temporary licenses are given to those who have not taken the state examination. The law permits the dental board to issue temporary dental licenses to those who are qualified to take the state examination if they are employed by the State or county, any legally incorporated eleemosynary dispensary, private school, or welfare center. A temporary license may also be issued to a person holding a license from another state and employed by the Department of Health (DOH) to provide dental services to Hansen's disease patients.

Under the law, a temporary license issued to a dentist servicing Hansen's disease patients remains valid for a three-year period. However, the law provides no time limitation for other temporary license holders. They may retain the temporary license so long as they remain in the designated employment. Technically, these other licensees could practice for an unlimited period without ever having to take or pass the dental examination. To avoid possible abuses, this loophole in the statute should be eliminated by specifically stipulating in the law how long all temporary licenses 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 would give candidates adequate time to prepare for the examination.

*Practice Restrictions. Ownership and corporations.* Under Chapter 448, HRS, only a licensed dentist is allowed to own, maintain, or operate a dental office. Additionally, as noted in Chapter 2, the law prohibits all but a few specially exempted corporations from providing dental services. The law, in effect, limits the

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

practice of dentistry to the traditional private practice model and prevents dentists from working for nondentists or forming corporations or partnerships with persons who are not licensed dentists.

Prohibited in the State, for example, are certain kinds of walk-in, retail store dental clinics which proponents claim can provide quality services at reduced costs for consumers.<sup>15</sup> Also prohibited are some large, in-house dental facilities established by businesses and unions to provide exclusive and low-cost dental service to members, employees, and their families. During recent years, many of these innovative dental clinics and facilities have been established across the Mainland.

The rapid growth of these new dental facilities is of major concern for many dentists with small private practices who are experiencing a corresponding decline in the number of their own patients. Many dentists are opposed to lifting these practice restrictions, fearing that such an action would result in a loss of quality patient care and would lead to unscrupulous practices by unlicensed owners more concerned with profits than with safe, quality dental services.

Those who favor removing these restrictions argue that the provisions are unnecessarily restrictive, reduce competition, and result in higher dental costs for consumers. According to the Council of State Governments' dental task force, for example, many state dental practice acts contain a variety of anticompetitive provisions. The task force reports: "Many acts prohibit anyone other than a dentist from owning an interest in a practice. The precise relationship of this restriction to public health and safety is not clear. . . . In the absence of convincing argument to the contrary, these provisions may be fairly construed as an example of how public policy can be shaped to serve private rather than public interests."<sup>16</sup>

The task force further states: "State practice acts that contain such limitations favor the private practice model. While the task force agreed that the delivery of dental services through the private practice method has been a highly effective and efficient system, they also agreed that it was not in the state interest to legislate against other innovative systems. . . . The task force concluded that it is a mistake to

15. The term retail store dentistry refers to dental services offered to the public within a retail department or drugstore setting. Typically, space is leased from the store by a separate administration group which, in turn, subleases to a dentist or dental group providing the actual dental services.

16. Special Issue, *Journal of Dental Education*, p. 62.

contain innovative efforts within the bounds of arbitrary limits on manpower, practice sites, and ownership . . . and that the restriction is not justified to prevent a potential abuse.”<sup>17</sup>

During the past few years, the U.S. Federal Trade Commission (FTC) has been actively investigating the dental industry. The purpose of this FTC action has been to determine whether existing restrictions in the industry reduce competition and artificially increase prices. In a notice of intent to make recommendations and invitation to comment dated January 1979, the FTC’s San Francisco Regional Office concurred with the Council of State Governments’ “Suggested State Dental Practice Act” which recommended that state dental boards should not limit the ownership of dental practices to licensed dentists.<sup>18</sup>

We agree with both the Council on State Governments and the FTC and believe that current statutory provisions that limit the ownership of dental practices and prohibit corporations from providing dental service are unreasonable and unnecessarily prohibitive. According to data provided by the ADA, there are currently 13 states which do not have these statutory restrictions.

The purpose of licensing any health professional should be to ensure the practitioner’s competence and to protect the health and safety of consumers. Licensing statutes should contain provisions clearly relevant to these two issues and should not unnecessarily limit marketplace competition. There may be grounds for the concern of some dentists that unrestricted ownership of dental practices could lead to unscrupulous practices. However, the board can prevent or minimize potential abuses by adopting rules that would ensure that professional standards are maintained.

We believe it is in the public’s best interest to allow innovative and possibly more efficient, accessible, and less expensive dental care delivery systems to develop. The consumer should have the opportunity to choose between traditional dental care and other, newer forms of dental services.

17. The Council of State Governments, *State Regulatory Policies: Dentistry and the Health Professions*, p. 12.

18. 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. 140.

**Dental assistants.** Under the law, a licensed dentist may employ dental hygienists or dental assistants to assist in the dentist's practice. Dental hygienists are required to be licensed and are regulated under Chapter 447, HRS. Dental assistants, on the other hand, are not licensed but are required under statutes to "perform all duties assigned to them under the general supervision, direction and responsibility of the dentist."<sup>19</sup>

During our evaluation, concerns were expressed about the confusion and lack of clarity regarding practice restrictions and allowable duties for dental assistants. One dental professional states, for example, that there exists a very gray and fuzzy area regarding those duties which assistants can legally perform. Another questions the hazards to patients when assistants, often with little or no formal training, are allowed to perform procedures which even trained and licensed dental hygienists are not legally permitted to do.

In its rules, the board classifies three types of dental assistants including: (1) the dental assistant (DA) who assists the dentist by performing such basic dental office duties as serving as a receptionist, handling patient billing, preparing patients for the dentist, etc.; (2) the qualified dental assistant (QDA) who has the necessary training and experience as a chairside assistant to learn how to perform expanded duty functions; and (3) the expanded duty dental assistant (EDDA) who is a QDA and possesses the training and experience to actually perform expanded duty functions under the direction and supervision of a licensed dentist.

Under present rules, the allowable duties for assistants vary according to their classification. A DA may perform any usual and reasonable chairside supportive procedure. The QDA may perform the duties of a DA and is permitted to be trained by the supervising dentist to perform expanded duty functions. The EDDA may perform any procedure delegated by the dentist when the dentist is physically present in the office to supervise the assistant. The EDDA, however, is specifically prohibited from performing eight procedures which require professional judgment and skill (e.g., diagnosis and treatment planning, cutting hard or soft tissue, completing restorations) including those procedures which are prohibited under Chapters 447 and 448.

19. Section 448-3, HRS.

The Council of State Governments' dental task force reports: "... many states do not regulate dental assistants at all, at least in the sense of stating a scope of practice. The result is often an anomaly: the formally trained and educated hygienist is restricted by a formal scope of practice to certain duties. The assistant, not explicitly restricted by a formal scope of practice, and in many cases with less formal education, does more. . . . At present, the scope of practice in some states is determined solely by the judgment of individual dentists. . . . This situation is fraught with potential for abuse and endangers the public."<sup>20</sup>

The rules should be clarified by providing a clearer and more explicit scope of practice for dental assistants. As currently written, the rules are unclear and subject to possible misunderstanding or misinterpretation. Current rules stipulate, for example, that dental assistants may perform "usual and reasonable chairside supportive procedures." The rules, however, neglect to define or explain the term. Consequently, these allowable procedures are subject to the interpretation of the individual dentist and may vary significantly from practitioner to practitioner.

Under current rules, the duties of the EDDA are defined only in terms of what is *not* allowed. A more concise and appropriate approach might be to delineate those specific duties which the EDDA is allowed to perform. We believe this would both tighten and clarify the rules and help to remove any confusion or uncertainty regarding the rules.

Finally, the law requires dental assistants to perform all duties assigned to them under the general supervision, direction, and responsibility of the dentist. We find, however, that the statutes and rules neglect to either define or explain what is meant by "general supervision." We believe that a minimum level of supervision is probably appropriate for the assistant performing such routine duties as office management, maintaining a clean operating area, preparing materials, etc. However, a more stringent level of supervision should be required for assistants performing more complex and potentially harmful procedures.

To provide necessary safeguards for the public, the law should require two levels of supervision for dental assistants. At the supervising dentist's discretion, dental assistant duties should be performed under the dentist's general or direct

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

supervision depending upon the technical complexity of the procedure, the potential harm involved, and the experience and competence of the assistant. Additionally, definitions for the terms "general supervision" and "direct supervision" should be included in the rules.

We provide two definitions for consideration: (1) general supervision means the licensed dentist authorizes the service or procedure to be performed by a dental auxiliary but does not require the dentist to be physically on the premises where or when such a service or procedure is being performed; and (2) direct supervision means the licensed dentist authorizes the service or procedure to be performed by a dental auxiliary and requires the dentist to be physically present to observe the procedure being performed or to approve the work performed by the auxiliary before dismissal of the patient.

**Denturism.** Denturism remains a major controversy within the dental profession. Some dentists believe that denturism represents the biggest problem and greatest threat to professional dentistry today. Basically, denturism is the independent practice of dental laboratory technicians in which these technicians are allowed to manufacture and sell dentures directly to the public. Dental technicians who support independent licensure are called denturists.

As in most other states, denturism is illegal in Hawaii. Although a dental technician is permitted to fabricate a denture, our statutes prohibit anyone but a licensed dentist from taking the necessary dental impression (from which the denture is manufactured) and fitting or adjusting the device for a patient. Dental technicians are allowed to fabricate dentures only upon the proper written authorization of a dentist. Doing so without authorization is considered practicing dentistry without a license.

The major argument for denturism is basically a financial one. Proponents for denturism believe that it will significantly lower the cost of denture services for the public. Denturists argue that they can make quality dentures more quickly and less expensively than dentists and claim the dentist is an unnecessary "middleman" who adds to the cost of the denture without significantly contributing to the public's health or safety.

Dentists, on the other hand, generally oppose the licensing of denturists on health and safety grounds. They believe denturists are untrained and unskilled practitioners who endanger the health and safety of the public and that legalizing denturism would basically allow inadequately trained personnel to practice dentistry. Dentists also claim that denturists are not trained to recognize oral pathology and that the trained dentist can best determine whether a patient's mouth and tissues will be properly receptive to the denture.

Organized dentistry in the United States remains staunchly opposed to denturism. The ADA, for example, defines denturism as "the unqualified and illegal practice of dentistry," and a denturist, according to the ADA, is "a person who is educationally unqualified and not licensed for the necessary protection of the public, to practice dentistry in any form on the public."<sup>21</sup> In 1977, the ADA's House of Delegates vigorously reaffirmed its position of total opposition to the denturist movement.

In Canada, eight of the country's ten provinces have legalized denturism. The response has been somewhat different in this country. Since 1955, a number of states have considered legislation to legalize denturism. During the 1977 and 1978 state legislative sessions, roughly one half the states rejected legislation that would have provided independent status for denturists.

Currently, denturism is legal in only five states—Arizona, Colorado, Idaho, Maine, and Oregon. Idaho and Oregon, however, are the only states that allow denturists to engage in totally independent practice. Denturists are licensed in Arizona, Colorado, and Maine, but they are required to practice under the direct supervision of a licensed dentist.

Based on available evidence, including the potential risks involved in the unsupervised practice of denturism, and the limited experience of a few states, we believe it would be premature at this time to consider seriously the independent practice of dental technicians in Hawaii. We believe that with additional time and experience, the State should be able to make a more informed and reasoned judgment on this issue. In the meanwhile, the board should continue to monitor the experience of other states.

21. Raymond A. Flanders. "The Denturism Initiative," *Public Health Reports*, vol. 96, no. 5, September—October 1981, p. 410.

## Conclusion

Our evaluation indicates that there is a continued need to regulate dentists. We also find, however, that several improvements are needed in the board's regulatory operations. Certain licensing provisions, for example, are unreasonable or unduly restrictive and should be eliminated or revised. Although the dental examination is generally fair and unbiased, a portion of the practical examination appears to be outdated and of questionable value. Finally, certain practice restrictions are unclear and confusing or unnecessarily prohibitive. These provisions should be clarified or eliminated.

## Recommendations

*We recommend that:*

1. *Chapter 448, Hawaii Revised Statutes, be reenacted to allow for the continued regulation of dentists. In reenacting the chapter, consideration be given to the following changes:*

*Establishing specified time limits for all temporary licenses.*

*Eliminating statutory provisions that restrict ownership of a dental practice to licensed dentists and prohibit corporations from providing dental services. Should this be done, we recommend that the board adopt rules to ensure that professional standards are maintained.*

*Providing general or direct supervision requirements for dental assistants depending upon the complexity of the procedure to be performed, the potential harm involved, and the experience and competence of the assistant.*

*Allowing licensure through credentials for qualified and licensed dentists from other states whose licensing requirements are equivalent to or more stringent than Hawaii's.*

2. *The board's rules be amended by specifying explicitly those duties which may be legally performed by dental assistants and providing definitions for the terms "general supervision" and "direct supervision."*

3. *The board evaluate and consider eliminating the required gold foil restoration and replacing it with a more relevant and up-to-date procedure.*

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APPENDIX

RESPONSES OF AFFECTED AGENCIES

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## COMMENTS ON AGENCY RESPONSES

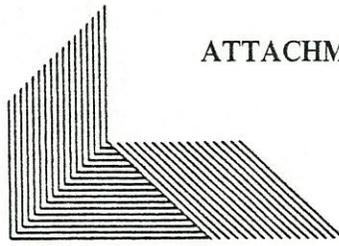
A preliminary draft of this Sunset Evaluation Report was transmitted on October 31, 1983 to the Board of Dental Examiners and the Department of Commerce and Consumer Affairs for their review and comments. A copy of the transmittal letter to the board is included as Attachment 1 of this Appendix. A similar letter was sent to the department. The responses from the board and the department are included as Attachments 2 and 3.

The board found the report to be comprehensive and agrees that regulatory operations of the board could be significantly improved by implementing statutory, rule, or operational changes in several key areas. The board also states that it will be discussing our recommendations at its meeting in January 1984 and that it will provide a full report on these recommendations to the Legislature.

The department agrees with our report that it is premature at this time to consider the independent practice of dental technicians and with our recommendations that a limitation be placed on temporary licenses, that the board amend its rules to specify those duties that may legally be performed by dental assistants, and that the terms "general supervision" and "direct supervision" be clearly defined.

ATTACHMENT 1

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



CLINTON T. TANIMURA  
AUDITOR

October 31, 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, Dentistry*. 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 dentists. If you have any comments on our recommendations, we would appreciate receiving them by November 30, 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

Enclosures

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 55 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 dentists. We found the report comprehensive and agree that regulatory operations of the board could be significantly improved by implementing statutory, rule, or operational changes in several key areas.

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 Sec

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

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 dentists.

The Department of Commerce and Consumer Affairs is in agreement with the Legislative Auditor's report that it is premature at this time to consider seriously the independent practice of dental technicians; that a limitation be placed on temporary license; that the Board of Dental Examiners' rules be amended to specify those duties which may be legally performed by dental assistants; and that the terms "general supervision" and "direct supervision" be clearly defined.

Sincerely yours,

Mary G. F. Bitterman  
Director