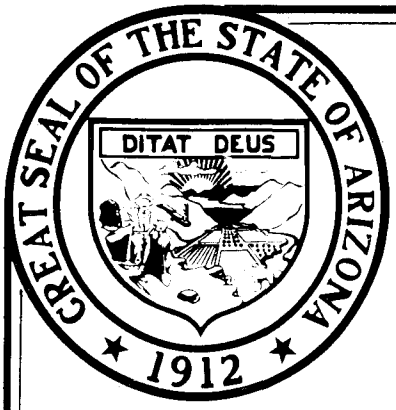

PERFORMANCE AUDIT

BOARD OF DENTAL EXAMINERS

Report to the Arizona Legislature
By the Auditor General
December 1987
87-14

DOUGLAS R. NORTON, CPA
AUDITOR GENERAL

STATE OF ARIZONA
OFFICE OF THE
AUDITOR GENERAL

LINDA J. BLESSING, CPA
DEPUTY AUDITOR GENERAL

December 21, 1987

Members of the Arizona Legislature
The Honorable Evan Mecham, Governor
Dr. Edward C. Carlson, D.M.D.
President, State Dental Board of Examiners

Transmitted herewith is a report of the Auditor General, A Performance Audit of the State Dental Board of Examiners. This report is in response to a March 3, 1987, resolution of the Joint Legislative Oversight Committee.

The report addresses the Dental Board's effectiveness in protecting public health and safety by regulating the practice of dentistry in Arizona. We found that the Board has improved its oversight of dentists since our last audit in 1981. However, the Board needs to strengthen its program for dealing with alcohol and drug abuse among dentists. Our review showed that the Board lacks an effective means for identifying problem dentists, ensuring that they receive adequate treatment and monitoring their progress. We also found that the Board takes too long to handle some consumer complaints; over half of the cases in our review sample required more than the 150 days allowed by law.

My staff and I will be pleased to discuss or clarify items in the report.

Respectfully submitted,

Douglas R. Norton
Auditor General

Staff: William Thomson
Mark Fleming
Martha Dorsey
Dennis Murphy

Enclosure

SUMMARY

The Office of the Auditor General has conducted a performance audit of the Arizona State Board of Dental Examiners (ASBDE) in response to a June 2, 1987, resolution of the Joint Legislative Oversight Committee. This performance audit was conducted as part of the Sunset Review set forth in Arizona Revised Statutes §§41-2351 through 41-2379.

The Board of Dental Examiners was established in 1913, at which time the practice of dentistry was first regulated. Licensure and regulation of dental hygienists was added to the Board's duties in 1947, and the certification and regulation of denturists was added in 1978. Currently, the nine member Board is responsible for approximately 2,900 licensed dentists, of whom 1,817 actually practice in the State. The Board also oversees approximately 1,400 licensed dental hygienists and 26 certified denturists.

ASBDE Lacks An Adequate Program To Deal With Chemical Dependency Problems Among Dentists (see pages 11 through 20)

The Arizona State Board of Dental Examiners lacks a sufficient program to deal with chemically dependent dentists. Although some experts estimate the incidence of chemical dependency among dentists may be as high as 10 percent, the Board has not aggressively attempted to identify dependent dentists. In addition, the Board has not adequately investigated the few allegations of dependency brought to its attention. For example, when the Board recently received a telephone complaint from an individual stating that a dentist, practicing under restrictions from a previous chemical dependency problem, "had the shakes," the Board took no action to determine if the allegations were valid.

The Board also needs to strengthen its ability to ensure that dentists receive appropriate dependency treatment. In most cases, the Board allows dependent dentists to select their own doctor and does not ensure that the doctors selected have expertise in treating chemical dependency. The Board does not require all dependent dentists to participate in Alcoholics Anonymous or some other dependency support group, and has never stipulated the frequency of attendance in

these groups. In contrast, the Arizona State Board of Medical Examiners (BOMEX) has developed a program to ensure that dependent physicians receive appropriate treatment.

Finally, even when the Dental Board has taken action in dependency cases, it has not properly monitored the dentists to ensure compliance with terms established to allow continued practice. Some dentists are not submitting required reports concerning psychiatric evaluations and treatment progress. Further, the Board seldom collects urine and blood samples as provided for in the consent agreements.

The Dental Board Could Improve Timeliness Of Handling Complaints (see pages 21 through 26)

Although the Dental Board has improved its overall handling of consumer complaints, the Board could resolve complaints more promptly. The Board has improved many deficiencies cited in previous audits. These improvements include complete investigations of consumer complaints and a substantial increase in the number of disciplinary actions taken. State law requires the Board to take initial action on a complaint within 150 days of beginning an investigation. However, an Auditor General sample of complaints received by the Board in fiscal years 1985-86 and 1986-87 found that 26 of 42 resolved complaints exceeded the 150 day statutory limit. Eight of the 26 took between 200 and 250 days to resolve. For example, in one case Board staff took 97 days to complete a two page summary report of a consumer's complaint and related records. In another case, board staff allowed 139 days to pass without following up on a request for patient records from a dentist. To avoid delays in resolving consumer complaints, the Board should implement a complaints tracking system to ensure that report summaries are completed in a timely manner and that requests for patient records and follow-ups on these requests are also timely.

Statutory Changes Are Needed To Improve The Board's Enforcement Effectiveness (see pages 27 through 30)

Several statutory changes are needed to improve the Board's enforcement efforts. First, the Board needs statutory authority to use clinical evaluations whenever it addresses a complaint informally. According to the Arizona Legislative Council, under existing statutes the Board can conduct a clinical evaluation of a complaining patient's dental condition only in connection with one of two informal complaint disposition methods. Second, the penalty for practicing dentistry without a license is too lenient. Current statutes classify the practice of dentistry without a license as a class 2 misdemeanor. In contrast, unlicensed practice of medicine or osteopathy is a class five felony. Finally, the Board needs statutory authority to send a letter of concern in those cases that might not merit a stronger action.

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INTRODUCTION AND BACKGROUND

The Office of the Auditor General has conducted a performance audit of the Arizona State Board of Dental Examiners in response to a June 2, 1987, resolution of the Joint Legislative Oversight Committee. This performance audit was conducted as part of the Sunset Review set forth in Arizona Revised Statutes §§41-2351 through 41-2379.

The practice of dentistry was first regulated in Arizona in 1913, when a Board of Examiners was established. Licensure and regulation of dental hygienists was added to the Board's duties in 1947, and denturists were certified and regulated beginning in 1978. Today the Board is responsible for approximately 2,900 licensed dentists, 64 percent of whom are practicing in Arizona. The Board also oversees about 1,400 licensed dental hygienists and 26 certified denturists.

The Board consists of nine members appointed by the Governor. Five members are licensed dentists, three are laypersons and one is a licensed dental hygienist. None of the Board members are denturists.

Staffing and Budget

The State Board of Dental Examiners is funded through fees charged for examination and licensure. Of the fees collected, 90 percent are retained for the Board's use and 10 percent are remitted to the State General Fund.

The Board's administrative staff includes an Executive Director, two full-time investigators and four clerical staff. The staff's duties include processing original and renewal applications for licensure, and investigating and processing complaints.

Table 1 shows the Board's revenue, expenditures and authorized staff for fiscal years 1985-86 through 1987-88.

TABLE 1

REVENUE, EXPENDITURES AND FTEs FROM THE DENTAL BOARD FUND [a]
FOR THE STATE BOARD OF DENTAL EXAMINERS
Fiscal Years 1985-86 through 1987-88
(unaudited)

	1985-86 Actual	1986-87 Actual	1987-88 Estimate
Funds Available			
Balance Beginning of fiscal year	$335,500	$321,200	$290,800
Revenues (licenses, fees, etc.) [a]	314,900	311,100	387,000
Total Funds Available	$650,400	$632,300	$677,800
Disposition of Funds			
FTE Positions	6.5	6.5	7.0
Personal Services	$146,300	$171,700	$185,100
Employee Related Expenditures	25,000	30,700	39,500
Professional/Outside Services	22,300	30,000	26,100
Travel			
In-State	5,200	4,200	9,000
Out-Of-State	5,100	3,200	7,100
Other Operating Expenditures	91,700	101,700	104,800
Equipment	33,600	0	0
Total Funds Expended	329,200	341,500	371,600
Balance Forward End of Fiscal Year	321,200	290,800	306,200
Total Disposition of Funds	$650,400	$632,300	$677,800

(a) This table depicts only 90 percent of Dental Board monies, which is deposited in the Dental Board Fund. The other 10 percent is deposited in the General Fund.

Source: Joint Legislative Budget Committee Appropriations report for fiscal year 1987-88, and General Accounting Office actual expenditure figures for fiscal year 1986-87.

Audit Scope and Purpose

This audit was conducted to evaluate the adequacy of regulation by the Board of Dental Examiners. Specifically we examined:

- Whether the board was sufficiently addressing cases involving chemical substance abuse by dentists.

- The Board's ability to efficiently resolve consumer complaints.

- The need for statutory changes to improve the Board's enforcement effectiveness.

The report also contains Other Pertinent Information regarding restrictions on the supervision and scope of licensure of dental hygienists. The section Areas For Further Audit Work addresses concerns we identified during the course of our audit but were unable to research due to time constraints.

This audit was conducted in accordance with generally accepted governmental auditing standards.

The Auditor General and staff express appreciation to the members and staff of the Board of Dental Examiners for their cooperation and assistance during the course of our audit.

SUNSET FACTORS

1. **Objective and purpose in establishing the Board**

Although the Board's enabling statutes contain no explicit statement of objective or purpose, the statutes provide the means to ensure competence and quality in the dental profession by authorizing the Board to examine, license or certify, and discipline dentists, dental hygienists and denturists. The Arizona Supreme Court clearly affirmed the Board's role in a 1941 decision.

> "The purpose and the only justification of the various statutes regulating the practice of medicine in its different branches is to protect the public against those who are not properly qualified to engage in the healing art." (Batty v. Arizona State Dental Board, 57 Arizona. 239, 254, 112 P. 2d 870 [1941]).

2. **The effectiveness with which the Board has met its objective and purpose and the efficiency with which it has operated**

The Board has been generally effective in regulating the dental profession through examination, licensure or certification, and complaint disposition. The Board has improved its effectiveness since the 1979 Sunset review by taking more appropriate disciplinary action on consumer complaints (see Finding II). For example, during fiscal year 1986-87, the Board revoked six and suspended three licenses, censured 20 licensees, placed 46 licensees on probation, and ordered restitution in 32 complaint cases, among other actions. Another improvement in the Board's effectiveness has been the creation of a central file for each practitioner, which allows Board staff to respond quickly to consumer inquiries about licensees.

However, the Board needs to improve its effectiveness in the following areas.

- Monitoring, investigating, taking disciplinary action on, and obtaining information regarding licensees who have chemical dependency problems (see Finding I).

- Reducing the time it takes to resolve consumer complaints (see Finding II).

3. **The extent to which the Board has operated within the public interest**

The Board is generally operating in the public interest by meeting its objective and purpose. In addition, the Board has issued a consumer information pamphlet, "A Guide for Filing Consumer Complaints Against Licensed Professions and Occupations." This pamphlet is designed to educate the public about the purpose and responsibilities of a professional and occupational licensing board, including the Dental Board.

4. **The extent to which rules and regulations promulgated by the Board are consistent with Legislative mandate**

Rules and regulations appear to be consistent with law. The most recent rules, promulgated in 1985, were certified by the Attorney General as required by law.

However, the Board's Assistant Attorney General expressed concern about rules and regulations dealing with the administration of anesthesia, which become effective January 1, 1988.

- R4-11-803 in essence restricts newly licensed dentists from administering a particular type of anesthesia.

- R4-11-802, which lists prerequisites to obtaining a permit to administer certain types of anesthesia, lacks two provisions which are necessary to protect the public health and safety, according to the Assistant Attorney General. The rule lacks a needed facility inspection requirement, and it does not address the need for maintaining proper equipment if a dentist employs an M.D. anesthesiologist to administer the anesthesia.

The Assistant Attorney General for the Board stated she planned to present proposed rule revisions at the December Board meeting so that the Board could approve emergency rules (effective for 90 days) to begin to address these problems.

5. **The extent to which the Board has encouraged input from the public before promulgating its rules and regulations and the extent to which it has informed the public as to its actions and their expected impact on the public**

The Board has complied with the Open Meeting Law and has otherwise encouraged input from the public before promulgating its rules and regulations. After relocating its office in 1980, the Board notified the Secretary of State of the change in location and that meeting notices would be posted on a bulletin board in the new office. In addition, the Board's Executive Director stated he sends out meeting notices regarding proposed rules and regulations to an extensive list of interested parties, consisting largely of licensees.

6. **The extent to which the Board has been able to investigate and resolve complaints within its jurisdiction**

The Board's decisions regarding disciplinary action resulting from complaints are generally appropriate, but many complaints are not resolved in a timely manner. As discussed in Finding II, Board actions during fiscal year 1986-87 demonstrated a significant improvement over those of previous years. In addition, we found no cause to question the decisions of the Board on the complaints we reviewed. However, the Board needs to resolve complaints more quickly. More than half of the 42 resolved complaints in our sample were not resolved within the statutory limit of 150 days. The excessive delays occurred because the Board was not obtaining records or preparing reports in a timely manner. To correct this problem, the Board should set up a system to track all complaints so unnecessary delays do not continue to occur (see Finding II, page 21).

7. **The extent to which the Attorney General or any other applicable agency of State Government has the authority to prosecute actions under enabling legislation**

The Board's statutes are adequate, according to the Board's Assistant Attorney General. Arizona Revised Statutes (A.R.S.) §32-1266 authorizes the Attorney General to prosecute actions under the enabling statutes and also allows the

Board to "employ other or additional counsel in its own behalf." The Executive Director stated the Attorney General's Office represents the Board in all legal matters.

8. The extent to which the Board has addressed deficiencies in its enabling statutes which prevent it from fulfilling its statutory mandate

The Board proposed legislation in the 1986 Legislative session to authorize it to keep confidential the information obtained and used regarding consumer complaints, increase the penalty for practicing without a license from a misdemeanor to a felony, and extend the time allowed for disposing of complaints, among other items. The legislation passed, but an amendment eliminated the proposal to increase the penalty for unlicensed practice. According to the Executive Director, the Board decided not to propose legislation for the 1988 session, but plans to propose legislation for the session following that. In this legislation, states the Executive Director, the Board plans to simplify the complaint review statutes, try again to increase the penalty for practicing dentistry unlicensed, and clarify miscellaneous items.

9. The extent to which changes are necessary in the laws of the Board to adequately comply with the factors listed in the Sunset Laws

Based on our audit work we recommend that the Legislature consider the following changes to the Board's statutes.

- Amend the statutes to require licensees and the Arizona State Dental Association to report to the Board any dentist who is or may be be unable to safely practice dentistry (see Finding I, page 11).

- Amend A.R.S. §32-1263.02 to allow the Board to use clinical evaluation committees in conjunction with informal interviews (see Finding III, page 29).

- Amend A.R.S. §32-1269 to increase the penalty for practicing without a license from a misdemeanor to a felony (see Finding III, page 29).

- Amend A.R.S. §32-1263.01 to authorize the Board to issue Letters of Concern to licensees when a reprimand or warning is in order but more severe disciplinary action is not warranted (see Finding III, page 29).

10. **The extent to which the termination of the Board would significantly harm the public health, safety or welfare**

Termination of the Board would significantly harm the public. The unlicensed practice of dentistry could pose a threat to consumers' health, safety and economic well-being. Several complaints about dentists involved critical safety considerations, such as one patient with serious medical problems who developed an aneurysm in reaction to medication administered by her dentist. Other complaint cases dealt with improperly fit (and expensive) dentures causing pain and digestive problems. Also, dentists frequently identify and treat periodontal (gum) disorders which, left untreated, could result in serious problems including the loss of the patient's natural teeth.

11. **The extent to which the level of regulation exercised by the Board is appropriate and whether less or more stringent levels of regulation would be appropriate**

Based on our review, the level of regulation exercised by the Board appears appropriate. However, we present Other Pertinent Information, which the Board may want to consider, regarding the level of regulation of dental hygienists (see page 31).

12. **The extent to which the Board has used private contractors in the performance of its duties and how effective use of private contractors could be accomplished**

The Board regularly contracts with dental practitioners when it conducts clinical evaluations regarding consumer complaints. Lay advisors also assist in the investigative process.

FINDING I

ASBDE LACKS AN ADEQUATE PROGRAM TO DEAL WITH CHEMICAL DEPENDENCY PROBLEMS AMONG DENTISTS

The Arizona State Board of Dental Examiners (ASBDE) lacks a sufficient program to deal with chemically dependent dentists. Although dentists may suffer from alcohol or drug dependency, the Board has not developed a comprehensive program to identify, investigate and act in cases involving chemically dependent dentists. Even when the Board has taken action in drug and alcohol cases, it has not properly monitored the dentists to ensure compliance with terms established to allow continued practice.

Potential For Chemical Dependency Exists Among Dentists

Drug and alcohol abuse can be a serious problem among health care professionals, including dentists. Although specific estimates for dentists are not available, the Arizona Medical Association (ARMA) Physician Health Committee estimates that approximately 85 percent of physician impairment involves alcoholism and/or drug abuse. ARMA further indicates that although there are no conclusive figures on the incidence of chemical dependency among health professionals, the most widely accepted figure appears to be 10 percent. According to the chairman of the ARMA Physician Health Committee, these estimates apply to most health professionals, including dentists. Approximately 2,900 dentists are licensed in Arizona and 1,800 actually practice in the state. Based on ARMA estimates, perhaps some 180 dentists in Arizona now or will sometime during their career suffer from a chemical dependency. Since 1982, the Board has identified 14 chemically dependent dentists, ten of whom were still under consent agreements with the Board as of October 1987.

In many cases, chemically dependent dentists can be treated and allowed to continue practicing without posing a threat to public health and safety. According to the chairman of the ARMA Physician Health Committee, it is appropriate for a licensing board to treat chemical dependency as an illness rather then a crime and allow continued practice. According to the Chairman, treating the illness as a crime and taking purely disciplinary actions (for example, license suspension or

revocation) can actually deter licensees with a chemical dependency, and those around them, from seeking treatment. For treatment to be successful, however, the appropriate licensing board should monitor the individual's progress and use its enforcement powers where necessary to ensure that the practitioner obtains treatment and is able to continue in practice without endangering patients.

ASBDE Has Not Developed A Comprehensive Program To Identify, Investigate And Take Action In Chemical Dependency Cases

The Board has not developed a comprehensive program to identify, investigate and act in cases involving chemically dependent dentists. The Board does not aggressively attempt to identify dentists with drug and alcohol problems. The Board does not adequately investigate when it does identify problems. In addition, the Board could take stronger action to place dentists in appropriate treatment programs.

Board does not systematically identify dependent dentists - The Board does not aggressively attempt to identify chemically dependent dentists. The Board lacks a referral system to encourage voluntary notification of dependency problems. In addition, Arizona law does not require dental professionals to report dentists with possible alcohol and drug problems to the Board.

The Board lacks a system that encourages dentists to seek assistance for chemical dependency problems. As a result, nearly all of the chemical dependency cases identified by the Board since 1982 have been the result of referrals from law enforcement agencies. Few cases resulted from self-referrals by dentists or referrals from associates or family. In contrast, the State Board of Medical Examiners (BOMEX) and the State's medical association operate a referral service for chemical dependency. According to BOMEX's Executive Director, this service allows dependent physicians, their families and associates to obtain information on available alternatives and treatment for chemical dependencies. According to the Executive Director, this referral service is the source of 85 to 90 percent of the chemically dependent physicians identified and assisted by BOMEX.

The Dental Board also lacks an important source of information about potential problems because its statutes do not require licensees to report dentists with a possible chemical dependency. For example, the Arizona State Dental Association (ASDA) identifies and assists chemically dependent dentists but does not notify the Board that the dentists are being treated for such problems. According to ASDA officials, this program has been operating for approximately four years and has identified an average of four to five dentists per year, about the same number of cases the Board handles. According to Arizona Legislative Council, the Board cannot require the association or any licensee to report chemically dependent dentists. (1)

BOMEX, on the other hand, has a mandatory reporting statute, under Arizona Revised Statutes §32-1451.

> **Any doctor of medicine, the Arizona medical association, inc., or any component county society thereof, any health care institution shall** (emphasis added) and any other person may, report to the board any information such doctor, health care institution, association, provider or individual may have which appears to show that a doctor of medicine is or may be medically incompetent, is or may be guilty of unprofessional conduct or is or may be mentally or physically unable safely to engage in the practice of medicine.

Board has not conducted adequate investigations - The Board has not adequately investigated the few allegations of dependency that have been brought to its attention. Although only two chemical dependency cases that required an investigation have been reported to the Board since 1982, these investigations were inadequate and untimely. In addition, in a recent incident the Board failed to investigate a dentist with a known dependency problem. The following cases, which resulted from anonymous complaints, represent the only two documented chemical dependency investigations by the Board since 1982, and illustrate the inadequate and untimely investigations conducted by the Board.

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(1) In fact, the Legislative Council further stated, "There is no statutory requirement that a dentist, a peer review committee or the ASDA report to the State Board any information that appears to show that the activities of a dentist may be grounds for [any] disciplinary action pursuant to A.R.S. Section §32-1263."

CASE 1

In March 1985 the Board received an anonymous complaint alleging a dentist had a drug and alcohol dependency. About the same time, a Board member reported that a member of the dentist's family contacted him about the dentist's possible dependency problem. The Board took no action until August 1985, when its investigators conducted an investigative hearing during which the dentist acknowledged a dependency problem. The investigators recommended that the Board place the dentist on probation until it received documentation of treatment he claimed to have received since the complaint had been filed in March. However, the Board tabled the complaint at its October meeting until it could obtain more information. Because of difficulties in obtaining the treatment reports from the dentist, a second investigative hearing was held on January 21, 1986, ten months after the Board received the initial complaint. At this hearing the investigators offered a consent agreement to the dentist placing him on five years probation and requiring him to obtain treatment for his dependency. The dentist signed the agreement on February 3, 1986. The Board accepted the consent agreement signed by the dentist on February 14, 1986.

COMMENTS

Although the Board had reasonable evidence that this dentist had a dependency problem, including information from one of its own members, it took almost one year to ensure that the dentist obtained the treatment necessary to prevent his drug and alcohol problems from endangering his patients.

CASE 2

In June 1983 the Board began an investigation of a dentist based on anonymous allegations that the dentist was using cocaine and heroin and inappropriately writing prescriptions for controlled drugs. According to the investigative file, the Board's investigation consisted of a day spent reviewing prescriptions at pharmacies in the dentists area and requesting information and assistance from the Department of Public Safety. Six months later, in December 1983, the staff investigators recommended that the Board dismiss the complaint because the prescription review had found no evidence of irregularities and DPS had not provided any information. However, during the prescription review, three pharmacists informed the Board investigator that they were aware of a possible drug problem involving the dentist and that the dentist had recently been hospitalized for a drug related problem. On April 11, 1986, the dentist signed a consent agreement in which he admitted to having been hospitalized in January 1986 for chemical dependency treatment. According to the Board investigators, this treatment was for the dentist's addiction to cocaine.

COMMENT

This case further illustrates the Board's inadequate investigation of dependency complaints. The evidence developed during the prescription review indicated that the dentist may have had a drug problem. However, neither the Board nor its investigators contacted or interviewed the dentist to determine if a dependency problem existed.

A more recent incident illustrates the Board's failure to investigate allegations against a dentist with a known dependency problem.

CASE 3

In September 1987 the Board received a telephone call from an individual complaining about the quality of care received from a dentist. The complainant reportedly said that the dentist "had the shakes." The Board's response was to send the patient a complaint form. By the end of October the complaint form had not been returned. However, this dentist had a known history of alcohol abuse, and was under suspension from another state when he began practicing in Arizona in 1985. The dentist was already licensed in Arizona at that time and the Board allowed him to begin practicing, but under a consent agreement placed him on probation and required him to obtain treatment for his alcohol dependency. Nearly four months later the Board revoked his license for continued abuse of alcohol. In June 1986 the Board reinstated the dentist's license after he completed an intensified in-patient treatment program. At that time, again under a consent agreement, the Board placed him on five years probation and required that he continue to obtain treatment for his dependency problem.

COMMENT

Although this dentist was practicing under a consent agreement with the Board for alcohol dependency and an allegation was received indicating a possible violation of this agreement, the Board did not contact the dentist to determine if the allegations were valid. According to the staff investigator, the dentist has been through extensive treatment for his dependency problem and is considered to be the Board's model for recovery.

Treatment requirements - The Board could strengthen its ability to ensure that dentists receive appropriate dependency treatment. In most cases, ASBDE allows chemically dependent dentists to select doctors and determine their overall treatment programs. According to the Chairman of the ARMA Physician Health Committee, these doctors may or may not have expertise in treating chemical dependency. In addition, the Board does not require all dependent dentists to participate in aftercare treatment such as Alcoholics Anonymous or other group therapy programs. When the Board has required aftercare, it has not specified the frequency of the dentist's attendance or approved the aftercare program chosen.

At least one alternative exists wherein a regulatory board maintains greater control over treatment requirements. For example, the Board of Medical Examiners has developed a treatment program for chemically dependent physicians which provides greater control over the treating physicians and aftercare programs.

The Board Has Not Properly Monitored Dependent Dentists

ASBDE has failed to properly monitor licensees with a chemical dependency to ensure compliance with consent agreements. Although the Board has established specific conditions for the continued practice of dentists admitting to a chemical dependency, the Board has not adequately monitored the dentists to ensure compliance. Although the Board has given a low priority to monitoring dentists under chemical dependency consent agreements, it could develop procedures for more efficient monitoring of these cases.

Conditions for continued practice - In most chemical dependency cases, the Board will allow the dentist to continue practice if certain conditions are agreed upon. These conditions are generally formalized in a consent agreement. The conditions of the consent agreement routinely include such provisions as:

- Probation for a period of three to six years.
- Psychological evaluation with reporting requirements to the Board.
- Treatment therapy with reporting requirements to the Board.
- Biofluid testing (e.g., urine or blood).
- Participation in Alcoholics Anonymous (AA) or other chemical dependency support group.
- Revocation of Drug Enforcement Administration (DEA) permit to prescribe narcotic drugs.
- Abstinence from use of narcotic drugs or alcohol.

Inadequate monitoring - The Board has not adequately monitored most chemically dependent dentists who have signed consent agreements. As a result, the Board cannot ensure that these dentists are able to continue practice without endangering their patients. Provisions of consent agreements that should be better monitored by the Board include biofluid testing, inconsistent and untimely reporting of initial psychiatric evaluation, treatment therapy and participation in Alcoholics Anonymous or other chemical dependency groups. In at least two cases the Board sent licensee files to archives storage before completion of the required probation.

The following case example illustrates the Board's inadequate monitoring of chemical dependency consent agreements.

CASE 4

In March 1987, a dentist admitted to Board investigators that he was using Oxycodones, Demerol and Percodan. Later that month, the Board received a letter from a doctor associated with a chemical dependency program indicating the dentist would be starting an out-patient treatment program "as soon as possible." On May 26, 1987, the dentist signed a consent agreement, which according to Board investigators included these stringent monitoring provisions because the dentist wanted to maintain his DEA permit to prescribe drugs.

- For the first 12 months of the five year probation, the dentist shall submit to twice weekly urinalysis at a facility chosen by the Board, with the results sent to the Board within 72 hours.

- The dentist shall submit monthly to the Board carbon copies of all prescriptions issued.

Additional provisions of the consent agreement included: 1) an initial psychiatric evaluation within 30 days, with a report sent to the Board immediately upon completion, 2) consultation with a psychologist and admission to a drug rehabilitation program if deemed necessary by the psychologist, and 3) active participation in Alcoholics Anonymous and/or a chemical dependency group, with quarterly reporting from the dentist's sponsor or counselor.

On October 1, 1987, Auditor General staff reviewed the consent agreement and related complaint file, and found that the Board had received no documentation on any of the provisions of the consent agreement except carbon copies of prescriptions issued by the dentist from early April through mid-July, 1987. Based on this information, ASBDE staff placed the dentist's case on the agenda for the Board's October 15, 1987, meeting and notified the dentist. However, the day before the Board meeting the dentist provided documentation indicating his completion of two urinalyses (for the current week) and one quarterly report from his treating doctor. Based on this limited and belated documentation, the Board took no action against the dentist at the October 15 meeting.

COMMENTS

This case illustrates the Board's failure to adequately monitor a dentist with an acknowledged chemical dependency. This was especially critical because the Board allowed the dentist to retain his DEA permit to prescribe narcotics. Even though the dentist had not complied at all with the terms of his consent agreement for most of its duration, the Board did not act to ensure adequate future compliance.

A review of the 14 chemical dependency consent agreements issued by the Board since 1982 shows that the Board has not been adequately monitoring the agreements.

- The Board has collected biofluid (urine and blood) samples in only two of 13 consent agreements that allow direct sampling by the Board.

- The Board has received reports of initial psychiatric evaluations and recommended treatment in only seven of ten consent agreements requiring such reports. Five of the seven reports were received after the deadline established in the consent agreement.

- The Board has received complete reports in only four of ten consent agreements that require periodic reports (bimonthly or quarterly) from therapists treating dentists. In two of the four cases, many reports were received after the deadlines established in the consent agreement.

- The Board has received complete reports in only two of five consent agreements that specifically require the dentist to participate in Alcoholics Anonymous or an equivalent chemical dependency group and provide periodic reports from the dentist's sponsor.

- The Board has not received the required written notification from two of four psychiatrists treating dependent dentists. The reports are needed to show that the dentists have successfully completed treatment by the end of their probations. The complaint files on the two dentists were sent by the Board to archive storage several months before the completion of the required probation and monitoring period.

Monitoring is a low priority - The Board appears to have given a low priority to monitoring dentists under chemical dependency consent agreements. As a result, the Board has not adequately fulfilled its responsibility to protect the public. However, the Board could develop procedures for more efficient monitoring of these cases.

The inadequacies in monitoring by the Board are due to the apparent low priority given to chemical dependency consent agreements. For example, at the time of our review, the Board did not have a listing of all the dentists under a chemical dependency consent agreement. In addition, the chemical dependency complaint files were not maintained in a central location, but were located with other consumer complaints.

According to ASBDE officials, the low priority for monitoring chemically dependent dentists results from the investigators' heavy workload and the need to address consumer complaints. However, our analysis indicates that the problem also results from the Board's limited information concerning the status of chemical dependency consent agreements. The Board could establish procedures to obtain timely information about dentists practicing under a chemical dependency consent agreement. For example, a tickler file system would remind Board staff when dentists must submit test results and other information required by their agreements. A cover sheet for each chemical dependency case would show all requirements that the dentist must meet to comply with a consent agreement and allow the Board to determine when such requirements are completed. BOMEX uses both methods to track its drug and alcohol cases.

The Board should also require status reports on dentists who appear before the Board so it can evaluate their progress in overcoming dependency problems. As noted earlier, according to BOMEX's Executive Director, BOMEX calls physicians under chemical dependency consent agreements for personal appearances about once every six months to review their progress and compliance. As a part of this review, the Board receives an updated status report on the dependent physician. The report includes the treating doctor's most recent evaluation, reports from group therapy meetings and results of urinalysis.

RECOMMENDATIONS

1. The Legislature should consider amending the Dental Board statutes to require dentists and the Arizona State Dental Association to report information indicating that a dentist may be professionally incompetent, guilty of unprofessional conduct or unable to safely practice dentistry.

2. The Board should develop a referral system to identify dentists who are or may be chemically dependent.

3. The Board should conduct adequate and timely investigations of dentists who are or may be chemically dependent.

4. The Board should fulfill its responsibility to ensure adequate control over dependent dentists' treatment by:
   A. Developing a list of acceptable doctors and treatment programs.
   B. Stipulating the frequency of attendance in aftercare treatment programs.

5. To properly monitor chemical dependency cases, the Board should:
   A. Establish a system for tracking chemical dependency in consent agreement cases.
   B. Provide Board members with status reports of dentists' progress toward overcoming dependency and meeting the conditions of consent agreements .

FINDING II

THE DENTAL BOARD COULD IMPROVE COMPLAINT HANDLING TIMELINESS

The Arizona State Board of Dental Examiners (ASBDE) could expedite its handling of consumer complaints. Although the Board has improved its overall handling of complaints, many complaints take excessive time to resolve. Delays by the Board in obtaining needed information have caused the untimeliness.

Board Has Improved Overall Handling of Complaints

ASBDE has improved its processing of consumer complaints since 1981. Previous Auditor General reports (report numbers 79-11 and 81-4) identified significant problems in the Board's handling of consumer complaints. However, the Board has corrected many of these problems in recent years.

Previous reports noted deficiencies - Previous audits of the Board revealed significant deficiencies in the way the Board processed consumer complaints. These deficiencies included the Board's failure to fully investigate allegations of substandard care, and its failure to adequately discipline dentists when allegations of substandard care were substantiated. Previous reports noted these examples.

- The Board dismissed consumer complaints in cases where allegations of unprofessional conduct or incompetent work had been substantiated by an investigative committee.
- The Board dismissed consumer complaints without a hearing if dentists agreed to make a refund or provide some form of restitution.
- Individual Board members and the Executive Director dismissed consumer complaints without the approval of a quorum of the Board and without holding a hearing.

The previous audit reports concluded that these deficiencies hindered the Board in its attempt to protect the citizens of Arizona from incompetent dental practitioners.

Improvements in deficient areas - Many of the deficiencies cited in the previous audits have been improved by the Board. Auditor General staff reviewed a sample of complaints received by the Board during fiscal years 1985-86 and 1986-87, and found marked improvements in complaint handling. This review showed that with the exception of one case,[1] the Board conducts complete investigations of consumer complaints as directed by statute. Further, the Board routinely accepts recommendations for disciplinary action from the investigative hearing committee or informal interview committee, and rarely reduces the recommended sanctions. Finally, as shown in Table 2, the Board has greatly strengthened its disciplinary actions against dentists when complaints are substantiated.

TABLE 2

DISCIPLINARY ACTION TAKEN BY BOARD
1978 VS. FISCAL YEAR 1986-87

	Complaints Received in 1978 & Resolved as of July 31, 1979	Complaints Resolved During Fiscal Year 1986-87
Disciplinary Action Taken		
Revocation	0	6
Suspension	0	3
Censure	0	20
Probation	0	46 (a)
Dismissal	70 (b)	132 (c)

(a) In some cases, both censure and probation were ordered by the Board.

(b) All 70 of the complaints were dismissed, although investigations by the Board indicated that substandard or inadequate dental care had occurred in at least 13 of the cases.

(c) In total, the Board took 201 disciplinary actions in 97 of the 229 complaints resolved. However, in most of the 97 complaints, more than one disciplinary action was taken. The actions shown in the table represent the more severe sanctions ordered by the Board.

Source: Auditor General performance audit of ASBDE, September 1979 and ASBDE report of complaint action taken during fiscal year 1986-87.

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(1) In this case, the Board allowed the dentist to sign a consent agreement in which the patient received a refund from the dentist and the Board dismissed the complaint without holding a hearing.

Many Complaints Require Excessive Time to Resolve

Although the Board has made improvements in complaint handling, many complaints take excessive time to resolve. The Board often does not obtain needed records or complete investigative reports in a timely manner. Without a tracking system, the Board cannot adequately monitor the status of its complaints.

Many complaint investigations exceed statutory time limits. State law requires the Board to take initial action on a complaint within 150 days of beginning an investigation. Arizona Revised Statutes §32-1263.02 requires committees to make written recommendations to the Board within 90 days of initiating an investigation. Once the Board receives such a recommendation, it must issue preliminary findings within 60 days. According to the Board's Chief Investigator, the Board considers the time limit to be in effect once a complaint is referred to a committee of dentists to clinically evaluate the complainant's condition.[1] However, a significant number of the Board's complaints greatly exceed the 150 day statutory limit. As illustrated in Table 3, in our sample of complaints received by the Board in fiscal years 1985-86 and 1986-87, 26 of the 42 sampled complaints that were resolved exceeded the 150 day statutory limit.

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(1) Not all complaints are referred to a committee for clinical evaluation. Complaints not concerning quality of care (for example illegal advertising, fraud or other criminal acts) and those in which the complainant has already had dental work redone, leaving nothing to evaluate, are not referred to a committee for clinical evaluation.

TABLE 3

ASBDE COMPLAINTS RESOLUTION TIME
FISCAL YEARS 1985-86 AND 1986-87

NUMBER OF DAYS TO RESOLVE COMPLAINT [a]	NUMBER OF CLOSED COMPLAINTS
LESS THAN 150	16
150 TO 180	11
181 TO 200	7
201 TO 220	5
221 TO 250	3

(a) This represents the number of days from the start of the investigation of the complaint (the date it was referred to a clinical evaluation committee) to an initial action by the Board. If a clinical evaluation was not conducted, the date the Board received the complaint is used as the first day.

Source: Auditor General survey of complaints received by ASBDE in fiscal years 1985-86 and 1986-87.

Excessive delays result because the Board cannot prepare needed reports and obtain records in a timely manner. Most of the complaints that took more than 200 days to resolve were delayed because of excessive time taken to prepare report summaries necessary to proceed with the complaint. In other cases, the Board was slow to make initial requests for patient records and failed to follow up on these requests when the records were not received in a timely fashion. The following case examples illustrate the excessive delays.

CASE 1

On March 6, 1986, the Board received a complaint from a patient concerning the quality of care received from a dentist. Twenty-nine days after receiving the complaint, Board staff sent a request to the dentist for the patient's records. These records were received on April 24, 1986. Ninety-seven days after receiving the records, on July 30, 1986, Board staff completed a two page summary report of the complaint and the related records. Although an investigative hearing was held on August 26, 1986, a report of the findings and recommendations of the hearing committee to the Board was not completed until September 22, 1986, 27 days after the hearing had been held. The Board voted to dismiss the complaint on October 10, 1986, 218 days after receiving the complaint.

COMMENTS

According to Board investigators, most of the delays in completing investigative reports were due to the workload of the staff investigator assigned to complete these reports. However, the initial delay in requesting patient records and the more than three months taken to complete a two page summary report indicate a more serious problem with the Board's ability to determine the status of cases during the complaint process.

CASE 2

The Board received a complaint on April 29, 1986, which involved the quality of care a patient had received from a dentist and a denturist. Within 30 days the Board requested and received the patient's records from the dentist and denturist. On June 3, 1986, the Board received the results of a clinical evaluation of the patient. Seventy-seven days later, on August 19, 1986, a three page summary of the evaluation committee's results and the patient records was completed by Board staff. Sixty-three days after an informal hearing (chaired by a Board member) was held on September 18, 1986, a report of the findings and recommendations of the committee to the Board was completed. The Board voted to dismiss the complaint on December 12, 1986, 212 days after receiving the complaint.

COMMENTS

This case further illustrates the Boards untimely resolution of consumer complaints because of delays in completing investigative reports. Delays of 77 days to complete a three page summary report indicate a problem with tracking complaints.

CASE 3

On June 11, 1986, the Board received a complaint from a patient concerning the quality of care received from a dentist. Twenty-seven days later, on July 8, 1986, the Board requested the patient records from the dentist. These records were received by the Board on November 24, 1986, 139 days after the Board requested them. According to the complaint file, there was no contact between the Board and the dentist during this time. A hearing was held on January 5, 1987, and the Board voted to dismiss the complaint on February 13, 1987, 247 days after receiving the complaint.

COMMENT

This case illustrates excessive time taken to resolve a complaint because of the Board's failure to make a timely request for patient records and follow up on this request. Although the Board has powers to subpoena records, they were not used in this case. The Board did not follow up on its request and appeared to be unaware that the dentist had not submitted the records.

ASBDE does not have a system of tracking complaints to determine their status during the complaint process. Without such a system, the Board cannot readily determine the status of open complaints and what action is needed to resolve these complaints. Although the Executive Director is currently evaluating automated tracking systems as part of an upgraded data processing system, the Board should consider the immediate implementation of a manual tracking system to avoid further delays.

RECOMMENDATION

The Board should implement a complaints tracking system to ensure that reports of investigative hearings, clinical evaluations and patient records summaries are completed in a timely manner and that requests for patient records and follow-ups on these requests are also timely and do not result in further delays.

FINDING III

STATUTORY CHANGES ARE NEEDED TO IMPROVE THE BOARD'S ENFORCEMENT EFFECTIVENESS

Several statutory changes are needed to improve the Board's enforcement efforts. Statutes need to be amended to allow for the use of clinical evaluations in all complaint investigations. The penalty for practicing dentistry without a license is too lenient. Finally, disciplinary actions currently available to the Board may be excessive in some cases.

Investigation Authority Needed For Informal Interview

The Board needs statutory authority to use clinical evaluations when it informally addresses a complaint. Current statutes give the Board authority to delegate its investigative powers in only one of the two informal methods it has available to adjudicate complaints. Yet, the statutory distinction appears unnecessary and may actually hinder enforcement effectiveness.

Under State law, the Board is required to address most of its complaints informally. Two informal disposition methods are available to the Board, under Arizona Revised Statutes §32-1263.02. The Board may either request an informal interview wherein a Board member acts as the interviewing officer, or may refer the matter to an investigative committee consisting of both dentists and laypersons who need not be Board members.

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(1) A.R.S. §32-1263.02, paragraph C, allows for a formal Board hearing only in two specific circumstances: a defendant licensee's refusal to cooperate or a summary suspension of the defendant's license. For formal hearings, the Board usually appoints a hearing officer and has a transcript made of the proceedings. Board decisions in these instances are made after the formal hearing takes place, when the Board has had the opportunity to review the transcript and other information.

Regardless of the method used, clinical evaluations are an essential component of most Dental Board investigations. The clinical evaluation, normally conducted by a committee of two licensees and one layperson who are not members of the Board, determines alleged substandard performance as evidenced by the complaining patient's dental condition. In fact, the Dental Board appears to be at an advantage over other health licensing boards, because evidence of substandard work can be examined relatively easily.

Legally, clinical evaluations can only be used in cases that have been assigned to investigative committees, and not in cases designated for informal interview. According to the Arizona Legislative Council, "[t]he statutes do not provide for the further delegation of investigative authority when the board requests an informal interview with a licensee. In this situation it is improper to forego an interview and refer the matter to a clinical evaluation committee instead." The Legislative Council representative further stated that the clinical evaluation committee could not legally be used in conjunction with the informal interview, even as a precursor to the actual interview.

However, the Board's Executive Director indicates that clinical evaluations are essential in the majority of the complaints the Board handles, whether they are handled by investigative committee or by informal interview. Although most complaints are reportedly handled through investigative committees, occasionally the Board or one of the parties in a complaint will request an informal interview so a Board member will be present. But, according to the Board's Executive Director, the method utilized does not affect the need for a clinical evaluation. The Executive Director also stated that, to his knowledge, the authority to use investigative means in conjunction with the informal interview was not intentionally omitted from the statutes. Since informal interviews are sometimes necessary or advisable, the Board needs statutory authority to use clinical evaluations in conjunction with informal interviews.

Unlicensed Dentistry Practice Should Be A Felony

The penalty for practicing dentistry without a license is lenient compared with other similar licensed professions. A.R.S. §32-1261 classifies the practice of dentistry without a license as a class 2 misdemeanor. In contrast, unlicensed practice under the statutes of both the Board of Medical Examiners and the Board of Osteopathic Examiners is a class five felony. The three professions perform some similar functions, which could result in a direct, immediate impact on the public health and safety. These functions include prescribing drugs, performing surgery and administering anesthesia.

The Dental Board's Executive Director stated he currently knows of six unlicensed dentists, and they tend to treat mostly elderly patients. Furthermore, at least one unlicensed dentist has allegedly prescribed drugs in his unauthorized practice. In this case, evidence suggests that the unlicensed dentist has been calling in prescriptions to pharmacies, using licensed dentists' names and prescription authorization numbers.

Additional Disciplinary Sanction May Be Needed

The Board needs statutory authority to use a sanction less restrictive than those currently available. At least three other health licensing boards have an option that allows them to communicate concern about licensee performance even though statutes may not have been violated.

According to A.R.S. §32-1263.01, the least severe disciplinary action available to the Board is censure, probation, or imposition of a fine or continuing education requirements. However, some cases may not need such direct disciplinary action and instead may require only a warning by the Board. For example, while no evidence may exist that a dentist's treatment was incorrect in a given situation, his behavior toward the patient may not have been appropriate. Or, no evidence is available to document inadequate treatment, but evidence suggests the treatment may have been questionable. In cases such as these, a letter of concern could be used to notify the practitioner that the Board is concerned about some aspect of the dentist's performance, even though it found no violation of Arizona statutes.

Three other medical licensing boards have the authority to issue letters of concern. The Board of Medical Examiners' (BOMEX) Executive Director states it issues about 90 to 100 letters of concern per year. The BOMEX Director says these letters are appropriate in cases where BOMEX wishes to advise a doctor of inappropriate performance but not serious enough to warrant more severe action. The Boards of Osteopathic Examiners and Nursing also have statutory authority to issue letters of concern, and their staff indicated they issue on average about 14 and 48 per year, respectively.

RECOMMENDATIONS

The Legislature should consider revising the statutes to:

1. Authorize the Board to use clinical evaluation committees when it refers complaints to informal interview.

2. Reclassify practicing dentistry without a license from a misdemeanor to a felony.

3. Authorize the Board to issue letters of concern in cases that warrant a less severe or different disciplinary action than censure, probation or requirement of continuing education.

OTHER PERTINENT INFORMATION

During the course of our audit we developed information regarding dental hygienists. The first section addresses increased costs to the public due to restrictions on the number of hygienists a dentist can supervise, and the second section reports on efforts to allow hygienists to practice without supervision by dentists.

Increased Costs Due To Restrictions On The Number Of Supervised Dental Hygienists

According to a study released in May 1987 by the Federal Trade Commission (FTC), the 15 states (including Arizona) that restrict the number of hygienists a dentist can supervise "should consider relaxing their restrictions." The study results indicate that this restriction increases the cost of dental visits and of several specific dental procedures. The FTC reported:

> "These price increases imposed substantial losses on consumers and on the U.S. economy. Our estimated loss to consumers exceeds $1 billion for 1970 and is approximately $700 million for 1982. [expressed in 1986 dollars] We estimate that the loss to the U.S. economy was more than $500 million in 1970, and more than $300 million in 1982. Because the number of states that imposed auxiliary use restrictions in 1982 is comparable to the number in 1985, our 1982 estimates provide a reasonable approximation of current losses due to the restrictions."

Study evidence, therefore, suggests that consumers would pay lower prices for dental visits and for several dental procedures if the restriction on the number of hygienists a dentist can supervise were relaxed.

Currently, Administrative Rule number R4-11-408 permits a dentist to supervise only two hygenists at any one time. [1] According to the FTC study, 14 other states also limit the number of hygienists a dentist can supervise, while 35 states and Washington, D.C. have no such restriction. [2]

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(1) Proposed revisions to the rules and regulations change this number to three. The Board has adopted the new rules, but they have not yet been certified by the Attorney General's office.

(2) The FTC study is based on 1982 data. However, in 1986 Colorado eliminated supervision requirements from its statutes. We have reflected this change in the figures we reported.

Restrictions On Independent Practice Of Dental Hygienists

Arizona law requires dental hygienists to practice under the supervision of a licensed dentist. Such a provision is common among most states. As of March 1987, only one state (Colorado) allowed some dental hygienists to practice independently. Colorado's law change occurred after hygienists had been allowed to practice independently in limited settings, such as schools and other institutions, for seven years. In addition, California recently authorized a pilot project to study the independent practice of dental hygienists.

Dentists are generally opposed to allowing hygienists to practice independently, for at least two reasons. First, dentists reportedly are concerned about the quality of care patients may receive under the new arrangement. However, in the study mentioned on page 33, the FTC reviewed literature which suggested that hygienists can provide quality care for all procedures they are trained to do. Second, some dentists fear that hygienists may begin to expand their scope of practice to include functions they are not adequately trained to perform, such as diagnosis, extended periodontal treatment and restorative work.

Supporters of hygienists' independent practice, on the other hand, say that the change would bring dental hygiene services to population groups who do not normally seek dental services. They maintain that the change would not take work away from dentists, since their reported goal is to perform preventive, and not restorative, dental services.

For several years now the Arizona Board of Dental Examiners has been trying to promulgate rules and regulations regarding dental hygienists, one of which would allow hygienists working for the Department of Corrections (DOC) to work without being directly supervised by a licensed dentist. A DOC official, a major proponent of the proposed rule, stated that the rule was desirable for several reasons. First, DOC feels it can provide more cost-effective care to inmates by employing hygienists who do not need to be directly supervised by dentists. Second, hygienists at DOC conduct their work in a clinical atmosphere, in which a doctor, nurse or

physician's assistant is usually available if the hygienist needs emergency assistance. According to the DOC official, the main potential safety problem may lie in the administration of anesthesia, and for this reason some medically trained emergency personnel should be present. However, this official felt the emergency personnel do not need to be dentists, since others are at least as experienced at dealing with such emergencies.

The Board's Executive Director stated that the proposed rules have been adopted by the Board and are awaiting review by the Governor's Review Council. The Executive Director anticipates that the rule allowing hygienists employed by DOC to practice under general supervision will face strong opposition.

AREAS FOR FURTHER AUDIT WORK

During the course of the audit, we identified two potential issues that we were unable to pursue because they were beyond the scope of our audit or we lacked sufficient time.

- **Should the board establish license reciprocity?**

  Currently, Arizona State Board of Dental Examiner's rules and regulations do not provide for reciprocal licensing. Arizona Revised Statutes §32-1235 grants the Board authority to promulgate regulations allowing the Board to accept evidence that an applicant for licensure has passed the examination of another state within the preceding five years, in lieu of requiring the applicant to pass the Arizona examination. However, the Board has not established the regulations necessary to enforce this statute. According to an authority in professional licensing and regulation, restrictions on reciprocity by licensing boards reduce the quality of service received by the public. Further audit work, including evaluations of the effects of reciprocity in other states and other licensed occupations, and what impact it might have on dentistry in Arizona, is needed to determine whether the Board should relax licensing requirements for out-of-state dentists.

- **Does the board have sufficient staff to adequately perform its duties?**

  According to some Board members and the Executive Director, the Board is insufficiently staffed to adequately perform licensing and regulatory duties mandated by statute. The Board requested two additional staff in its last budget requests, but received only a half-time position. However, the Board has not conducted a comprehensive staffing analysis to determine the number of staff positions necessary to perform its duties and what impact increased electronic data processing capability might have on staffing needs. Further audit work, including an evaluation of the Board's processes and staffing patterns and an estimation of staff resources, is needed to determine whether the Board is sufficiently staffed to perform its duties.

Arizona State Board of Dental Examiners

5060 North 19th Avenue, Suite 406
Phoenix, Arizona 85015
Telephone (602) 255-3696

December 14, 1987

Douglas R. Norton
Auditor General
2700 N. Central, Suite 700
Phoenix, Arizona 85004

Dear Mr. Norton:

The Arizona State Board of Dental Examiners has reviewed the performance audit completed in response to the March 3, 1987, resolution of the Joint Legislative Oversight Committee. The Board found the audit to be positive and constructive and found no substantive areas in which we disagreed.

The Board has instituted or will develop a number of changes to correct deficiencies or to meet the recommendations of the audit.

FINDING I: ASBDE Lacks An Adequate Program To Deal With Chemical Dependency Problems Among Dentists

FINDING II: The Dental Board Could Improve Complaint Handling Timeliness

These two findings have many interrelated problems, most of which involve staffing and data processing capabilities.

Staffing:

The Board was authorized an additional .5 FTE for this years budget to handle investigations and follow-ups; but found that half an FTE with the correct dental background was difficult to fill and would be even more difficult to train. We opted for two dentists that would work part time to fill the .5 exempt FTE positions and relieve existing trained staff for the investigations and follow-ups. These two new positions would essentially work on Friday only to administer hearings. They have been selected and their first hearings were on December 4, 1987.

A comprehensive analysis will be instituted in the first quarter of 1988. This analysis will start with a 30 day detailed time and motion study, a productivity analysis, an employee position appraisal and finish with a recommended action for the Board.

Data Processing:

The Board has a good word processor which has very little data processing capabilities. Complaint handling or timeliness, along with follow-up on substance abuse cases, would be greatly enhanced with a good software program for in-house tracking. We have identified the type of software tracking package that would fill our needs; the tracking system used by the Arizona State Bar.

We have contacted (12-87) the Department of Administration for analysis of our data processing needs and this analysis is underway.

Substance Abuse Program:

We have conferred with the Medical Board and the Dental Association, both of whom have substance abuse programs: additionally we have received information from programs in California, Illinois, Oregon and Missouri. We found the program presently used by the Medical Board most appropriate for our situation and will institute our program based on theirs or "piggy-back" on theirs - if that would be agreeable with them.

FINDING III: Staturory Changes Are Needed to Improve the Board's Enforcement Effectiveness

The Board feels that a general overhaul of our statutes is in order -- to both clarify and simplify the entire Chapter 11 of Title 32. A committee for this purpose was appointed in December 1987; the chairman is Dr. Tom Bahr. The committee's challenge is to complete the draft of legislation by September 1988.

The Board will also consider other changes and issues in the audit, but wished to use the above to start aggressively and positively.

We wish to complement the Auditor General on the professionalism of the staff that conducted this audit. They spent several months with us almost without notice, they were never intrusive and always considerate.

Sincerely,

Mathew H. Wheeler
Executive Director