

VIRGINIA BOARD OF DENTISTRY

AGENDAS

September 12-13, 2013

Department of Health Professions

Perimeter Center - 9960 Mayland Drive, 2nd Floor Conference Center - Henrico, Virginia 23233

PAGE

September 12, 2013

9:00 a.m. Formal Hearing

September 13, 2013

Board Business

8:45a.m. Nominating Committee

- September 9, 2011 Minutes -1-
- September 7, 2012 Minutes -2-

9:00 a.m. Call to Order – Dr. Levin, Interim President

Evacuation Announcement – Ms. Reen

Public Comment

Approval of Minutes

- July 31, 2009 New Member Orientation P1
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Nominating Committee Report

12:30

Formal Hearing Reconvene

UNAPPROVED - DRAFT

**BOARD OF DENTISTRY
MINUTES of the NOMINATING COMMITTEE MEETING**

Thursday, September 9, 2011

Perimeter Center
9960 Mayland Drive, Suite 200
Richmond, VA 23233
Board Room 4

- CALL TO ORDER:** The meeting was called to order at 8:40 a.m.
- PRESIDING:** Jeffrey Levin, D.D.S., Chair
- MEMBERS PRESENT:** Augustus A. Petticolas, Jr., D.D.S.
Meera A. Gokli, D.D.S
- STAFF PRESENT:** None
- QUORUM:** All members were present.
- APPROVAL OF MINUTES:** Dr. Levin asked for a motion to approve the minutes of the September 17, 2010 meeting. Dr. Gokli made the motion which was seconded and passed.
- NOMINATIONS:** Dr. Levin advised that nominations were needed for the offices of president, vice-president and secretary/treasurer for election during the September 9, 2011 Board meeting. Following a discussion of eligible members, Dr. Gokli moved to nominate Dr. Hall for president, Dr. Petticolas for vice-president and Dr. Boyd, D.D.S. for secretary/treasurer. The motion was seconded and carried unanimously.
- ADJOURNMENT:** With all business concluded, the Committee adjourned at 8:48 a.m.

Jeffrey Levin, D.D.S., Chair

Date

Sandra K. Reen, Executive Director

Date

UNAPPROVED - DRAFT

**BOARD OF DENTISTRY
MINUTES of the NOMINATING COMMITTEE MEETING**

Thursday, September 7, 2012

**Perimeter Center
9960 Mayland Drive, Suite 200
Richmond, VA 23233
Board Room 3**

- CALL TO ORDER:** The meeting was called to order at 8:45 a.m.
- PRESIDING:** Martha C. Cutright, D.D.S., Chair
- MEMBERS PRESENT:** Jeffrey Levin, D.D.S.
- STAFF PRESENT:** Sandra K. Reen, Executive Director for the Board
- QUORUM:** All members were present.
- APPROVAL OF MINUTES:** Not addressed.
- NOMINATIONS:** Dr. Cutright advised that nominations were needed for the offices of president, vice-president and secretary/treasurer for election during the September 7, 2012 Board meeting. Following a discussion of eligible members, Dr. Levin moved to nominate Dr. Boyd for president, Dr. Levin for vice-president and Dr. Cutright, D.D.S. for secretary/treasurer. The motion was seconded and carried unanimously.
- ADJOURNMENT:** With all business concluded, the Committee adjourned at 8:53 a.m.

Martha C. Cutright, D.D.S., Chair

Sandra K. Reen, Executive Director

Date

Date

UNAPPROVED - DRAFT

BOARD OF DENTISTRY
NEW MEMBER ORIENTATION

Friday, July 31, 2009

Department of Health Professions
9960 Mayland Drive, Suite 200
Richmond, Virginia

- CALL TO ORDER:** The meeting was called to order at 12:45 p.m.
- PRESIDING:** Sandra K. Reen, Executive Director
- MEMBERS PRESENT:** Herbert R. Boyd, III, D.D.S.
Martha C. Cutright, D.D.S.
- STAFF PRESENT:** Howard M. Casway, Sr. Asst. Attorney General
Alan Heaberlin, Deputy Executive Director
Huong Q. Vu, Administrative Assistant
- ORIENTATION:** Ms. Reen welcomed Dr. Boyd and Dr. Cutright to the Board and explained the composition of the Board. She reviewed the Board's structure and staffing. She then noted the various laws, regulations and documents in the member's reference handbook.
- Ms. Vu reviewed the state's policies on travel, per diems and reimbursement requests.
- Mr. Casway explained his role with the Board and discussed the powers and duties of health regulatory boards, the major provisions of the Dentistry Chapter of the **Code of Virginia**, the **Regulations Governing the Practice of Dentistry and Dental Hygiene**, the **Administrative Process Act** and the **Freedom of Information Act**.
- Mr. Heaberlin explained and discussed the disciplinary case process, the roles of Enforcement and APD, provided examples of notices and decision documents. He then walked through the Probable Cause Review form and discussed the information needed to close a case and to move a case forward for an advisory letter, confidential consent agreement, pre-hearing consent order or informal conference.
- ADJOURNMENT** The training was adjourned at 3:45 p.m.

Meera A. Gokli, D.D.S., President

Sandra K. Reen, Executive Director

Date

Date

UNAPPROVED - DRAFT

**BOARD OF DENTISTRY
NEW MEMBER ORIENTATION**

Friday, September 6, 2012

Department of Health Professions
9960 Mayland Drive, Suite 200
Richmond, Virginia

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- CALL TO ORDER:** The meeting was called to order at 9:10 p.m.
- PRESIDING:** Herbert R. Boyd, III, D.D.S., Secretary-Treasurer
- MEMBERS PRESENT:** Martha C. Cutright, D.D.S.
Jeffrey Levin, D.D.S.
Charles E. Gaskins, III, D.D.S.
Melanie C. Swain, R.D.H.
Tammy K. Swecker, R.D.H.
James D. Watkins, D.D.S.
- STAFF PRESENT:** Sandra K. Reen, Executive Director
Howard M. Casway, Sr. Asst. Attorney General
Kelley W. Palmatier, Deputy Executive Director
Huong Q. Vu, Operations Manager
- ORIENTATION:** Dr. Boyd welcomed Dr. Gaskins, Ms. Swain, Ms. Swecker, and Dr. Watkins to the Board and said he hopes everyone will enjoy being on the Board as much as he does.
- Ms. Reen explained the Board's three areas of work (Licensure, Regulation, and Discipline) and noted in response to a question that the Board does not have jurisdiction over anyone who has never been licensed by the Board.
- Mr. Casway explained his role as Board Counsel and discussed the powers and duties of health regulatory boards, the major provisions of the Dentistry Chapter of the **Code of Virginia**, the **Regulations Governing the Practice of Dentistry and Dental Hygiene**, the **Administrative Process Act** and the **Freedom of Information Act**. He noted that Guidance Documents have no force of law; that they are the Board's interpretation of what the current laws mean or require. He also discussed member responsibilities for:
- conducting proceedings,
 - avoiding conflicts of interest, and
 - directing questions or requests for assistance related to Board business to the executive director.
- Ms. Reen reviewed the Board's structure and staffing. She then noted the various laws, regulations and documents in the member's reference handbook. She added that the Bylaws do not contemplate the current situation with officers so they will need to be revised.
- Ms. Palmatier explained and discussed the disciplinary case process and the roles of Enforcement and APD. She then walked through the Probable Cause Review form and discussed the information needed to

close a case and to move a case forward for an advisory letter, confidential consent agreement, pre-hearing consent order or informal conference. She also reviewed the laminated guides staff prepared on case reviews, probable cause decisions and disciplinary action. She encouraged members to use the guides to help them work through their assigned cases and to call the assigned case manager or her if they have any questions about a case.

Ms. Reen asked if there were any questions about the formal hearing then explained that formal hearings are scripted so members are prompted by the presiding officer at appropriate times to ask questions and that discussion of the case is done in closed session.

ADJOURNMENT

The training was adjourned at 12:10 p.m.

Herbert R. Boyd, III, D.D.S., President

Sandra K. Reen, Executive Director

Date

Date

**VIRGINIA BOARD OF DENTISTRY
MINUTES
MARCH 7, 2013**

TIME AND PLACE: The meeting of the Board of Dentistry was called to order at 11:10 a.m. on March 7, 2013, in Board Room 4, Department of Health Professions, 9960 Mayland Drive, Suite 201, Henrico, Virginia.

PRESIDING: Herbert R. Boyd, III, D.D.S., President

**BOARD MEMBERS
PRESENT:**

Martha C. Cutright, D.D.S.
Surya P. Dhakar, D.D.S.
Charles E. Gaskins, III, D.D.S.
Jeffrey Levin, D.D.S.
Melanie C. Swain, R.D.H.
Tammy K. Swecker, R.D.H.
James D. Watkins, D.D.S.

**BOARD MEMBERS
ABSENT:**

Myra Howard, Citizen Member
Evelyn M. Rolon, D.M.D.

STAFF PRESENT:

Sandra K. Reen, Executive Director for the Board
Elaine J. Yeatts, DHP Senior Policy Analyst
Kelley Palmatier, Deputy Executive Director for the Board
Huong Vu, Operations Manager for the Board

OTHERS PRESENT:

Howard M. Casway, Senior Assistant Attorney General

**ESTABLISHMENT OF
A QUORUM:**

With eight members of the Board present, a quorum was established.

CONFLICT TRAINING:

Mr. Casway provided training for Board members on appearance and conflict issues which addressed the following topics:

- Be fair and impartial;
- Avoid appearance of impropriety and actual conflicts;
- Be concerned about public perceptions and always be mindful that the Board protects the public;
- All Board business must take place in public forums;
- Participate and facilitate decisions;
- Once the Board votes, all members should support the Board's decision;

- Do not represent that you speak for the Board unless the Board has specifically authorized your representation;
- Board discussion, activities, and actions should be carefully documented for future reference and public accountability;
- Possible conflicts are financial, personal, or informational in nature;
- Be familiar with the Board's basic law and regulations and consistently uphold them; and
- Prepare by reading agenda materials and case documents.

Mr. Casway took questions and then closed by saying that members should ask the executive director or board counsel for guidance when questions about conduct or conflicts arise. He added that deferring to the executive director to respond to policy and process questions from colleagues or the public was always advisable.

REVIEW OF ADA GUIDELINES FOR CONSCIOUS/MODERATE SEDATION CE TRAINING AND THE BOARD'S REGULATORY REQUIREMENTS:

Ms. Reen stated that the following presentations on the "ADA Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry" and the Board's regulatory history for sedation are being provided to lay the foundation for the Board providing guidance on the management of applications for enteral conscious/moderate sedation permits where course content is in question. She noted that the question affects about 30 permit holders and about 28 pending permit applications. The Board's guidance will assist her and the Credentials Committee in addressing the applications and permit holders.

Ms. Yeatts reviewed the definitions and standards for enteral sedation courses in the 2005, 2007, and 2012 ADA Guidelines. Ms. Reen reviewed the Board's regulatory provisions from 1984 to the present. She pointed out that the regulations adopted June 29, 2005, required dentists administering anesthesia or sedation to meet the 2005 education requirements by June 28, 2006.

By consensus, the Board decided that in order to be accepted, verifications must document compliance with the ADA guidelines as follows:

- Courses taken prior to November 1, 2007, must meet or exceed the 2005 Guidelines for an intensive course in "Enteral and/or Combination inhalation-Enteral Conscious Sedation (Combined Sedation)" – not less than 18 hours of instruction, plus 20 clinically-oriented experiences. Hands-on clinical participation is required.

- Courses taken on or after November 1, 2007, must meet or exceed the 2007 Guidelines for a competency course in “Moderate Enteral Sedation” – not less than 18 hours of didactic instruction, plus 20 clinically-oriented experiences, including at least three live clinical dental experiences and 17 additional experiences.
- Courses taken on or after November 1, 2012, must meet or exceed the October 2012 Guidelines for a competency course in “Moderate Enteral Sedation” – not less than 18 hours of didactic instruction, plus 20 clinically-oriented experiences, including at least three live clinical dental experiences and 17 additional experiences.

APPLICATIONS FOR ENTERAL CONSCIOUS/SEDATION PERMITS:

Closed Meeting: Dr. Gaskins moved that the Board convene a closed meeting pursuant to Section 2.2-3711(A)(7) of the *Code of Virginia* for consultation and the provision of legal advice to consider applications for Enteral Conscious/Moderate Sedation Permits. Additionally, Dr. Gaskins moved that Board Counsel, Howard Casway, and Board staff - Ms. Reen, Ms. Palmatier, and Ms. Vu - attend the closed meeting because their presence in the closed meeting is deemed necessary and will aid the Board in its deliberations. The motion was seconded and passed.

Reconvene: Dr. Gaskins moved that the Board certify that it heard, discussed or considered only public business matters lawfully exempted from open meeting requirements under the Virginia Freedom of Information Act and only such public business matters as were identified in the motion by which the closed meeting was convened. The motion was seconded and passed.

Ms. Swecker moved that any current enteral conscious/moderate sedation permit holder and applicant who may not satisfy the applicable Board regulations and “ADA guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry” shall be notified of the deficiencies. The affected applicants and permit holders may become compliant by completion of a course that satisfies the 2012 ADA Guidelines. Another option is a request to appear before the Credentials Committee or an agency subordinate to address their qualifications. The motion was seconded and passed.

ADJOURNMENT: With all business concluded, the meeting was adjourned at 5:30 p.m.

Herbert R. Boyd, III, D.D.S., President

Sandra K. Reen, Executive Director

Date

Date

**VIRGINIA BOARD OF DENTISTRY
MINUTES
MARCH 8, 2013**

TIME AND PLACE: The meeting of the Board of Dentistry was called to order at 9:03 a.m. on March 8, 2013, in Board Room 4, Department of Health Professions, 9960 Mayland Drive, Suite 201, Henrico, Virginia.

PRESIDING: Herbert R. Boyd, III, D.D.S., President

**BOARD MEMBERS
PRESENT:**

Martha C. Cutright, D.D.S.
Surya P. Dhakar, D.D.S.
Charles E. Gaskins, III, D.D.S.
Myra Howard, Citizen Member
Jeffrey Levin, D.D.S.
Melanie C. Swain, R.D.H.
Tammy K. Swecker, R.D.H.
James D. Watkins, D.D.S.

**BOARD MEMBERS
ABSENT:**

Evelyn M. Rolon, D.M.D.

STAFF PRESENT:

Sandra K. Reen, Executive Director for the Board
Dianne L. Reynolds-Cane, M.D., DHP Director
Elaine J. Yeatts, DHP Senior Policy Analyst
Kelley Palmatier, Deputy Executive Director for the Board
Huong Vu, Operations Manager for the Board

OTHERS PRESENT:

Howard M. Casway, Senior Assistant Attorney General

**ESTABLISHMENT OF
A QUORUM:**

With nine members of the Board present, a quorum was established.

PUBLIC COMMENT:

None

**APPROVAL OF
MINUTES:**

Dr. Boyd asked if the Board members had reviewed the December 6, 2012 Formal Hearing minutes. Dr. Watkins moved to accept the minutes. The motion was seconded and carried.

Dr. Boyd asked if the Board members had reviewed the December 7, 2012 Business minutes. Dr. Gaskins noted that in the section addressing 18VAC60-20-107 the one vote "against" should be change to "*abstaining*." By consensus, the Board agreed. Dr.

Gaskins moved to accept the minutes as amended. The motion was seconded and carried.

Dr. Boyd asked if the Board members had reviewed the January 16, 2013 and February 14, 2013 Telephone Conference Call minutes. Dr. Gaskins moved to accept these minutes. The motion was seconded and carried.

**DHP DIRECTOR'S
REPORT:**

Dr. Cane reported that three (3) agency bills were passed this year:

- HB 1791 on suspension of license, registration or certificate by a health regulatory agency.
- HB 2136 on adding methasterone and prostanazol to the Schedule III controlled substances list.
- SB 950 on updating terminology of practice of medicine and other healing arts.

Dr. Cane added that she plans to attend the National Governors Association Conference next week to discuss reducing prescription drug abuse. She stated that the four areas on the agenda are monitoring, education training, disposal, and enforcement. She noted that DHP was the lead in the plan, and Virginia was granted \$45,000 for this project.

**LIAISON/COMMITTEE
REPORTS:**

Board of Health Professions (BHP). Dr. Levin stated that no meeting has been held since his last report.

AADB. Dr. Levin stated that the Mid-Year meeting is being held in April 2013, and the Board plans to send a representative.

ADEX. Dr. Cutright stated that the draft ADEX report is in the agenda package. She noted that Virginia was inadvertently omitted in the listing of attendees, but the final report will reflect her attendance.

SRTA. Dr. Watkins reported that SRTA's experience with transitioning to the ADEX exam format is favorable.

Examination Committee. Dr. Cutright noted that the Committee did not meet yesterday but will meet today after the business meeting.

Executive Committee. Dr. Boyd reported that the Committee met yesterday to revise the current Bylaws, which are presented for Board consideration and action. Dr. Levin moved to accept the amended Bylaws. The motion was seconded and passed.

LEGISLATION AND REGULATIONS:

Report of 2013 General Assembly. Ms. Yeatts reported the following bills were passed:

- HB 1349 on definition and licensure of dental hygiene and dental hygienist
- HB 1422 on requirements for pharmacists to dispense interchangeable biosimilar biological products.

Status Report on Regulatory Actions. Ms. Yeatts reported the following:

- Sedation and Anesthesia permits for dentists - The proposed final regulations are at the Department of Planning and Budget for review. The emergency regulations will expire on September 13, 2013. The Board may need to request a six-month extension at the next meeting.
- Periodic Review – The proposed regulations to establish four chapters have been at the Secretary's Office for 277 days.

Correction of a Code citation and a term. Ms. Yeatts stated that this is presented for Board action because the Code referenced in 18VAC60-20-220(B) should be "54.1-2722," and the term used in 18VAC60-20-220(D) should be "dental."

Dr. Levin moved to adopt the amendments as presented, as an action exempt from the Administrative Process Act requirements. The motion was seconded and passed.

Response to Petition for Rulemaking from AADH. Ms. Yeatts stated that the petition to be added to the list of approved CE sponsors, submitted by the American Academy of Dental Hygiene (AADH), is presented for Board action.

She added that, if the Board accepts the petition, she recommends using the fast-track action regulatory process. She noted that if the Board rejects the petition, it must state its reason for denial.

Ms. Swecker moved to accept the AADH petition and to take fast-track action to amend the regulation. The motion was seconded and passed.

BOARD DISCUSSION/ACTION:

Review of Public Comment Topics. Ms. Reen noted that there were written comments to consider.

Ms. Reen stated that Joy Sylvester-Johnson, Rescue Mission CEO, requests that the Board undertake a legislative initiative for

establishing a provisional license for international dentists who are not licensed in Virginia to practice in free clinic and community health center operations under the mentorship of a certified dentist. Dr. Gaskins moved to reject the proposed request. The motion was seconded and passed.

Ms. Reen advised the Board to defer discussion of Dr. Griffin's concern about the EKG requirement until the public comment period for the proposed final regulations is closed.

Ms. Reen stated that the comment from Mr. Price is provided to make the Board aware that he is asking his state representatives to address his concerns about the work of the Board.

Ms. Reen stated that she is requesting guidance on the response to be given to Dr. Dameron, who asks if he is required to have both a laryngeal mask airway and a laryngoscope as stated in 18VAC60-20-120.1.3 of the Emergency Regulations for Sedation and Anesthesia permits. Dr. Levin suggested that both should be required, and the Board agreed by consensus.

CITA Exam. Dr. Watkins stated that NC Board only accepts the CITA exam, while VA accepts all regional clinical exams. He added that VA graduates cannot be licensed in NC if they do not take the CITA exam. He noted that it is unfair for graduates who live near the adjoining border and asked the Board to request that the NC Board address this inequity.

Ms. Reen commented that the Board sent this request to the NC Board about a year ago, and no response has been received. Dr. Watkins asked if the Board should send another letter to NC Board. Dr. Boyd referred this matter to the Examination Committee for further discussion.

REPORT ON CASE ACTIVITY:

Ms. Palmatier reported that in the second quarter of FY2013 the Board received a total of 77 patient care cases and closed a total of 60 for a 78% clearance rate. She added that the current caseload older than 250 days is 25%, and 90% of all cases were closed within 250 business days. She advised that the Board did not meet the agency's performance goals. She added that for the month of December 2012, the Board received 28 cases and closed 42, mostly as a result of the "blitz" that we had on December 6, 2012. She hoped that the Board members will continue with case review on dates when administrative hearings are scheduled until the board no longer has a backlog.

**BOARD COUNSEL
REPORT:**

Mr. Casway stated that he has nothing to report.

**EXECUTIVE
DIRECTOR'S
REPORT/BUSINESS:**

Sanctioning for Billing Practice Violations. Ms. Reen stated that the Policy on Sanctioning for Failure to Comply with Insurance and Billing Practices is presented for Board consideration and action. This policy is developed as a Guidance Document through which the Board delegates to its executive director the authority to make decisions on cases with only billing issues. She added that the proposal is consistent with the guidance documents on advertising and continuing education. Discussion followed about reporting fraudulent activity to the police for criminal prosecution. It was noted that the Enforcement Division does coordinate investigations with law enforcement agencies.

Dr. Gaskins moved to adopt the guidance document. The motion was seconded and passed.

Board minutes. Ms. Reen asked the Board and Mr. Casway for guidance on keeping the minutes since board members have questions about the minutes. She reported that the requirements specified in the Freedom of Information Act are:

- Date, time, and location of meeting;
- Members of the public body recorded as present and absent;
- Summary of the discussion on matters proposed, deliberated or decided; and
- A record of any votes taken.

It was asked if the minutes should record who asked questions or made comments in the meeting. Mr. Casway said it is not necessary to state who said what, but the minutes should be a summary of the matters discussed. Ms. Reen said she would work to reduce the number of references to specific individuals and to be more concise. By consensus, the Board decided to keep minutes consistent with current practices.

Dr. Dhakar asked if it is permissible to vote against the decision reached in closed session when a special conference committee returns to open session. Mr. Casway responded that it is and that the minutes would need to reflect the number of yes votes and no votes.

**APPLICATIONS FOR
GENERAL
CONSCIOUS/SEDATION
PERMITS:**

Dr. Boyd announced that the Board met in closed session yesterday to receive legal advice on these applications. He read the adopted motion and then asked if anyone wanted to discuss this subject further. By consensus, the Board affirmed its motion and decided that no further discussion was needed.

**CASE
RECOMMENDATIONS: Case# 146265**

Closed Meeting: Dr. Levin moved that the Board convene a closed meeting pursuant to Section 2.2-3711(A)(27) of the *Code of Virginia* for the purpose of deliberation to reach decisions in the matters of Case # 146265. Additionally, Dr. Levin moved that Board staff, Ms. Reen, Ms. Vu, and Ms. Palmatier and Mr. Casway, Board Counsel, attend the closed meeting because their presence in the closed meeting is deemed necessary and will aid the Board in its deliberations.

Reconvene: Dr. Levin moved that the Board certify that it heard, discussed or considered only public business matters lawfully exempted from open meeting requirements under the Virginia Freedom of Information Act and only such public business matters as were identified in the motion by which the closed meeting was convened. The motion was seconded and passed.

Ms. Howard moved to accept the recommended Order of the Credentials Committee for Case # 146265. The motion was seconded and passed.

ADJOURNMENT: With all business concluded, the meeting was adjourned at 11:15 a.m.

Herbert R. Boyd, III, D.D.S., President

Sandra K. Reen, Executive Director

Date

Date

UNAPPROVED

VIRGINIA BOARD OF DENTISTRY

MINUTES

SPECIAL SESSION - TELEPHONE CONFERENCE CALL

- CALL TO ORDER:** The meeting of the Board of Dentistry was called to order at 5:20 p.m., on April 2, 2013, at the Department of Health Professions, Perimeter Center, 2nd Floor Conference Center, 9960 Mayland Drive, Henrico, Virginia 23233.
- PRESIDING:** Jeffrey Levin, D.D.S., Vice-President
- MEMBERS PRESENT:** Martha C. Cutright, D.D.S.
Surya P. Dhakar, D.D.S.
Charles E. Gaskins, III, D.D.S.
Evelyn M. Rolon, D.M.D.
Melanie C. Swain, R.D.H.
James D. Watkins, D.D.S.
- MEMBERS ABSENT:** Herbert R. Boyd, III, D.D.S.
Myra Howard
Tammy K. Swecker, R.D.H.
- QUORUM:** With seven members present, a quorum was established.
- STAFF PRESENT:** Kelley W. Palmatier, Deputy Executive Director
Indy Toliver, Adjudication Specialist
Donna Lee, Discipline Case Manager
- OTHERS PRESENT:** Howard Casway, Senior Assistant Attorney General
Corie Wolf, Assistant Attorney General
- Demetrios Milonas, DDS
Case Nos.: 145092 and
147805** The Board received information from Ms. Wolf regarding a Consent Order signed by Dr. Milonas for the resolution of his case in lieu of proceeding with the formal hearing.
- DECISION:** Dr. Gaskins moved that the Board adopt the Consent Order pertaining to Dr. Milonas as presented. The motion was seconded and passed unanimously.
- ADJOURNMENT:** With all business concluded, the Board adjourned at 5:27 p.m.

Jeffrey Levin, D.D.S., Vice-President

Sandra K. Reen, Executive Director

Date

Date

UNAPPROVED

VIRGINIA BOARD OF DENTISTRY

MINUTES

SPECIAL SESSION - TELEPHONE CONFERENCE CALL

CALL TO ORDER: The meeting of the Board of Dentistry was called to order at 5:18 p.m., on April 24, 2013, at the Department of Health Professions, Perimeter Center, 2nd Floor Conference Center, 9960 Mayland Drive, Henrico, Virginia 23233.

PRESIDING: Herbert R. Boyd, III, D.D.S.

MEMBERS PRESENT: Martha C. Cutright, D.D.S.
Jeffrey Levin, D.D.S.
Evelyn M. Rolon, D.M.D.
Melanie C. Swain, R.D.H.
Tammy K. Swecker, R.D.H.
James D. Watkins, D.D.S.

MEMBERS ABSENT: Surya P. Dhakar, D.D.S.
Charles E. Gaskins, III, D.D.S.
Myra Howard

QUORUM: With seven members present, a quorum was established.

STAFF PRESENT: Sandra K. Reen, Executive Director
Lorraine McGehee, Deputy Director, Administrative Proceedings Division
Indy Toliver, Adjudication Specialist
Donna Lee, Discipline Case Manager

OTHERS PRESENT: Howard M. Casway, Senior Assistant Attorney General
James Schliessmann, Assistant Attorney General

**Gregory Hughes, D.D.S.
Case Nos.: 148248 and
150066** The Board received information from Mr. Schliessmann in order to determine if Dr. Hughes' impairment from mental illness constitutes a substantial danger to public health and safety. Mr. Schliessmann reviewed the case and responded to questions.

Closed Meeting: Ms. Swecker moved that the Committee convene a closed meeting pursuant to § 2.2-3711(A)(27) of the Code of Virginia for the purpose of deliberation to reach a decision in the matter of Gregory Hughes. Additionally, Ms. Swecker moved that Ms. Reen, Mr. Casway and Ms. Lee attend the closed meeting because their presence in the closed meeting is deemed necessary and their presence will aid the Committee in its deliberations. The motion was seconded and passed.

Reconvene: Ms. Swecker moved that the Committee certify that it heard, discussed or considered only public business matters lawfully exempted from open meeting requirements under the Virginia Freedom of Information Act and only such public business matters as were identified in the motion by

which the closed meeting was convened. The motion was seconded and passed.

DECISION:

Dr. Levin moved that the Board summarily suspend Dr. Hughes' right to renew his license to practice dentistry in the Commonwealth of Virginia in that he is unable to practice dentistry safely due to impairment resulting from mental illness, and schedule him for a formal hearing. Following a second and discussion, a roll call vote was taken. The motion passed unanimously.

Dr. Levin moved that the Board offer a consent order to Dr. Hughes that would accept the voluntary permanent surrender of his privilege to renew or reinstate his license to practice dentistry in the Commonwealth of Virginia. Following a second and discussion, a roll call vote was taken. The motion passed unanimously.

ADJOURNMENT:

With all business concluded, the Board adjourned at 5:52 p.m.

Herbert R. Boyd, III, D.D.S., President

Sandra K. Reen, Executive Director

Date

Date

**VIRGINIA BOARD OF DENTISTRY
FORMAL HEARING
June 6, 2013**

TIME AND PLACE: The meeting of the Virginia Board of Dentistry was called to order at 9:20 a.m., on June 6, 2013 in Board Room 4, Department of Health Professions, 9960 Mayland Drive, Suite 201, Henrico, Virginia.

PRESIDING: Herbert R. Boyd, III, D.D.S., President

MEMBERS PRESENT: Martha C. Cutright, D.D.S.
Surya P. Dhakar, D.D.S.
Evelyn M. Rolon, D.M.D.
Melanie C. Swain, R.D.H.
Tammy K. Swecker, R.D.H.

MEMBERS EXCUSED: Charles E. Gaskins, III, D.D.S
Jeffrey Levin, D.D.S.
James D. Watkins, D.D.S.

MEMBER ABSENT: Myra Howard, Citizen Member

STAFF PRESENT: Sandra K. Reen., Executive Director
Huong Q. Vu, Operations Manager

COUNSEL PRESENT: Howard M. Casway, Senior Assistant Attorney General

OTHERS PRESENT: Wayne T. Halbleib, Senior Assistant Attorney General
Indy Toliver, Adjudication Specialist
Denise Holt, Court Reporter, Crane-Snead & Associates, Inc.

ESTABLISHMENT OF A QUORUM: With six members present, a quorum was established.

**Sam E. English, D.D.S.
Case No.: 132888 and
137309**

Dr. English appeared with counsel, Joseph D. Morrissey, in accordance with a Notice of the Board dated November 6, 2012.

Mr. Morrissey asked the Board to convene a closed meeting to discuss settlement. The request was granted.

Closed Meeting: Dr. Cutright moved that the Board enter into a closed meeting pursuant to §2.2-3711(A)(27) and Section 2.2-3712(F) of the Code of Virginia to consider settlement in the matter of Dr.

English. Additionally, it was moved that Board staff, Ms. Reen, Ms. Vu, Board counsel, Mr. Casway, Dr. English, Mr. Morrissey, Mr. Goldman, Mr. Halbleib, and Ms. Toliver attend the closed meeting because their presence in the closed meeting was deemed necessary and would aid the Board in its deliberations. The motion was seconded and passed.

Reconvene:

Dr. Cutright moved to certify that only public matters lawfully exempted from open meeting requirements under Virginia law were discussed in the closed meeting and only public business matters as were identified in the motion convening the closed meeting were heard, discussed or considered by the Board. The motion was seconded and passed.

The Board reconvened in open session pursuant to § 2.2-3712(D) of the Code.

Closed Meeting:

Dr. Cutright moved that the Board enter into a closed meeting pursuant to §2.2-3711(A)(27) and Section 2.2-3712(F) of the Code of Virginia to consider settlement in the matter of Dr. English. Additionally, it was moved that Board staff, Ms. Reen, Ms. Vu, and Board counsel, Mr. Casway to attend the closed meeting because their presence in the closed meeting was deemed necessary and would aid the Board in its deliberations. The motion was seconded and passed.

Reconvene:

Dr. Cutright moved to certify that only public matters lawfully exempted from open meeting requirements under Virginia law were discussed in the closed meeting and only public business matters as were identified in the motion convening the closed meeting were heard, discussed or considered by the Board. The motion was seconded and passed.

The Board reconvened in open session pursuant to § 2.2-3712(D) of the Code.

Decision:

Dr. Boyd reported that in lieu of holding the formal hearing, Dr. English and the Board have agreed to a Consent Order which requires that Dr. English be:

- assessed an \$18,000.00 monetary penalty and
- placed on INDEFINITE PROBATION subject to the following terms and conditions:
 1. Completion of continuing education consisting of 14 hours in practice management, 7 hours in ethics, and 7 hours in recordkeeping and risk management;
 2. Obtaining a financial audit of patient transactions by an independent certified forensic accountant; and
 3. restitution in full on the accounts of Patients A-M.

Ms. Swecker moved to adopt the agreed to Findings of Fact and Conclusions of Law and the Sanctions as read by Dr. Boyd. The motion was seconded and passed.

ADJOURNMENT: The Board adjourned at 1:15 p.m.

Herbert R. Boyd, III, D.D.S., President

Sandra K. Reen, Executive Director

Date

Date

**VIRGINIA BOARD OF DENTISTRY
CASE RECOMMENDATION
June 6, 2013**

- TIME AND PLACE:** The meeting of the Virginia Board of Dentistry was called to order at 12:45 p.m., on June 6, 2013 in Board Room 4, Department of Health Professions, 9960 Mayland Drive, Suite 201, Henrico, Virginia.
- PRESIDING:** Herbert R. Boyd, III, D.D.S., President
- MEMBERS PRESENT:** Martha C. Cutright, D.D.S.
Surya P. Dhakar, D.D.S.
Evelyn M. Rolon, D.M.D.
Melanie C. Swain, R.D.H.
Tammy K. Swecker, R.D.H.
- MEMBERS EXCUSED:** Charles E. Gaskins, III, D.D.S
Jeffrey Levin, D.D.S.
James D. Watkins, D.D.S.
- MEMBER ABSENT:** Myra Howard, Citizen Member
- STAFF PRESENT:** Sandra K. Reen., Executive Director
Huong Q. Vu, Operations Manager
- COUNSEL PRESENT:** Howard M. Casway, Senior Assistant Attorney General
- ESTABLISHMENT OF A QUORUM:** With six members present, a quorum was established.
- CASE RECOMMENDATIONS:** **Case# 148819, #149148, #149643, #149644, and # 149976**
- Closed Meeting:** Dr. Cutright moved that the Board convene a closed meeting pursuant to Section 2.2-3711(A)(27) of the *Code of Virginia* for the purpose of deliberation to reach decisions in the matters of Case # 148819, #149148, #149643, #149644, and # 149976. Additionally, Dr. Cutright moved that Board staff, Ms. Reen, Ms. Vu, and Mr. Casway, Board Counsel, attend the closed meeting because their presence in the closed meeting is deemed necessary and will aid the Board in its deliberations.
- Reconvene:** Dr. Cutright moved that the Board certify that it heard, discussed or considered only public business matters lawfully exempted from open meeting requirements under the Virginia Freedom of

Information Act and only such public business matters as were identified in the motion by which the closed meeting was convened. The motion was seconded and passed.

Ms. Swecker moved to accept the recommended Orders of the Credentials Committee for Case # 148819, #149148, #149643, #149644, and # 149976. The motion was seconded and passed.

ADJOURNMENT: The Board adjourned at 1:00 p.m.

Herbert R. Boyd, III, D.D.S., President

Sandra K. Reen, Executive Director

Date

Date

UNAPPROVED - DRAFT

**BOARD OF DENTISTRY
NEW MEMBER ORIENTATION**

Friday, July 26, 2013

Department of Health Professions
9960 Mayland Drive, Suite 200
Richmond, Virginia

-
- CALL TO ORDER:** The meeting was called to order at 9:51 a.m.
- PRESIDING:** Jeffrey Levin, D.D.S., Interim President
- MEMBERS PRESENT:** Al Rizkalla, D.D.S.
Bruce S. Wyman, D.M.D.
- STAFF PRESENT:** Sandra K. Reen, Executive Director
Kelley W. Palmatier, Deputy Executive Director
Huong Q. Vu, Operations Manager
- ORIENTATION:** Dr. Levin welcomed Dr. Rizkalla and Dr. Wyman to the Board and said he is currently serving as the interim President. He added that the Board will hold officer elections at its September meeting. He commented that it is an honor to serve as a Board member and noted that there is a steep learning curve. He stated that when there is a question about anything it is best to contact Board staff. He then reviewed the Bylaws and the Code of Conduct for Members and Ms. Reen explained the information in the Board of Dentistry binder.
- Ms. Vu reviewed the state's policies on travel, per diems and conflict of interest training.
- Ms. Reen stated that being a Board member is a prestigious position but it does not include individual privileges because the Board speaks as a body. She added that she is the spokesperson for the Board and asked the new members to direct questions and requests for assistance related to Board business to her. She then explained the Board's three areas of work; licensure, regulation, and discipline. She gave an overview of the Board's structure, staffing, and memberships in SRTA and ADEX as well as its participation in AADB meetings. She indicated that serving as an examiner is optional.
- Ms. Palmatier explained and discussed the disciplinary case process and the roles of Enforcement and APD. She then walked through the Probable Cause Review form and discussed the information needed to close a case and to move a case forward for an advisory letter, confidential consent agreement, pre-hearing consent order or informal conference. She also reviewed the laminated guide staff prepared on case reviews, probable cause decisions and disciplinary action. She encouraged the new members to use it to help them work through their cases and urged them to call the assigned case manager or her if they have any questions about a case.
- ADJOURNMENT** The training was adjourned at 4:00 p.m.

**Virginia Board of Dentistry
New Member Orientation
July 26, 2013**

2

Jeffrey Levin, D.D.S., Interim President

Sandra K. Reen, Executive Director

Date

Date

The **American Association of Dental Boards (AADB)** held its Mid-Year Meeting in Chicago on April 21 and 22, 2013. The main topic and focus of the meeting was on Maintenance of Licensure, otherwise known as “continued competency”.

Much of the discussion centered on the need for determining continued competency and the charge and role of the different State Boards in protecting the public through some form of maintenance of licensure of the Boards’ licensees. There was not much doubt that this is an area that must be brought out of the political arena and something positive be done in the near future or else we will be faced with some likely undesired form of maintenance of licensure forced on us from outside of our profession.

Many, if not all, of the specialty licensure groups have some form of maintaining the specialists’ certification of board certified status. Most call for recertification at least every ten years through various forms of recertification and testing.

It was pretty much agreed that the responsibility of the state boards was to protect the public and that is accomplished through the regulation of licensees which is typically done through the use of three different tools. Initial competency of new graduates is accomplished through various clinical regional exams. Secondly, licensees that are the subject of a complaint undergo disciplinary investigations and if found at fault, actions can be taken against the licensee that can include mandated continuing education hours. Lastly, continuing education hours are required in many states to renew a license.

However, a big concern in the area of continuing education hours is that merely attending or completing a continuing education course does not assure knowledge transfer and therefore competency or remediation of the licensee unless a pre-test and a post-test are taken and passed. This is also true of licensees that are taking continuing education course as part of a Board Order Sanction.

I would urge the Board to discuss and consider some form of maintenance of licensure or continued competency. I would also ask each of you to visit the American Association of Dental Boards website at www.dentalboards.org. Once on the website look on the upper tool bar to the left handside of the screen for a tab labeled “Meetings”. If you click on that tab, you can scroll down to the Mid-Year Meeting for 2013 that I attended and all of the powerpoint presentations from the meeting are

there online for you to review. I found the presentations to be very informative and enlightening. I hope each of you will take a few minutes to review them and begin a discussion. I realize that this is a hot topic and will stir our licensees into a frenzy. However, in my opinion, that situation could be handled by grandfathering all current licensees under the current method of maintenance of licensure, completing the required continuing education requirements for renewal while at the same time fulfilling our charge of protecting the public.

**REPORT OF THE SRТА DENTAL EXAMINATION COMMITTEE AT 2013 SRТА ANNUAL MEETING
BY: DR. JAMES WATKINS**

The Dental Examination committee met on Thursday, August 8, 2013 at the Francis Marion Hotel in Charleston, SC with the dental educators, SRТА members, and guests from ADEX, NERB and the University of Alabama. Concerns and suggestions from the entire group were discussed. From that discussion, the following recommendations were made and are supported by the dental examination committee:

RECOMMENDATIONS TO THE ADEX EXAMINATION COMMITTEE FOR 2015

1. For the Periodontal Scaling section, if a candidate does not have enough calculus, instead of having the candidate continue with the procedure with no chance of passing, it is suggested that the candidate receive a penalty for misdiagnosis and be allowed one more selection on the same patient or allow a second patient.

2. Change the time allowed for the Fixed Prosthodontic section from 4 hours to 3 hours.

3. For #4 of the ADEX Exam committee changes for 2014, change "may not" to "can not".

"4. Recommend scoring anterior and posterior Restorative procedures separately. If a candidate passes the first procedure and fails the second, then the candidate only needs to retake the second procedure. If the candidate fails the first procedure, he/she MAY NOT proceed to the second procedure and will need to retake both procedures."

RECOMMENDATIONS FOR THE ADEX DENTAL EXAM FOR 2014

1. Add to the candidate manual:

a. Any shroud is acceptable

b. Frequently Asked Questions

c. Illustration of correctly completed Modification form

d. Description for "remaining calculus" for the Periodontal Scaling section.

2. Increase the number of examiners, chiefs, and captains assigned per exam site, depending on the number of anticipated candidates. Also, be aware of the number of chairs available in the scoring area and auxiliary runners needed.

3. Require CFE's to check modification request forms before sending the patient to the express chair.

FYI: VCU had 107 dental graduates take the SRТА exam and 83 passed on the first attempt, 20 passed on the second attempt and 2 passed on the third attempt; which leaves two who had not yet passed. Therefore, 98% of the VCU graduates passed the SRТА exam in 2013 (through 7-31-2013).

DATES FOR THE SRТА EXAMINATION SITES WERE PRESENTED TO COMMITTEE MEMBERS. (see attached)

PROPOSED AMENDMENTS TO THE SRТА BYLAWS FOR 2013 FROM THE BYLAWS COMMITTEE WERE VOTED ON AT THE GENERAL ASSEMBLY MEETING ON SATURDAY, AUGUST 10. (see attached)

THE 2014 SRТА ANNUAL MEETING WILL BE HELD AT EMBASSY SUITES, KINGSTON PLANTATION IN MYRTLE BEACH, SC. THE DATES ARE AUGUST 7-10, 2014.

A CAPTAINS AND CHIEFS TRAINING MEETING IS TENTATIVELY BEING PLANNED FOR JANUARY 9-11, 2014 IN FT. LAUDERDALE.

Proposed amendments to the SRTA Bylaws for 2013 from the Bylaws Committee and approved by the Board of Directors

Page 10 ARTICLE V - BOARD OF DIRECTORS, SECTION 4. DUTIES

M. The Board of Directors shall have the power to appoint Exchange Examiners, who are examiners from other dental or dental hygiene testing agencies, to serve for a period of one year. Examiners from other testing agencies wishing to serve as an Exchange Examiner must make application to the Board of Directors. Applicants must meet requirements set forth in these bylaws, Article VIII, Section 5, B, and be recommended to the Board of Directors by the state board of dentistry where they are currently licensed.

Page 17 ARTICLE VIII - EXAMINATIONS - CANDIDATES AND EXAMINERS

SECTION 1. DENTAL STUDENTS

- A. Dental candidates are eligible for the clinical test when the dean or his/her designated person, of a dental school accredited by the Commission on Dental Accreditation of the American Dental Association certifies that the candidate is eligible and is in the last semester of for the D.D.S. or D.M.D. degree requirements and will complete the degree requirements by August 31 of the current year, if the candidate is applying to take an examination between January 1 and August 31, or by January 31 of the following year if the candidate is applying to take an examination between September 1 and December 31 and will receive that degree within 18 months of the examination date.**
- B. Failure to complete the degree requirements within the approved timeframe shall invalidate the candidate's examination results.**
- C. The candidate must show proof of current malpractice insurance covering his or her participation in the SRTA examinations.**
- D. A candidate may apply to retake each failed or incomplete section of the examination during the following available examination period. A candidate may attempt each examination section up to three (3) times during the eighteen (18) months after the date he/she took the first section. After three failures of any one section, the entire examination must be retaken.**

SECTION 2. DENTISTS

- A. A dentist who has graduated from a dental school accredited by the Commission on Dental Accreditation of the American Dental Association at the time that he or she received the D.D.S. or D.M.D. degree; or who is individually approved by the participating board, is eligible for the clinical tests on the condition that the person has conducted himself or herself in a professional and ethical manner.**
- B. The candidate must show proof of current malpractice insurance covering his or her participation in the SRTA examination.**
- C. A candidate may apply to retake each failed or incomplete section of the examination during the following available examination period. A candidate may attempt each examination section up to three (3) times during the eighteen (18) months after the date he/she took the first section. After three failures of any one section, the entire examination must be retaken.**

SECTION 3. DENTAL HYGIENE STUDENTS

- A. Dental hygiene candidates are eligible for the ^{EXAMINATION}clinical test during the final quarter or semester of their dental hygiene program and when the director or administrator from the dental hygiene program accredited by the Commission**

on Dental Accreditation of the American Dental Association certifies that the candidate is eligible, ~~is in the final semester of the degree or certification program, and will complete for the degree or certificate . by August 31 of the current year, if the candidate is applying to take an examination between January 1 and August 31, or by January 31 of the following year if the candidate is applying to take an examination between September 1 and December~~

- B. Failure to complete the degree or certificate requirements within twelve (12) months of the examination shall invalidate the candidate's examination results.
- C. The candidate shall show proof of current malpractice insurance covering his or her participation in the SRTA examination.

D. A candidate who fails the examination may apply to retake the examination at the next available testing site. A candidate may attempt the examination up to three (3) times during the ~~eighteen~~ ^{Twelve} ~~(18)~~ months following their first attempt.

SECTION 4. DENTAL HYGIENISTS

- A. A dental hygienist who has graduated from a dental hygiene program accredited by the Commission on Dental Accreditation of the American Dental Association, at the time that he or she received the degree, diploma or certificate, or who is individually approved by the participating board, is eligible for the clinical tests on the condition that the person has conducted himself or herself in a professional and ethical manner.
- B. The candidate must show proof of current malpractice insurance covering his or her participation in the SRTA examination.

C. A candidate may apply to retake the examination at the next available examination testing site. A candidate may attempt the examination up to three (3) times during the ~~eighteen~~ ^{Twelve} ~~(18)~~ months after the date he/she took the first examination.

SECTION 5. EXAMINERS

A. Dentists and dental hygienists who serve as examiners for SRTA must be graduates of CODA accredited dental schools or CODA accredited dental hygiene programs and must have successfully passed the National Board Dental Examinations or the National Board Dental Hygiene Examinations. Examiners shall include active and associate members of the Southern Regional Testing Agency and, in so far as possible, each participating board shall be represented at each examination site.

B. Exchange Examiners: Exchange Examiners are appointed by the Board of Directors for a period of one year. Exchange Examiners must meet the following requirements.

1. Be a licensed dentist or licensed dental hygienist, and
2. Be a graduate of a CODA accredited dental school or CODA accredited dental hygiene program, and
3. Have successfully passed the National Board Dental Examinations or the National Board Dental Hygiene Examinations, and
4. Be a current examiner for another dental or dental hygiene licensure testing agency, and
5. Be recommended to the SRTA Board of Directors by the state board of dentistry where he or she is currently licensed.
6. Complete and sign a Conflict of Interest agreement upon acceptance of an examination assignment.
7. Must be or have been a member of a state Board of Dentistry.

**SOUTHERN REGIONAL TESTING AGENCY
2014 DENTAL EXAMINATION DATES**

Dental Examiners,

Please indicate on the chart below which examinations you are available for in **2014** and for which position(s).
Please return this form by **August 31, 2013** to the SRTA office, attention Suzanne Porter

Fax 757-318-9085, Email sporter@srtta.org

This information will be sent to the Dental Examination Committee.

NAME: _____				
DATE	SITE	TYPE OF EXAM	AVAILABLE	POSITION (CHECK ALL THAT APPLIES)
JANUARY 31- FEBRUARY 1	WVU MORGANTOWN, WV	PIE I MANIKIN	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> EXAMINER <input type="checkbox"/> CHIEF <input type="checkbox"/> CFE CAPTAIN <input type="checkbox"/> CFE <input type="checkbox"/> SCORING CAPTAIN
JANUARY 31- FEBRUARY 1	MUSC CHARLESTON, SC	PIE I MANIKIN	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> EXAMINER <input type="checkbox"/> CHIEF <input type="checkbox"/> CFE CAPTAIN <input type="checkbox"/> CFE <input type="checkbox"/> SCORING CAPTAIN
FEBRUARY 14-15	UT MEMPHIS, TN	PIE I MANIKIN	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> EXAMINER <input type="checkbox"/> CHIEF <input type="checkbox"/> CFE CAPTAIN <input type="checkbox"/> CFE <input type="checkbox"/> SCORING CAPTAIN
FEBRUARY 14-15	UK LEXINGTON, KY	PIE I MANIKIN	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> EXAMINER <input type="checkbox"/> CHIEF <input type="checkbox"/> CFE CAPTAIN <input type="checkbox"/> CFE <input type="checkbox"/> SCORING CAPTAIN
FEBRUARY 28- MARCH 1	VCU RICHMOND, VA	PIE I MANIKIN	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> EXAMINER <input type="checkbox"/> CHIEF <input type="checkbox"/> CFE CAPTAIN <input type="checkbox"/> CFE <input type="checkbox"/> SCORING CAPTAIN
MARCH 7-8	WVU MORGANTOWN, WV	PIE II PATIENT, COMPLETE AND SECTIONAL	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> EXAMINER <input type="checkbox"/> CHIEF <input type="checkbox"/> CFE CAPTAIN <input type="checkbox"/> CFE <input type="checkbox"/> RESTORATIVE CAPTAIN
MARCH 21-22	MUSC CHARLESTON, SC	PIE II PATIENT, COMPLETE AND SECTIONAL	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> EXAMINER <input type="checkbox"/> CHIEF <input type="checkbox"/> CFE CAPTAIN <input type="checkbox"/> CFE <input type="checkbox"/> RESTORATIVE CAPTAIN
MARCH 28-29	UL LOUISVILLE, KY	COMPLETE AND SECTIONAL	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> EXAMINER <input type="checkbox"/> CHIEF <input type="checkbox"/> CFE CAPTAIN <input type="checkbox"/> CFE <input type="checkbox"/> RESTORATIVE CAPTAIN
APRIL 4-5	VCU RICHMOND, VA	PIE II PATIENT, COMPLETE AND SECTIONAL	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> EXAMINER <input type="checkbox"/> CHIEF <input type="checkbox"/> CFE CAPTAIN <input type="checkbox"/> CFE <input type="checkbox"/> RESTORATIVE CAPTAIN
APRIL 4-5	UT MEMPHIS, TN	PIE II PATIENT, COMPLETE AND SECTIONAL	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> EXAMINER <input type="checkbox"/> CHIEF <input type="checkbox"/> CFE CAPTAIN <input type="checkbox"/> CFE <input type="checkbox"/> RESTORATIVE CAPTAIN

Page 2

NAME:

DATE	SITE	TYPE OF EXAM	AVAILABLE	POSITION (CHECK ALL THAT APPLIES)
APRIL 11-12	MMC NASHVILLE, TN	PIE I MANIKIN	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> EXAMINER <input type="checkbox"/> CHIEF <input type="checkbox"/> CFE CAPTAIN <input type="checkbox"/> CFE <input type="checkbox"/> SCORING CAPTAIN
APRIL 18-19	UK LEXINGTON, KY	PIE II PATIENT, COMPLETE AND SECTIONAL	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> EXAMINER <input type="checkbox"/> CHIEF <input type="checkbox"/> CFE CAPTAIN <input type="checkbox"/> CFE <input type="checkbox"/> RESTORATIVE CAPTAIN
MAY 2-3	MMC NASHVILLE, TN	PIE II PATIENT, COMPLETE AND SECTIONAL	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> EXAMINER <input type="checkbox"/> CHIEF <input type="checkbox"/> CFE CAPTAIN <input type="checkbox"/> CFE <input type="checkbox"/> RESTORATIVE CAPTAIN
MAY 2-3	MUSC CHARLESTON, SC	COMPLETE AND SECTIONAL	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> EXAMINER <input type="checkbox"/> CHIEF <input type="checkbox"/> CFE CAPTAIN <input type="checkbox"/> CFE <input type="checkbox"/> RESTORATIVE CAPTAIN
MAY 30-31	VCU RICHMOND, VA	COMPLETE AND SECTIONAL	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> EXAMINER <input type="checkbox"/> CHIEF <input type="checkbox"/> CFE CAPTAIN <input type="checkbox"/> CFE <input type="checkbox"/> RESTORATIVE CAPTAIN
JUNE 6-7	UT MEMPHIS, TN	COMPLETE AND SECTIONAL	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> EXAMINER <input type="checkbox"/> CHIEF <input type="checkbox"/> CFE CAPTAIN <input type="checkbox"/> CFE <input type="checkbox"/> RESTORATIVE CAPTAIN
OCTOBER 3-4	MMC NASHVILLE, TN	COMPLETE AND SECTIONAL	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> EXAMINER <input type="checkbox"/> CHIEF <input type="checkbox"/> CFE CAPTAIN <input type="checkbox"/> CFE <input type="checkbox"/> RESTORATIVE CAPTAIN
DECEMBER 6-8	UT MEMPHIS, TN	COMPLETE AND SECTIONAL	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> EXAMINER <input type="checkbox"/> CHIEF <input type="checkbox"/> CFE CAPTAIN <input type="checkbox"/> CFE <input type="checkbox"/> RESTORATIVE CAPTAIN

SOUTHERN REGIONAL TESING AGENCY

DENTAL HYGIENE EDUCATORS MEETING

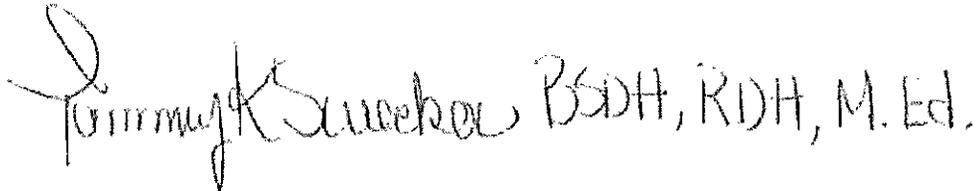
August 8, 2013

1:00p.m.-3:00p.m.

- I. Call to order: Tammy Swecker BSDH, M.Ed.
- II. Educators Present: Barbara Ebert, Wallace State University, Alabama
Susan Collier, University of Louisville, Kentucky
Beth Mobilian, Concorde Career College, Tennessee
Joseph Evans, Western Kentucky University, Kentucky
Janice Williams, Tennessee State University, Tennessee
Sue Kirchner, Hillsborough Community College, South Carolina
Debra Grubbs, Greenville Technical College, South Carolina
Amber Shuler, Wytheville Community College, Virginia
Elaine Smith Wytheville Community College, Virginia
- III. Review of 2013 Examination process, possible changes and general comments:
 - a. Overall consensus of educators of the 2013 SRTA exam was the examination was organized and went well.
 - b. Manual content was concise and easy to understand, SRTA quick tips were very helpful and scope of content was good.
 - c. Advised changes to Dental Hygiene Procedures Form:
 - i. Change in grading for radiographs:
 1. Currently candidates may earn all 8 points or lose all 8 points if any radiographic errors are made.
 2. Since the candidates ability to analyze and take radiographs of diagnostic quality is an important component of the exam, grading of radiographs was revised providing one point(+/-) for each of the following criteria:
 - a. All contacts broken on at least one film in the series
 - b. No cone cut unless affected area can be seen on another film in the series
 - c. Correct horizontal angulation
 - d. Correct vertical angulation
 - e. At least 2mm of bone visible around the apices of each tooth (discussion of taking a panorex if tooth had long root structure or candidate truly could not obtain apices of some teeth- advised by radiology instructor that a statement to the examiner would suffice as taking a panorex would over expose the patient to unnecessary radiation)
 - f. No processing, chemical, or technical errors
 - g. Film was positioned properly in the mouth
 - h. Radiographs were mounted properly

- d. Revise page 37 section Candidates comments to examiners: add patient is a gagger unable to obtain 2mm of bone at apices of #28, narrow palate, lingual mandibular tori
- e. Educators would like to see consistency with the exam from year to year and reduction of changes
- f. Modification of page 56 section 16 paragraph three to state:
 - i. Case presentation is a scored part of the examination and will be completed independently. It is the candidate's responsibility to critically analyze patient data. The candidate cannot request the recommendation of a licensed dental or dental hygiene professional for patient selection.
- IV. Pre-Orientation presentation- overall comments were supportive of quality and presenter's knowledge of exam and ability to answer candidates questions effectively
- V. Pre – Orientation on examination day- discussed possibility of working with each site to see if holding an orientation the night before for candidates would be beneficial- several educators liked having the 6:45 orientation the day of the examination.
- VI. ADEX EEM- The dental hygiene educators recommend ADEX to consider the National Board Dental Hygiene Examination as the electronic examination module. Justification: The NBDHE is a case based examination testing the competency of an entry level dental hygienist.
- VII. Many schools are interested in SRТА's assistance with Mock Clinical Board Exams- Educators were advised to contact Kathleen White to schedule a Mock Clinical Board Exam. SRТА will provide an examiner to calibrate faculty and use of the iPads for instant grading of students.

Respectfully submitted:



Tammy K. Swecker BSDH, RDH, M. Ed.

Tammy K. Swecker BSDH. M.Ed.

DENTAL HYGIENE EXAMINATION COMMITTEE

REPORT TO THE BOARD OF DIRECTORS: AUGUST 9, 2013

The Dental Hygiene Examination Committee met on Thursday, August 8, 2013 and Friday, August 9, 2013 at the Francis Marion Hotel in Charleston, South Carolina. The following people were present at the meeting.

Thursday, August 8, 2013

Members:

Sherie Barbare, Chair
Jan Jolly
Marlene Fullilove
Mary Ann Burch
Dina Vaughan
Tammy Swecker
Janet McMurphy

State:

South Carolina
Arkansas
Tennessee
Kentucky
West Virginia
Virginia
Mississippi

Guests:

Beth Casey Thompson
Dianne Embry
Tanya Riffe
Jennifer Lamb
Nan Dreves
Elaine Murphy
Gordon Bray, DDS
Kathleen White
Christina Pickman
Jessica Bui
Airica Puckett
Mary Warner
Sue Lilly
Debbie Southall
Trudy Levitan
Jacqueline Pace
Mara Beth Womack

Representing:

Examiner- TN
Examiner- KY
Examiner- SC
Examiner- AR
ADEX
Examiner- SC
Examiner/CFC- SC
SRTA Office
SRTA Office
SRTA Office
Examiner - TN
Examiner- TN
Examiner- WV
Examiner - VA
Examiner- VA
Examiner- VA
Examiner- KY

Guests:

Barbara Ebert
Joseph Evans
Susan Collier
Amber Shuler
Elaine Smith
Janice Williams
Beth Mobillian
Debra Grubbs
Susan Kirchner
Kathy Heiar

Representing:

Educator- Wallace State
Educator- WKU
Educator- UL
Educator- WCC
Educator- WCC
Educator- TSU
Educator- CCC
Educator- GTC
Examiner- NERB
Examiner- NERB

Friday, August 9, 2013

Sherie Barbare- DHEC Chair- SC
Jan Jolly- AR
Tanya Riffe- SC
Marlene Fullilove-TN
Mary Ann Burch- KY
Mara Beth Womack- KY

Nan Dreves- ADEX
Tammy Swecker- VA
Debbie Southall- VA
Sue Lilly- WV
Jennifer Lamb- AR
Trudy Levitan- VA

Dianne Embry- KY
Jessica Bui- SRTA
Janet Brice McMurphy- MS
Dina Vaughan, WV
Mary Warner- TN

The committee discussed the current year examination criteria, pass rates, and the examiner survey results. Educators left after the discussion of examination statistics and criteria for a break out session led by Tammy Swecker, SRTA Examiner from Virginia and Senior Clinical Coordinator for Dental Hygiene at VCU. The DHEC wants to express its gratitude to all the educators for their presence and valuable contribution to the meeting discussions.

Recommended changes to the dental hygiene criteria for 2014 are in the attachment to this report.

Sherie Barbare's term as the DHEC Chair expires at the close of this Annual Meeting. She was re-elected to another two year term. Dina Vaughan's term of office with the Board of Examiners expires at the conclusion of the 2014 Annual Meeting.

The committee reconvened on Friday, August 9 to take care of unfinished business from Thursday.

Respectfully submitted,

Sherie Barbare, DHEC Chair

ATTACHMENT: MOTIONS

DHEC REPORT TO THE BOARD OF DIRECTORS AUGUST 9, 2013

Motion:

#1	Add remaining calculus found on unassigned surfaces as a criterion for final case presentation.
#2	Revise computer-scoring program to allow candidates to enter their case selection information and surfaces with qualifying calculus on the web-site within one week of the examination date.
#3	To administer the ADEX Dental Hygiene Examination starting in 2015.
#4	To request that the computer module of the ADEX examination (CSCE) be an optional component.
#5	Request changes to the BrightLink program to include the ability to print a list of assigned surfaces for scoring calculus removal skills for examiners to use during final evaluation.
#6	To assess a 15 point deduction for any candidate who has four or more validated areas of remaining calculus.
#7	Eliminate the list of individual radiograph criteria. Radiographs of the selected teeth must be of sufficient quality for diagnosing caries, periodontal health, or other dental diseases and abnormalities.
#8	Request that the Executive Director write a letter to the University of Tennessee outlining the issues encountered by the SRTA Dental Hygiene examiners over the past 10 years. The DHEC would like to ask if they are interested in continuing to be a testing site for dental hygiene and, if so, what their plan will be for improving on-site examiner and candidate accommodations.
#9	To re-implement the Dental Hygiene candidate post examination surveys.

APPROVED

**BOARD OF DENTISTRY
MINUTES OF EXAMINATION COMMITTEE and
CLINICAL EXAM ADVISORY PANEL
FEBRUARY 1, 2013**

TIME AND PLACE: The Examination Committee convened on February 1, 2013, at 9:40 a.m., at the Department of Health Professions, Perimeter Center, 2nd Floor Conference Center, 9960 Mayland Drive, Henrico, VA 23233.

PRESIDING: Martha C. Cutright, D.D.S.

MEMBERS PRESENT: James D. Watkins, D.D.S.
Tammy K. Swecker, R.D.H.

MEMBERS ABSENT: None

OTHER BOARD MEMBERS PRESENT: Hebert R. Boyd, D.D.S.

CLINICAL EXAM ADVISORY PANEL: Mark Crabtree, D.D.S., Virginia Dental Association
Marge Green, R.D.H., Virginia Dental Hygienists Association
Charles Hackett, Jr., D.D.S., Old Dominion Dental Society
Paul Wiley, D.D.S., VCU School of Dentistry

PANEL MEMBER ABSENT: Kathleen White, Southern Regional Testing Agency (SRTA)

STAFF PRESENT: Sandra K. Reen, Executive Director, Board of Dentistry
Huong Vu, Operations Manager

ESTABLISHMENT OF QUORUM: All members of the Committee were present.

APPROVAL OF MINUTES: Dr. Cutright asked if the Committee members had reviewed the September 9, 2011 minutes. No changes or corrections were made. Dr. Watkins moved to accept the September 9, 2011 minutes. The motion was seconded and passed.

Virginia Board of Dentistry
Examination Committee
February 1, 2013

REVIEW OF
MATERIALS FROM
CALIFORNIA:

Dr. Cutright asked all to introduce themselves and to state which organization they represent and their preliminary thoughts on the California portfolio exam. After introductions, Dr. Cutright stated that the goal of this meeting is to identify and discuss any issues related to developing a portfolio exam with the VCU School of Dentistry, modeled on the California exam.

Ms. Reen noted that the Code of Virginia would not need to be amended to undertake a portfolio exam, but regulatory action might be needed.

Ms. Green asked if the California Board plans to offer this exam to dental hygienists. Ms. Reen replied no. Ms. Green asked to incorporate a dental hygiene portfolio exam in the initiative and noted that there are six (6) accredited dental hygiene programs in Virginia.

Dr. Crabtree commented that the group needs to think about the value of having independent third party assessments and of assuring the anonymity of candidates in any exam format. He added that another dental school will be opening in Virginia at Bluefield College, which will have 10 chairs and will partner with dental practices to provide educational opportunities.

Ms. Reen noted that she was unsuccessful in getting a contact person at Bluefield College to invite participation on the advisory panel. She went on to state that the California Board has agreed to share their model because of their interest in having use of the model expand to allow for the mobility of candidates.

Dr. Crabtree asked if the Hammond and Buckendahl and the Ranney and Hambleton reports, referenced in the 2009 Comira report, could be obtained for the panel. He noted that the Hammond and Buckendahl report does not support the use of portfolio exams for dental licensure because the model does not provide an assessment of minimum skills that is administered independent of the training program. He added that the Ranney and Hambleton report identified several criteria for the success of a portfolio model, including administration by independent parties.

Dr. Watkins encouraged changing the standard for exams from establishing "minimal competency" to a more positive statement such as "proficiency."

Ms. Reen pointed out that the California model includes the

participation of examiners from outside schools to strengthen the credibility of the process and ensure objectivity of ratings.

Ms. Reen went on to say that unlike the Virginia Board, the California Board approves dental schools and already has oversight. Dr. Wiley replied that he thinks the reference to approved schools is specific to the portfolio exam because all of the schools are CODA accredited. Dr. Watkins asked if the Board sends representatives to participate in the CODA site visits in Virginia. Ms. Reen replied that the Board does not have a policy requiring representation, but the invitations to participate are sent to board members. She added that three or four members have elected to participate. She also added that she checked California's web page, and Dr. Wiley's understanding about the relationship of the Board and the schools is correct.

Dr. Crabtree stated that the financial impact needs to be addressed and that an audit program would be needed. Dr. Watkins questioned whether the demand for the exam would be worth the expense and resources required. Ms. Swecker stated her concern is that the number of students who may elect to take the exam would be very limited due to lack of mobility. Dr. Crabtree added the concern of who determines the qualification of the students to take the exam.

Ms. Reen noted that the cost to take the California exam is \$350 versus the regional exams, which cost well over \$1000 plus patient expenses. She commented that it appears, based on the discussion thus far, that Virginia may need a different model because of the difference in scale between one dental school in Virginia versus six schools in California.

Dr. Cutright asked the panel members to give their advice on how the Board should proceed.

Dr. Wiley said that the School wants to develop a portfolio exam because students are assessed as they work on patients of record over a course of treatment whereas regional exams are a snapshot. He added that a portfolio exam would:

- reduce the disruptions associated with regional exams,
- reduce the costs to students, and
- have students working with faculty, so the exemption from licensure would definitely apply.

He noted that failure of a section of a regional exam in the first attempt is rarely an indicator of a lack of competence because with very few exceptions the section is passed on the second attempt.

Virginia Board of Dentistry
Examination Committee
February 1, 2013

Dr. Crabtree commented that it is not clear how the California schools are going to be audited by the Board. He said this is a very important factor in deciding if a portfolio is workable in Virginia.

Ms. Reen noted that California has not implemented their exam at this time because its regulations are not in effect. She asked the panel members to state how they think the Board should proceed.

Dr. Crabtree stated that the VDA currently has no policy on portfolio exams. He said if the Board wants to go ahead with the portfolio exam, the Board needs to ensure candidate anonymity and a separation between the school and the Board in the administration of the exam. He said the Board needs a study specific to Virginia, so the place to start might be with a request for proposals.

Ms. Green stated that psychometric validity needs to be addressed, adherence to national standards is necessary, and she agrees a study specific to Virginia is needed. She suggested exploring a partnership between the school and the regional examining agencies.

Ms. Reen noted that Workforce data, which was collected with the 2012 renewals, shows that about 46% of dentists in Virginia completed dental school in Virginia. She said she will provide the survey results at the next meeting.

Dr. Watkins said the Board should consider the feasibility of a portfolio exam and suggested that a modified proposal be developed for discussion.

Dr. Wiley stated that portfolio exam is good for all, Board-school-public, with accepting risks. He added that VCU cannot replicate the clinical experiences required by California before the portfolio can be attempted. He recommended taking a more global look at the portfolio model.

Dr. Hackett stated that there is not enough data to support implementation of the California model, so more information is needed.

Ms. Reen stated that it appears the consensus of the panel is that the California model will not work in Virginia. She suggested that the Committee meet to discuss the advice received for conducting a study and the need for an alternate model before convening another meeting with the Advisory Panel.

Virginia Board of Dentistry
Examination Committee
February 1, 2013

Dr. Cutright said that a meeting of the Committee was in order and then thanked the Panel members for their participation. She asked that they stay tuned for more information from the Board.

ADJOURNMENT: With all business concluded, the Committee adjourned at 12:00 p.m.

Martha C. Cutright, D.D.S.

Martha C. Cutright, D.D.S. Chair

3/8/2013

Date

Sandra K. Reen

Sandra K. Reen, Executive Director

3/8/2013

Date

UNAPPROVED DRAFT
BOARD OF DENTISTRY
MINUTES OF EXAMINATION COMMITTEE
MARCH 8, 2013

TIME AND PLACE: The Examination Committee convened on March 8, 2013, at 11:30 a.m., at the Department of Health Professions, Perimeter Center, 2nd Floor Conference Center, 9960 Mayland Drive, Henrico, VA 23233.

PRESIDING: Martha C. Cutright, D.D.S.

MEMBERS PRESENT: James D. Watkins, D.D.S.
Tammy K. Swecker, R.D.H.

MEMBERS ABSENT: None

STAFF PRESENT: Sandra K. Reen, Executive Director, Board of Dentistry
Huong Vu, Operations Manager

ESTABLISHMENT OF QUORUM: All members of the Committee were present.

APPROVAL OF MINUTES: Dr. Cutright asked if the Committee members had reviewed the February 1, 2013 minutes. No changes or corrections were made. Dr. Watkins moved to accept the February 1, 2013 minutes. The motion was seconded and passed.

DISCUSS THE CLINICAL EXAM ADVISORY PANEL'S ADVICE: Dr. Watkins commented that the CA portfolio model won't work in VA. He made the following suggestions:

- Scaling down the CA model;
- Looking at other portfolio models; and
- Hiring examiners.

After much discussion, the Committee agreed by consensus to take the following actions:

- Ms. Reen is to draft and circulate for review a letter to Dr. Sarrett asking that the VCU School of Dentistry (School)

assist in addressing the feasibility of instituting portfolio examinations for dental and dental hygiene candidates by developing descriptions of the models for exam content and administration that would be feasible for administration at the School. The request should ask if it is feasible to plan for the digital review and evaluation of student performance by an objective examiner.

- Request that the School share the model with current students and survey them to determine the interest level in having a portfolio option for licensure to practice in Virginia. The goal is to determine if there would be enough candidates to support implementation of a portfolio option.
- Look at policy options for the Board such as:
 - identifying one or more viable models for independent administration of a portfolio exam,
 - exempting the top 10% of the School's students from the clinical exam requirement, and
 - establishing a hybrid exam by combining the School's portfolio model with the PIE I non-patient based ADEX exam.

The Committee will meet to review the information collected and then reconvene the Clinical Exam Advisory Panel to discuss the information.

**FUTURE OF DENTAL
LAW EXAM:**

Ms. Reen asked the Committee to consider the recommendation it wishes to make to the Board about the future of the Dental Law Exam. She advised that the expectation for licensees to voluntarily take the Exam for CE credit was not realized and, as a consequence, there were not enough candidates to make it financially feasible for testing agencies to contract for administration of the exam. She added that she is revising the exam to reflect recent regulatory changes, such as the Emergency Regulations for Sedation/Anesthesia Permits, so that it might be administered to respondents at the Board office.

Following discussion of the options - eliminating the exam, requiring it periodically for all licensees, and/or requiring the exam for

**Virginia Board of Dentistry
Examination Committee
March 8, 2013**

applicants the Committee agreed by consensus to review other states' requirements for passage of law exams before making a recommendation to the Board.

CITA EXAM:

Ms. Reen noted that the Board assigned the discussion of corresponding with the NC Board about acceptance of other exams, in addition to CITA, to the Committee. The concern identified was that the VA Board accepts all regional exams, so NC graduates can easily move to VA, whereas NC only accepts CITA, which limits the mobility of VA graduates and licensees. After discussion of the issue and the lack of response by the NC Board to the Board's prior request for acceptance of additional regional exams, by consensus, the Committee agreed to recommend that this matter not be pursued by the Board.

ADJOURNMENT:

With all business concluded, the Committee adjourned at 1:45 p.m.

Martha C. Cutright, D.D.S, Chair

Sandra K. Reen, Executive Director

Date

Date

**Agenda Item: Regulatory Actions - Chart of Regulatory Actions
(As of August 20, 2013)**

Board of Dentistry		
Chapter		Action / Stage Information
[18 VAC 60 - 20]	Regulations Governing Dental Practice	<p><u>Periodic review: reorganizing chapter 20 into four new chapters: 15, 21, 25 and 30</u> [Action 3252]</p> <p>Proposed - <i>At Governor's Office for 148 days</i> [Stage 6150]</p>
[18 VAC 60 - 20]	Regulations Governing Dental Practice	<p><u>Sedation and anesthesia permits for dentists</u> [Action 3564]</p> <p>Proposed - <i>At Governor's Office for 39 days</i> [Stage 6454] Emergency regulations expire: 9/13/13 Request for 6-month extension posted (see attached)</p>
[18 VAC 60 - 20]	Regulations Governing Dental Practice	<p> <u>Addition of AAHD to approved continuing education providers</u> [Action 3919]</p> <p>Fast-Track - <i>Register Date: 8/12/13</i> [Stage 6499] Effective: 9/26/13</p>

Yeatts, Elaine J. (DHP)

From: townhall@dph.virginia.gov
Sent: Monday, August 19, 2013 9:17 AM
To: Yeatts, Elaine J. (DHP)
Subject: Extension of Emergency Regulation Requested

The Department of Health Professions is requesting this emergency regulation be extended until 3/15/2014 for the following reason:

The Code of Virginia (Section 54.1-2709.5) requires dentists who provide or administer sedation or anesthesia in a dental office to obtain a permit issued by the Board. Emergency regulations authorizing issuance will expire on 9/13/13. The Board submitted proposed regulation to replace the emergency regulations on Townhall on 1/31/13; the proposed regulations are still awaiting approval in the Governor's office. Therefore, it is impossible to complete the replacement of the emergency regulations by the 9/13/13 expiration. The Board's inability to issue new sedation and anesthesia permits would seriously impact dental care in the Commonwealth.

Board: Board of Dentistry

Chapter: Regulations Governing Dental Practice (18 VAC 60-20)

Action: Sedation and anesthesia permits for dentists

Stage: Emergency/NOIRA 3564 / 6009

For processing this request please go to [The Virginia Regulatory Town Hall](#)

Agenda Item: Response to Petitions for Rulemaking

Included in your agenda package are:

Copies of three petitions:

Deborah Hickman (requirements for DAII certification) – submitted an original and a revised petition
(Material from DANB on the DAII petition is included in a separate package sent with the agenda)

Terry Dickinson (grounds for unprofessional conduct)

Vahid Tavakoli (5-year warranty on crowns and bridges)

Copies of comments on regulations

A copy of applicable sections of the regulations

Staff Note:

There was a comment period on the petition from July 29, 2013 to August 28, 2013.

Each petition will be considered individually.

Board action:

The Board may accept the petitioner's request for amendments to regulations and initiate rulemaking by adoption of a Notice of Intended Regulatory Action or by fast-track action

OR

The Board may reject the petitioner's request for amendments. If the petition is rejected, the Board must state its reasons for denying the petition.



COMMONWEALTH OF VIRGINIA

Board of Dentistry CRP JUN 27 2013

9960 Mayland Drive, Suite 300
Richmond, Virginia 23233-1463

(804) 367-4538 (Tel)
(804) 527-4428 (Fax)

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Petition for Rule-making

JUN 27 2013

The Code of Virginia (§ 2.2-4007) and the Public Participation Guidelines of this board require a person who wishes to petition the board to develop a new regulation or amend an existing regulation to provide certain information. Within 14 days of receiving a valid petition, the board will notify the petitioner and send a notice to the Register of Regulations identifying the petitioner, the nature of the request and the plan for responding to the petition. Following publication of the petition in the Register, a 21-day comment period will begin to allow written comment on the petition. Within 90 days after the comment period, the board will issue a written decision on the petition.

Please provide the information requested below. (Print or Type)

Petitioner's full name (Last, First, Middle initial, Suffix.)
Deborah Hickman

Street Address
109 Turtle Creek Rd Apt 3

Area Code and Telephone Number
434-293-3773

City
Charlottesville

State
VA

Zip Code
22901

Email Address (optional)
Coffeelover1954@yahoo.com

Fax (optional)
434-973-7695

Respond to the following questions:

1. What regulation are you petitioning the board to amend? Please state the title of the regulation and the section/sections you want the board to consider amending.

§54.1-2729.01

2. Please summarize the substance of the change you are requesting and state the rationale or purpose for the new or amended rule.

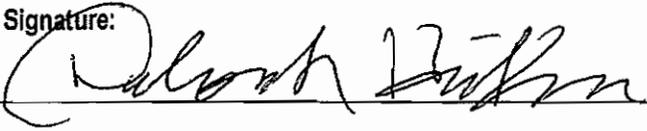
I have filed a petition for an amendment adding another pathway to acquire DA II and after speaking with DANB and further research I want to file an amendment to that petition. I am enclosing documentation from DANB for two states and the District of Columbia that have the pathways I am speaking of. I would like Virginia to possibly adopt a standardized exam or to accept the DANB CRFDA in conjunction with documentation from current employers as to competency of individuals that have multiple years of experience. Thank you

...legal authority of the board to take the action requested. In general, the legal authority for the adoption of regulations by the board is found in § 54.1-2400 of the Code of Virginia. If there is other legal authority for promulgation of a regulation, please provide that Code reference.

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JUN 27 2013

Signature:



Board of Dentistry
Date:

6/25/13

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JUN 27 2013

Board of Dentistry

- Dental Assistant II (DA II)

To perform expanded functions under the direct supervision of a licensed dentist in the state of **North Carolina**, one must be classified as a DA II. To qualify as a DA II, one must:

1. Hold a current Cardiopulmonary Resuscitation (CPR) certification, AND
- 2a. Successfully complete a CODA-accredited dental assisting program or one academic year or longer in a CODA-accredited dental hygiene program, or
- 2b. Complete two years of the preceding five (3,000 hours) of full-time employment and experience as a chairside assistant, radiography training as required by law, and a three-hour course in dental office emergencies, and a three-hour course in sterilization and infection control, OR
- 2c. Pass the national DANB Certified Dental Assistant (CDA) exam.

To qualify to perform coronal polishing, a DA II must:

1. Successfully complete a North Carolina Board-approved seven-hour (three hours of didactic and four hours of clinical) coronal polishing course.

To qualify to monitor patients under nitrous oxide, a DA II must:

1. Successfully complete a North Carolina Board-approved seven-hour course in nitrous oxide-oxygen conscious sedation.

- Expanded Duty Dental Assistant (EDDA)

To perform expanded functions under the direct supervision of a licensed dentist in the state of **South Carolina**, a dental assistant must earn status as an Expanded Duty Dental Assistant (EDDA). To qualify, one must:

1. Graduate from a CODA-accredited dental assisting program, OR
2. Complete two years of continuous full-time employment as a chairside dental assistant

- Registered Dental Assistant Qualified in Designated Expanded Functions

To perform designated expanded functions under the direct supervision of a licensed dentist in the **District of Columbia**, an auxiliary must:

1. Be a Registered Dental Assistant (see requirements above), AND
- 2a. Satisfactorily complete training in a CERP-approved program, OR
- 2b. Satisfactorily complete a training program or course recognized by the Commission on Dental

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JUN 27 2013

Board of Dentistry

Accreditation (CODA), OR

2c. Satisfactorily complete a training program or course recognized by DANB.

Note: A dentist may delegate designated expanded functions to a dental assistant who does not meet these requirements if the assistant had been performing the tasks on the effective date of these regulations (July 15, 2011), has demonstrated competency to perform the tasks to the supervising dentist's satisfaction, and registers within 12 months of the effective date.



COMMONWEALTH OF VIRGINIA

Board of Dentistry

DHP JUN 13 2013

9960 Mayland Drive, Suite 300
Richmond, Virginia 23233-1463

(804) 367-4538 (Tel)
(804) 527-4428 (Fax)

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Petition for Rule-making

JUN 13 2013

Board of Dentistry

The Code of Virginia (§ 2.2-4007) and the Public Participation Guidelines of this board require a person who wishes to petition the board to develop a new regulation or amend an existing regulation to provide certain information. Within 14 days of receiving a valid petition, the board will notify the petitioner and send a notice to the Register of Regulations identifying the petitioner, the nature of the request and the plan for responding to the petition. Following publication of the petition in the Register, a 21-day comment period will begin to allow written comment on the petition. Within 90 days after the comment period, the board will issue a written decision on the petition.

Please provide the information requested below. (Print or Type)

Petitioner's full name (Last, First, Middle initial, Suffix)
Hickman, Deborah, B.

Street Address
109 Turtle Creek Rd. Apt 3

Area Code and Telephone Number
434-293-3773

City
Charlottesville

State
Virginia

Zip Code
22901

Email Address (optional)
Coffeelover1954@yahoo.com

Fax (optional)

Respond to the following questions:

1. What regulation are you petitioning the board to amend? Please state the title of the regulation and the section/sections you want the board to consider amending.

18VAC60-20-72. Registration by endorsement as a dental assistant II.

2. Please summarize the substance of the change you are requesting and state the rationale or purpose for the new or amended rule.

I am requesting a change in the pathways to obtaining a DAII. I am requesting that a dental assistant that currently holds a valid CDA issued by Dental Assisting National Board and successfully completes the newest certification offered by DANB which is a CRFDA be allowed to take an exam without attending a dental assisting school.

the legal authority of the board to take the action requested. In general, the legal authority for the adoption of regulations by the board is found in § 54.1-2400 of the Code of Virginia. If there is other legal authority for promulgation of a regulation, please provide that Code reference.

The board made the ruling and subsequent approval of pathways for obtaining. I am requesting an additional pathway be added for practicing assistants that are dedicated to their field, have the skills and the desire to further their knowledge and be more of an asset to their employer but due to lack of availability of CODA schools in ALL areas and that we work full time and cannot travel or quit work to attend be allowed to approach this through an additional pathway.

Robert B. Williams CDARDA

6/11/13

Signature:

Date:

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JUN 13 2013

Board of Dentistry



Dental Assisting National Board, Inc.

Measuring Dental Assisting Excellence®

VIA FEDEX

August 1, 2013

Board of Directors

Chair

Frank A. Maggio, D.D.S.
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Michigan

D. Bradley Dean, D.D.S., M.S.
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Washington, D.C.

Katharine J. Noble, B.S.N.H.,
CDA, RDA, HMC (FMF),
United States Navy
Maine

Jennifer Stone, CDA, EFDA
Pennsylvania

Executive Director

Cynthia C. Durley, M.Ed., MBA

Attention: Elaine J. Yeatts, Senior Policy Analyst
Virginia Board of Dentistry
9960 Mayland Drive, Suite 300
Richmond, VA 23233

Dear Distinguished Members of the Virginia Board of Dentistry:

I am writing on behalf of the Dental Assisting National Board, Inc. (DANB) in regard to the petition of Deborah Hickman submitted on June 18, 2013 and published for public comment on July 15, 2013.

According to the notice posted on the Virginia Regulatory Town Hall website, Ms. Hickman is asking the Board to consider the following request: *To amend 18VAC60-20-72 to allow a dental assistant who holds a valid CDA issued by the Dental Assisting National Board and successfully completes the CRFDA certification to take the examination without attending dental assisting school.*

Upon receiving this notice, I took the liberty of contacting Ms. Hickman to gain some clarification about her request. My understanding from speaking with her is that Ms. Hickman would like the Board to allow dental assistants who hold DANB's Certified Dental Assistant [CDA] certification to take the exam that the Virginia Board of Dentistry accepts for Dental Assistant II (DA II) registration without taking the required expanded functions course if they have earned DANB's Certified Restorative Functions Dental Assistant (CRFDA) certification.

After our conversation, I shared some information with Ms. Hickman about requirements in other states for dental assistants who perform some of the functions that are within the DA II scope of practice. I am including copies of the same materials that I sent to Ms. Hickman along with these comments as Attachments C, D, and E. I am aware that Ms. Hickman submitted a second petition following my conversation with her, in which she modified her request.

To assist the Virginia Board of Dentistry in considering whether to amend the requirements for dental assistants to qualify for DA II registration and what role DANB's CRFDA certification might play in any amendment, I am providing 25 copies of each of the following documents:

- Attachment A: Brief, two-page overview of the CRFDA certification program
- Attachment B: Exam blueprints for the six component exams that make up the CRFDA certification
- Unlettered attachment: DANB's CRFDA exam application packet
- Attachment C: Overview of State Requirements for Dental Assistants to Perform Selected Restorative Functions - Amalgams and Composites (6/4/13)

Virginia Board of Dentistry
August 1, 2013
Page 2

- Attachment D: Overview of State Requirements for Dental Assistants to Perform Selected Restorative Functions – Take Final Impressions (2/18/13)
- Attachment E: Analysis of Permission to Delegate Restorative Function to Dental Assistants: Place and Remove Retraction Materials (5/2/12)

(I am enclosing one copy of each of these documents in 25 individual envelopes along with a copy of this letter.)

As you know, DANB is the American Dental Association-recognized national certification board for dental assistants, administering the nationally recognized Certified Dental Assistant™ (CDA®) certification program. Current certification as a DANB CDA is required to qualify for Dental Assistant II registration in Virginia. DANB's exams meet nationally accepted test development standards, and DANB's CDA and Certified Orthodontic Assistant (COA) certification programs are accredited by the National Commission on Certifying Agencies (NCCA). DANB will apply to NCCA for accreditation of its new CRFDA certification program as soon as this program meets the NCCA exam candidate/certificant volume threshold for application to accredit a new program. DANB certifications and exams are currently recognized or required to meet dental assisting qualifications by 38 states, the District of Columbia, the U.S. Air Force and the Department of Veterans Affairs.

As part of our mission, DANB collects and compiles information about dental assisting laws and regulations nationwide and takes note of trends in oral healthcare, so that we may be ready to assist the stakeholders who rely on our services to measure the competency of allied dental personnel. If there is any additional information that DANB can provide to assist the Virginia Board of Dentistry as it considers whether to amend the requirements to earn DA II registration in Virginia, please do not hesitate to contact me.

Sincerely,


Katherine Landsberg
Assistant Director, Government Relations

CC: Sandra Reen, Executive Director, Virginia Board of Dentistry
Cynthia C. Durley, DANB Executive Director
Deborah Hickman, CDA

[prev](#) | [next](#)**18VAC60-20-61. Educational requirements for dental assistants II.**

A. A prerequisite for entry into an educational program preparing a person for registration as a dental assistant II shall be current certification as a Certified Dental Assistant (CDA) conferred by the Dental Assisting National Board.

B. To be registered as a dental assistant II, a person shall complete the following requirements from an educational program accredited by the Commission on Dental Accreditation of the American Dental Association:

1. At least 50 hours of didactic course work in dental anatomy and operative dentistry that may be completed on-line.
2. Laboratory training that may be completed in the following modules with no more than 20% of the specified instruction to be completed as homework in a dental office:
 - a. At least 40 hours of placing, packing, carving, and polishing of amalgam restorations and pulp capping procedures;
 - b. At least 60 hours of placing and shaping composite resin restorations and pulp capping procedures;
 - c. At least 20 hours of taking final impressions and use of a non-epinephrine retraction cord; and
 - d. At least 30 hours of final cementation of crowns and bridges after adjustment and fitting by the dentist.
3. Clinical experience applying the techniques learned in the preclinical coursework and laboratory training that may be completed in a dental office in the following modules:
 - a. At least 80 hours of placing, packing, carving, and polishing of amalgam restorations;
 - b. At least 120 hours of placing and shaping composite resin restorations;
 - c. At least 40 hours of taking final impressions and use of a non-epinephrine retraction cord; and
 - d. At least 60 hours of final cementation of crowns and bridges after adjustment and fitting by the dentist.
4. Successful completion of the following competency examinations given by the accredited

educational programs:

- a. A written examination at the conclusion of the 50 hours of didactic coursework;
- b. A practical examination at the conclusion of each module of laboratory training; and
- c. A comprehensive written examination at the conclusion of all required coursework, training, and experience for each of the corresponding modules.

C. All treatment of patients shall be under the direct and immediate supervision of a licensed dentist who is responsible for the performance of duties by the student. The dentist shall attest to successful completion of the clinical competencies and restorative experiences.

Statutory Authority

§ [54.1-2400](#) of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 27, Issue 11, eff. March 2, 2011; amended, Virginia Register Volume 29, Issue 3, eff. November 22, 2012.

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[prev](#) | [next](#)**18VAC60-20-72. Registration by endorsement as a dental assistant II.**

A. An applicant for registration by endorsement as a dental assistant II shall provide evidence of the following:

1. Hold current certification as a Certified Dental Assistant (CDA) conferred by the Dental Assisting National Board or another national credentialing organization recognized by the American Dental Association;
2. Be currently authorized to perform expanded duties as a dental assistant in another state, territory, District of Columbia, or possession of the United States;
3. Hold a credential, registration, or certificate with qualifications substantially equivalent in hours of instruction and course content to those set forth in [18VAC60-20-61](#) or if the qualifications were not substantially equivalent the dental assistant can document experience in the restorative and prosthetic expanded duties set forth in [18VAC60-20-230](#) for at least 24 of the past 48 months preceding application for registration in Virginia.

B. An applicant shall also:

1. Be certified to be in good standing from each state in which he is currently registered, certified, or credentialed or in which he has ever held a registration, certificate, or credential;
2. Be of good moral character;
3. Not have committed any act that would constitute a violation of § [54.1-2706](#) of the Code of Virginia; and
4. Attest to having read and understand and to remain current with the laws and the regulations governing dental practice in Virginia.

Statutory Authority

§ [54.1-2400](#) of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 27, Issue 11, eff. March 2, 2011.

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[prev](#) | [next](#)**18VAC60-20-230. Delegation to dental assistants.**

A. Duties appropriate to the training and experience of the dental assistant and the practice of the supervising dentist may be delegated to a dental assistant under the direction or under general supervision required in [18VAC60-20-210](#), with the exception of those listed as nondelegable in [18VAC60-20-190](#) and those which may only be delegated to dental hygienists as listed in [18VAC60-20-220](#).

B. Duties delegated to a dental assistant under general supervision shall be under the direction of the dental hygienist who supervises the implementation of the dentist's orders by examining the patient, observing the services rendered by an assistant and being available for consultation on patient care.

C. The following duties may only be delegated under the direction and direct supervision of a dentist to a dental assistant II who has completed the coursework, corresponding module of laboratory training, corresponding module of clinical experience, and examinations specified in [18VAC60-20-61](#):

1. Performing pulp capping procedures;
2. Packing and carving of amalgam restorations;
3. Placing and shaping composite resin restorations;
4. Taking final impressions;
5. Use of a nonepinephrine retraction cord; and
6. Final cementation of crowns and bridges after adjustment and fitting by the dentist.

Statutory Authority

§ [54.1-2400](#) of the Code of Virginia.

Historical Notes

Derived from VR255-01-1 § 5.4, eff. September 1, 1987; amended, Virginia Register Volume 5, Issue 7, eff. February 1, 1989; Volume 7, Issue 19, eff. July 17, 1991; Volume 9, Issue 19, eff. July 15, 1993; Volume 10, Issue 19, eff. July 13, 1994; Volume 11, Issue 3, eff. April 6, 1995; Volume 11, Issue 9, eff. April 6, 1995; Volume 12, Issue 26, eff. October 16, 1996; Volume 15, Issue 5, eff. December 23, 1998; Volume 22, Issue 23, eff. August 23, 2006; Volume 27, Issue 11, eff. March 2, 2011.

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Petition Information

Petition Title	Requirements for a dental assistant II
Date Filed	6/18/2013 [Transmittal Sheet]
Petitioner	Deborah Hickman
Petitioner's Request	To amend 18VAC60-20-72 to allow a dental assistant who holds a valid CDA issued by the Dental Assisting National Board and successfully completes the CRFDA certification to take the examination without attending dental assisting school.
Agency's Plan	The petition will be published on July 15, 2013 in the Register of Regulations and also posted on the Virginia Regulatory Townhall at www.townhall.virginia.gov to receive public comment ending August 4, 2013. The request to amend regulations and any comments for or against the petition will be considered by the Board at its meeting scheduled for September 13, 2013.
Comment Period	Ended 8/4/2013

7/22/13 4:03 pm

Commenter: Nancy L. Daniel CDA - J. Sargeant Reynolds Community College ***Requirements for Level II Dental Assistant**

The CRFDA is a written exam and does not contain a practicum part. The educational requirements for Level II contain significant number of didactic, lab, and clinical hours towards practical experience. There is no way that by completing ONLY the CRFDA exam would a dental assistant be competent enough to execute the duties under Level II. However the CRFDA exam could be used towards the credential requirement prior to entering a Level II educational program. The board may want to consider this option.

7/24/13 7:59 pm

Commenter: Angela Smith, BA, CDA - J. Sargeant Reynolds Community College ***Dental Assistant II/CRFDA**

Please consider that current Virginia law states a DAII requires both didactic and practical(lab/clinical) experience in restorative procedures before being allowed to perform such procedures. The CRFDA exam is only a test of what the person knows from a didactic situation. Practical experience in these procedures is necessary. We wouldn't think of allowing a dentist to practice without having simulation and then real world experience before opening his/her own dental practice. Thank you.

7/29/13 11:58 am

Commenter: Dag Zapatero DDS ***DA-II pathways for registration**

While I am sympathetic to the current DA-II guidelines established and supported by current DA-II, I would support an additional pathway for DA-II registration. If a DA has passed the national written exam and had 10 years of continuous hands on experience in general dentistry without any disciplinary action taken against them, they should be considered for registration.

Petition Information	
Petition Title	Requirements for dental assistants II
Date Filed	7/10/2013 [Transmittal Sheet]
Petitioner	Deborah Hickman
Petitioner's Request	To amend regulations pertaining to requirements for dental assistants II to add another pathway for registration.
Agency's Plan	The petition will be published on July 29, 2013 in the Register of Regulations and also posted on the Virginia Regulatory Townhall at www.townhall.virginia.gov to receive public comment ending August 28, 2013. The request to amend regulations and any comments for or against the petition will be considered by the Board at its meeting scheduled for September 13, 2013

Commenter: Nancy Daniel CDA J. Sargeant Reynolds Community College *

Another Pathway for Level II

Not sure what the petitioner would like to see but the two pathways required at this time have been established to help protect the public. A dental assistant who is interested in registering for Level II must either complete an educational program/course modules or be grandfathered in with proof of same curriculum hours and clinical experience received in another state .

7/29/13 8:08 pm

Commenter: Angela Smith, BS, CDA - J. Sargeant Reynolds Community College *

Additional pathway to register for DAII

I believe the current regulations as set by the board and passed into law protect the health of the public. Procedures performed on patients should be done by practitioners who have actually practiced said procedures in controlled settings - lab through simulation and clinic under observation of a licensed dentist, this is important to public health. As I stated on the initial petition for rulemaking, a dentist would not be allowed to perform procedures without having first performed simulation procedures and then under observation in clinic during 3rd and 4th years of dental school...and the same with hygienists and their abilities to perform scaling and root planing or dental prophylaxis. These licensed professionals require education and training prior to performing procedures....dental assistant II must comply with the same practices. Grandfathering assistants into the DAII registration is acceptable with documentation that meets current standards.

8/22/13 8:44 pm

Commenter: Austin Westover, DDS *

Making it feasible

The problem with the current pathway to become a DAU level 2 is that the vast majority of dental assistants are trained on the job. The educational requirements to becoming a DAU level 2 is not feasible for many assistants who have been practicing for decades, but cannot afford to quit their jobs for a significant period of time to go through the necessary schooling.

My understanding of the purpose of the creation of DAU 2s was to free up the dentist such that he could see more patients, and therefore, increase access to care by allowing more patient visits per dentist. As of right now, I hear that there are virtually no DAU 2s in the state.

If we want to see DAU 2s in practice, we have to make it feasible. Why can't someone establish an online curriculum with evening / weekend practicals to help those dental assistants currently in practice utilize this new regulation? How hard is it to teach someone how to place string under the gums or pack some metal into a hole?



Dental Assisting National Board, Inc.

Measuring Dental Assisting Excellence®

VIA FEDEX

August 1, 2013

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Executive Director

Cynthia C. Durley, M.Ed., MBA

Attention: Elaine J. Yeatts, Senior Policy Analyst
Virginia Board of Dentistry
9960 Mayland Drive, Suite 300
Richmond, VA 23233

Dear Distinguished Members of the Virginia Board of Dentistry:

I am writing on behalf of the Dental Assisting National Board, Inc. (DANB) in regard to the petition of Deborah Hickman submitted on June 18, 2013 and published for public comment on July 15, 2013.

According to the notice posted on the Virginia Regulatory Town Hall website, Ms. Hickman is asking the Board to consider the following request: *To amend 18VAC60-20-72 to allow a dental assistant who holds a valid CDA issued by the Dental Assisting National Board and successfully completes the CRFDA certification to take the examination without attending dental assisting school.*

Upon receiving this notice, I took the liberty of contacting Ms. Hickman to gain some clarification about her request. My understanding from speaking with her is that Ms. Hickman would like the Board to allow dental assistants who hold DANB's Certified Dental Assistant [CDA] certification to take the exam that the Virginia Board of Dentistry accepts for Dental Assistant II (DA II) registration without taking the required expanded functions course if they have earned DANB's Certified Restorative Functions Dental Assistant (CRFDA) certification.

After our conversation, I shared some information with Ms. Hickman about requirements in other states for dental assistants who perform some of the functions that are within the DA II scope of practice. I am including copies of the same materials that I sent to Ms. Hickman along with these comments as Attachments C, D, and E. I am aware that Ms. Hickman submitted a second petition following my conversation with her, in which she modified her request.

To assist the Virginia Board of Dentistry in considering whether to amend the requirements for dental assistants to qualify for DA II registration and what role DANB's CRFDA certification might play in any amendment, I am providing 25 copies of each of the following documents:

- Attachment A: Brief, two-page overview of the CRFDA certification program
- Attachment B: Exam blueprints for the six component exams that make up the CRFDA certification
- Unlettered attachment: DANB's CRFDA exam application packet
- Attachment C: Overview of State Requirements for Dental Assistants to Perform Selected Restorative Functions - Amalgams and Composites (6/4/13)

Virginia Board of Dentistry
August 1, 2013
Page 2

- Attachment D: Overview of State Requirements for Dental Assistants to Perform Selected Restorative Functions – Take Final Impressions (2/18/13)
- Attachment E: Analysis of Permission to Delegate Restorative Function to Dental Assistants: Place and Remove Retraction Materials (5/2/12)

(I am enclosing one copy of each of these documents in 25 individual envelopes along with a copy of this letter.)

As you know, DANB is the American Dental Association-recognized national certification board for dental assistants, administering the nationally recognized Certified Dental Assistant™ (CDA®) certification program. Current certification as a DANB CDA is required to qualify for Dental Assistant II registration in Virginia. DANB's exams meet nationally accepted test development standards, and DANB's CDA and Certified Orthodontic Assistant (COA) certification programs are accredited by the National Commission on Certifying Agencies (NCCA). DANB will apply to NCCA for accreditation of its new CRFDA certification program as soon as this program meets the NCCA exam candidate/certificant volume threshold for application to accredit a new program. DANB certifications and exams are currently recognized or required to meet dental assisting qualifications by 38 states, the District of Columbia, the U.S. Air Force and the Department of Veterans Affairs.

As part of our mission, DANB collects and compiles information about dental assisting laws and regulations nationwide and takes note of trends in oral healthcare, so that we may be ready to assist the stakeholders who rely on our services to measure the competency of allied dental personnel. If there is any additional information that DANB can provide to assist the Virginia Board of Dentistry as it considers whether to amend the requirements to earn DA II registration in Virginia, please do not hesitate to contact me.

Sincerely,


Katherine Landsberg
Assistant Director, Government Relations

CC: Sandra Reen, Executive Director, Virginia Board of Dentistry
Cynthia C. Durley, DANB Executive Director
Deborah Hickman, CDA

**ALSO REVIEW
DANB COMMENTS AND
MATERIALS
IN THE SEPARATE
PACKAGE**



COMMONWEALTH OF VIRGINIA

Board of Dentistry

9960 Mayland Drive, Suite 300
 Richmond, Virginia 23233-1463

(804) 367-4538 (Tel)
 (804) 527-4428 (Fax)

Petition for Rule-making

The Code of Virginia (§ 2.2-4007) and the Public Participation Guidelines of this board require a person who wishes to petition the board to develop a new regulation or amend an existing regulation to provide certain information. Within 14 days of receiving a valid petition, the board will notify the petitioner and send a notice to the Register of Regulations identifying the petitioner, the nature of the request and the plan for responding to the petition. Following publication of the petition in the Register, a 21-day comment period will begin to allow written comment on the petition. Within 90 days after the comment period, the board will issue a written decision on the petition.

Please provide the information requested below. (Print or Type)		
Petitioner's full name (Last, First, Middle initial, Suffix,)		
Terry D. Dickinson, D.D.S.		
Street Address	Area Code and Telephone Number	
3460 Mayland Court #110	804-288-5750	
City	State	Zip Code
Henrico	Virginia	23233
Email Address (optional)	Fax (optional)	

Respond to the following questions:

1. What regulation are you petitioning the board to amend? Please state the title of the regulation and the section/sections you want the board to consider amending.

18VAC60-20-180 (Advertising)

2. Please summarize the substance of the change you are requesting and state the rationale or purpose for the new or amended rule.

Concerns have been expressed by VDA member dentists about the unethical use of contracts between dentists and marketing/promotional companies which promote the use of voucher systems to solicit potential patients. These arrangements are based around an arrangement which, in the VDA's opinion, constitute a form of fee-splitting which we believe is unethical (and so stated in ADA's Principles of Ethics and Code of Professional conduct). According to the Principles, 'dentists shall not accept or tender 'rebates' or 'split fees' '. It further states that 'A dentist is allowed to pay for any advertising permitted by the Code, but is generally not permitted to make payments to another person or entity for the referral of a patient for professional services'. This prohibition against a dentist's accepting or tendering rebates or split fees applies to business dealings between dentists and any third party, not just other dentists. Thus a dentist who pays for advertising or marketing services by sharing a specified portion of the professional fees collected from prospective or actual patients with the vendor providing the advertising or marketing services is engaged in fee splitting. Therefore, we would ask the Board to consider addressing these concerns. We also believe that it is unethical for any dentist to advertise or offer gifts as an inducement to secure dental patients and would ask the Board to include that in its deliberations.

We would suggest language that would reflect these concerns such as:

'It is unlawful for any dentist to offer rebates, split fees, or commissions for services rendered to a patient to any person other than a partner, employee or employer. It shall also be unlawful for any dentist directly or indirectly offering, giving, soliciting, or receiving or agreeing to receive, any fee or other consideration to or from a third party for the referral of a patient or client or in connection with the performance of professional services- other than a discount or reduction in an established fee or price for a professional service or product. Nothing contained in this section shall prohibit a dentist from providing a gift to a patient, or from providing a credit for dental services to a patient, provided the gift or credit does not exceed a value to be determined.'

3. State the legal authority of the board to take the action requested. In general, the legal authority for the adoption of regulations by the board is found in § 54.1-2400 of the Code of Virginia. If there is other legal authority for promulgation of a regulation, please provide that Code reference.

The authority is invested in the Board of Dentistry to take the necessary actions to protect the public via 54.1-2400 of the Code of Virginia.

Signature:

Date: 6/24/13

As a faculty member at VCU having conducted over 30 clinical trials in Periodontics and 30 Years of practice I would like to make some comments on the proposed regulations.

Proposed regulation

- 1) To require all dentists to give a five-year warranty on crowns and bridges to ensure work is durable and thorough.

This regulation at best would be very difficult to administer. Bridges and crowns fail for many reasons, many of which are not in the control of the dentist. Periodontal disease, cracked teeth, decay, high caries rates and trauma all can be the reason that a bridge or crown would fail. Determining if these were pre-existing, or after the prosthesis was placed is at best a nightmare to determine in some cases. The word thorough at the end of the regulation could imply that the dentist has anticipated all of these problems whether they existed before or after the prosthesis was placed, making the dentist responsible when they were not. Also what is a failure under this regulation? Would the following be failures: Sensitive teeth, small or large piece of porcelain broken off, recession resulting in compromised esthetics, new decay, cracked teeth, need for a root canal, need for periodontal disease?

In today's world every warranty for any item has pages of small print that define what failures are to be covered, will this be allowed and how will the board determine if the wording is correct?

For these reasons this regulation should not be put in force.

Proposed Regulation

3) To specify that a dentist cannot: 1) offer rebates, split fees or commissions for services rendered to a patient to any person other than a partner, employee or employer; nor 2) directly or indirectly receive a fee or other consideration to or from a third party for the referral of a patient or client

How would this impact a clinical trial? If we offer a patient a clinical trial in which there is a reduced fee or no fee or reimbursement for the patient's time would this breach this regulation? i. e. would this be a rebate to a patient who is a person? If a third party web site referred a patient that was paid for by a dentist would this breach this regulation? What is the definition of other consideration?

Again this would be a difficult regulation to administer.

Thank you for considering these opinions

Dr. John C. Gunsolley DDS, MS

Professor of Periodontics

Department of Periodontics

Virginia Commonwealth University

Yeatts, Elaine J. (DHP)

From: mayer levy [mayer-susan@msn.com]
Sent: Tuesday, July 30, 2013 9:27 AM
To: Yeatts, Elaine J. (DHP)
Cc: Dr. Terry Dickinson; Dr. Guy Levy; seaplane; Ellen Byrne/HSC/VCU; Dr. David Sarrett
Subject: Prohibition on fee-splitting, etc.

Elaine J. Yeatts
Agency Regulatory Coordinator

Please record my support of the petition for Prohibition on Fee-Splitting, Rebates, or Commissions to a Third Party for Dental Services.

Not only is such conduct unethical, it is a Federal criminal act. Such conduct removes a patient protection. Nontransparent referral is not in the best interest of the patient because financial transactions should not be the guiding factor to provide appropriate treatment or treatment by the appropriate provider.

Thank you,

Mayer G. Levy, DDS
VA 3256

Yeatts, Elaine J. (DHP)

From: Guy G Levy DDS [guy@guylevydds.com]
Sent: Tuesday, July 30, 2013 2:53 PM
To: Yeatts, Elaine J. (DHP)
Subject: Fee Splitting and Ethical Dentistry

Elaine J. Yeatts
Agency Regulatory Coordinator

Dear Ms. Yeatts,

Please record my support of the petition for Prohibition on Fee-Splitting, Rebates, or Commissions to a Third Party for Dental Services.

Not only is such conduct unethical, it is a Federal criminal act. Such conduct removes a patient protection. Nontransparent referral is not in the best interest of the patient because financial transactions should not be the guiding factor to provide appropriate treatment or treatment by the appropriate provider.

Thank you for your consideration,

Guy

Guy Levy, DDS
3120 Kiln Creek Parkway, Suite L
Yorktown, VA 23693
757-877-9281 phone
www.levyhoffman.com

DHP JUL 22 2013



American
Dental
Hygienists'
Association

V i r g i n i a
The Virginia Dental Hygienists' Association

July 16, 2013

Elaine J. Yeatts
Agency Regulatory Coordinator
Board of Dentistry
9960 Mayland Drive, Suite 300
Richmond, VA 23233

RECEIVED
JUL 22 2013
Virginia Board of Dentistry

Dear Ms. Yeatts,

On behalf of the Virginia Dental Hygienists' Association (VDHA), we respectfully ask you to support the petition filed on July 10, 2013 by Terry Dickinson, DDS that would prohibit fee-splitting, rebates or commissions to a third-party for dental services.

To amend regulations for unprofessional conduct to specify that a dentist cannot: 1) offer rebates, split fees or commissions for services rendered to a patient to any person other than a partner, employee or employer; nor 2) directly or indirectly receive a fee or other consideration to or from a third party for the referral of a patient or client.

VDHA's values align with the qualities of best business practice to include transparency and fairness. These methods of fee-splitting and commissions fail to demonstrate ethical behavior by not providing full disclosure to patients. Prohibiting any arrangement that includes; fee-splitting, rebates or commissions to a third-party for dental services falls under VDHA's principles that any technique that does not uphold best practice standards is deemed unprofessional conduct.

We appreciate the ongoing efforts required to balance judgments and hope that you will continue to look to VDHA as a resource. Please do not hesitate to contact me or Ralston King (VDHA Lobbyist) at rking@whiteheadconsulting.net or 804-310-2718 with any questions, comments or concerns.

Best Regards,

Pamuela A. Kitner, RDH, BSDH
President
Virginia Dental Hygienists' Association

Cc: Sandra Reen, Executive Director
Cathy Berard, VDHA Governmental & Professional Affairs Council Chair
Cal Whitehead, VDHA Lobbyist

VDHA
28 North 8th Street, 2nd FL
Richmond, VA 23219

RICHMOND VA 230
16 JUL 2013 PM 11



Comments on Dickinson petition

From: Paul Hartmann, DDS [<mailto:paul.hartmann@omsp.com>]
Sent: Tuesday, August 20, 2013 8:42 AM
To: Reen, Sandra (DHP)
Subject: Petition for Fee Splitting in Dentistry in the Commonwealth

Dear Ms. Reen:

It was brought to my attention recently that this is **not** already in the rules and regs in Virginia. I would venture to guess that most dentists in Virginia think this is already on the books. We certainly were taught in dental school that it was considered unethical behavior for professionals. When I think of the potential, I am horrified at the potential for misbehavior. As a specialist, I can envision referring doctors requesting kickbacks! It may seem far fetched, but unfortunately, the largest practices in many cases are the ones that push the regulations to their limits (advertising). The patients of the Commonwealth need your protection. We are always creating rules and regulations to control the behavior of the most avaricious and unethical 1%. I would strongly encourage you to pass this provision. I am not posting this on the open site as my practice is economically dependent upon the dentists that you seek to regulate...as are all specialists.

Paul K. Hartmann, DDS

Oral and Maxillofacial Surgery of Williamsburg

1323 Jamestown Road, Suite 203

Williamsburg, VA 23185

Telephone: (757) 253-2393 FAX: (757) 259-0433

[prev](#) | [next](#)**18VAC60-20-180. Advertising.**

A. Practice limitation. A general dentist who limits his practice shall state in conjunction with his name that he is a general dentist providing only certain services, e.g., orthodontic services.

B. Fee disclosures. Any statement specifying a fee for a dental service which does not include the cost of all related procedures, services, and products which, to a substantial likelihood, will be necessary for the completion of the advertised services as it would be understood by an ordinarily prudent person shall be deemed to be deceptive or misleading. Where reasonable disclosure of all relevant variables and considerations is made, a statement of a range of fees for specifically described dental services shall not be deemed to be deceptive or misleading.

C. Discounts. Discount offers for a dental service are permissible for advertising only when the nondiscounted or full fee and the final discounted fee are also disclosed in the advertisement. The dentist shall maintain documented evidence to substantiate the discounted fee.

D. Retention of broadcast advertising. A prerecorded copy of all advertisements on radio or television shall be retained for a six-month period following the final appearance of the advertisement. The advertising dentist is responsible for making prerecorded copies of the advertisement available to the board within five days following a request by the board.

E. Routine dental services. Advertising of fees pursuant to subdivision F 3 of this section is limited to procedures which are determined by the board to be routine dental services as set forth in the American Dental Association's "Code on Dental Procedures and Nomenclature," as published in Current Dental Terminology (CDT-2007/2008), which is hereby adopted and incorporated by reference.

F. The following practices shall constitute false, deceptive, or misleading advertising within the meaning of § [54.1-2706](#) (7) of the Code of Virginia:

1. Publishing an advertisement which contains a material misrepresentation or omission of facts;
2. Publishing an advertisement which contains a representation or implication that is likely to cause an ordinarily prudent person to misunderstand or be deceived, or that fails to contain reasonable warnings or disclaimers necessary to make a representation or implication not deceptive;
3. Publishing an advertisement which fails to include the information and disclaimers required by this section;
4. Publishing an advertisement which contains a claim of professional superiority, claims to be a

specialist, or uses any of the terms to designate a dental specialty unless he is entitled to such specialty designation under the guidelines or requirements for specialties approved by the American Dental Association (Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists, October 2001), or such guidelines or requirements as subsequently amended and approved by the dental disciplinary board, or other such organization recognized by the board; and

5. A dentist not currently entitled to such specialty designation shall not represent that his practice is limited to providing services in a specialty area without clearly disclosing in the representation that he is a general dentist. A specialist who represents services in areas other than his specialty is considered to be practicing general dentistry.

G. Signage. Advertisements, including but not limited to signage, containing descriptions of the type of dentistry practiced or a specific geographic locator are permissible so long as the requirements of §§ [54.1-2718](#) and [54.1-2720](#) of the Code of Virginia are complied with.

Statutory Authority

§ [54.1-2400](#) of the Code of Virginia.

Historical Notes

Derived from VR255-01-1 § 4.4, eff. September 1, 1987; amended, Virginia Register Volume 5, Issue 7, eff. February 1, 1989; Volume 7, Issue 19, eff. July 17, 1991; Volume 9, Issue 19, eff. July 15, 1993; Volume 10, Issue 19, eff. July 13, 1994; Volume 11, Issue 3, eff. April 6, 1995; Volume 11, Issue 9, eff. April 6, 1995; Volume 15, Issue 5, eff. December 23, 1998; Volume 23, Issue 15, eff. May 2, 2007.

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Petition Information	
Petition Title	Prohibition on fee-splitting, rebates or commissions to a third-party for dental services
Date Filed	7/10/2013 [Transmittal Sheet]
Petitioner	Terry Dickinson, DDS
Petitioner's Request	To amend regulations for unprofessional conduct to specify that a dentist cannot: 1) offer rebates, split fees or commissions for services rendered to a patient to any person other than a partner, employee or employer; nor 2) directly or indirectly receive a fee or other consideration to or from a third party for the referral of a patient or client.
Agency's Plan	The petition will be published on July 29, 2013 in the Register of Regulations and also posted on the Virginia Regulatory Townhall at www.townhall.virginia.gov to receive public comment ending August 28, 2013. The request to amend regulations and any comments for or against the petition will be considered by the Board at its meeting scheduled for September 13, 2013.

Commenter: Dag Zapatero, DDS *

Prohibition on fee-splitting, rebates or commissions to a third-party for dental services

I am in full agreement with Dr. Dickerson position on this matter. These rebates and fee split contracts undercut our profession as a whole and removes diagnosis and treatment planing from the realm of the dentist.

We already have seen our patients of record have their teeth cleaned at a discount for one time only and then return to our office for the next cleaning. Who does this help? We need to encourage actions which promote the dentist patient relationship and not promote offers which use price to lure patients of record away from other dentist. Who is following up to see that all treatment was provided as specified by the agreements? Why should we allow non-dentist to determine what procedures are sold to patients before a proper history and exam are preformed? I support this petition. Dag Zapatero, DDS

7/29/13 11:12 pm

Commenter: David Sarrett, DMD, MS, Virginia Commonwealth University *

Prohibition on fee-splitting, rebates or commissions to a third-party for dental services

Fee-splitting, rebates or commissions to a third-party for dental services are considered unethical actions for dentist members of the American Dental Association. This has been the case for very long time. The reason this is not a good practice and not in the best interest of patients is it creates incentives for the dentist to provide unnessecary treatment to patients who are referred through third parties. The emergence of marketing services that sell dental services online to patients in return for splitting the fees with the dentist has made this a much more common problem than in the past. Passing this regulation will be in the best interest of patients.

7/29/13 11:59 pm

Commenter: S.T. *

Agreed

As a dental student, I am surprised to find out that this practice has not yet been made illegal. One of roles of a professional is to place the patients' interests first. This role is compromised if choices affecting patients are determined by monetary gain. Patients do not benefit from fee splitting. The referring doctor should always

choose the specialist who can provide the best quality of service to the patients and not be tempted to choose specialists based on commission. Remove the temptation by formally outlawing fee splitting. How one would enforce the ban of under-the-table fee splitting is beyond me.

7/30/13 12:30 pm

Commenter: David Black, DDS *

Split fees

I support Dr Dickinson's position. This further supports ADA's position in our code of ethics.

8/1/13 9:17 am

Commenter: William Harper DDS *

Fee Splitting

Fee splitting is obviously unethical and dangerous to the public.

In addition, if fee splitting is allowed to continue, it will create a disastrous make-money-at-all-cost environment for dentistry. It is no secret that younger dentists are facing record financial burdens, and even though they have full intentions of practicing fairly and ethically, they have to pay loans and feed their families. If we allow new dentists, or any dentists, to be surrounded by colleagues who split fees or insurance companies who pay to keep patients in-network, then these dentists will be forced to create their own fee-splitting practices just to stay ahead, and patients will suffer.

Lets keep our profession honest and dependent on good dentistry, not Survivor-type alliances.

8/13/13 5:38 pm

Commenter: Kirk M. Norbo, D.M.D. Virginia Dental Assoc. President *

Fee splitting

Our profession is concerned with the increasing trend of unethical business practices that include fee splitting, rebates, and payments for patient referrals. The primary goal of Virginia Dental Association dentists is to deliver quality dental care to our patients in a safe and ethical manner. We feel that treatment decisions may be negatively impacted by these monetary incentives. The VDA has taken an active role in addressing this activity and encourages the Board of Dentistry to support regulation that will discourage this behavior.

8/17/13 10:51 am

Commenter: William J, Bennett, D.D.S. *

Fee Splitting/Rewards/Patient solicitation

Monetary payments - rewards - gifts - to third parties for solicitation of patients should be illegal.

It is considered illegal behavior by the Federal Government in their healthcare contracts and also laws dealing with dental equipment and supply sales. Other states and professions consider it illegal. The American Dental Association states that the behavior is unethical in their ADA Principals of Ethics and Code of Professional Conduct. Numerous other dental organizations such as the Academy of General Dentistry, American College of Dentists, International College of Dentists, dental speciality organizations and more all consider this activity unethical.

Solicitation of patients through any monetary incentives or services provided is a misrepresentation and harmful to the public and reputations of all ethically practicing healthcare providers. This activity should be considered illegal in Virginia and now properly addressed by the Virginia Board of Dentistry.

Respectfully submitted,

8/18/13 10:15 pm

Commenter: Bruce R Hutchison, DDS *

Fee Splitting

Fee splitting (paying someone (anyone) to have them refer a patient to you)- is unethical and should be illegal. The ADA Code of Professional Conduct and Ethical Behavior has listed fee splitting as unethical behavior for many years. If you just step back and think clearly about it- why should someone get rewarded for referring a patient for dental care? This is clearly a conflict of interest. If you were truly concerned with finding the best care for someone- would you need to be rewarded for it? Paying for referrals in any form causes the focus to go from what's in the best interest of the patient to "What's in it for me?" This does not lead to better care and can lead to referral to the highest bidder. Clearly not in the best interest of the patient. If this is matter is not settled, the Board will not be doing it's best to "Protect the public."

Fee splitting is already illegal in several (many) other states.

I believe the Board of Dentistry regulations say a dentist can be reprimanded for unethical behavior- but there is no reference to what ethical behavior is. The ADA and The American College of Denists both have specific Codes. Perhaps these should be adopted by the Board to have a reference for "Ethical behavior." Again, I believe several states have adopted the ADA Code of Professional Conduct as a guideline document in reference to ethical behavior.

Patients are best served by an ethical, well behaved and intentioned profession of Dentistry. While the Board may not see itself as the enforcer fo ethical conduct- it should be- that would help promote better dental care within the Commonwealth, and as a result, further protect the public.

8/19/13 1:51 pm

Commenter: Gisela Fashing, DDS *

Prohibition on fee splitting, etc.

The world has changed a great deal since I began practicing dentistry, when advertising was illegal and we had to practice only under our own name. Now we have drug companies advertising medications of all types directly to the public, we have lawyers advertising their services to right all wrongs nightly on TV, and we have dentists advertising in all media- including on the sides of a car which the dentist drives around town for a year, then promises to give it to the lucky winner of a contest for people who refer a new patient to that dentist. In fact, the ethics of the entire population is questionable if one bases one's judgement on current events in the entertainment industry and politics. However, it's time to draw the line somewhere and this is at least a place to start to control the excesses and to keep the playing field level for all dentists and their patients.

8/20/13 5:45 pm

Commenter: Catherine Oden Fulton, DDS *

Fee splitting

When I first saw GroupOn, I thought what a great way to drive patients in the door. I buy a GroupOn on occasion like many women I know. The thought that this new form of advertising was fee splitting never crossed my mind. However, once I learned that physicians and dentists are held to higher advertising standards, I understood why it was technically considered fee splitting.

GroupOn and other internet coupons are here to stay. We're in the Information Age. Time has shown that those practices that market heavily benefit financially. There are Invisalign practices that give away I Pads to every new patient and Align Technologies promotes these marketing ideas. I don't have an MBA to know what works

and what doesn't; there is too much risk involved for my participation. I'm also of a different generation where such practices were frowned upon by colleagues.

I don't envy you and the decisions that you will be making in the future. I do see plenty of healthcare providers using these internet advertising devices and I do not think the majority of the public think it distasteful or illegal. It's a part of daily life.

The law was probably written before the internet explosion. Its purpose was to prevent doctors from paying for referrals. GroupOn is a form of advertising. Certainly those who receive partial payment are in the advertising business and not endorsing these doctors.

There are new regulations for HealthCare companies to report how much money is being spent on entertaining clients. I can't believe how much money some of my colleagues spend on general dental office staff to generate referrals. The gift giving to them and patients is staggering, but apparently quite effective. This upsets me more than GroupOn; however, both degrade the profession.

I'm not sure how I want the board to rule on this. Advertising is different from buying referrals from other professionals.

8/20/13 9:34 pm

Commenter: Sebastiana G Springmann DDS *

fee splitting

Fee splitting is considered unethical for American Dental Association members. The ADA Code of Ethics is an appropriate guideline for the Virginia Board of Dentistry to endorse. The public would be adequately protected if all dentists were to abide by the Code.

8/21/13 12:26 pm

Commenter: Michael J. Link, D.D.S. *

fee splitting petition

Marketing a business is part of the modern day philosophy for all types of industry. However, in dentistry, paying a third party to refer you patients is not only unethical but very dangerous. By paying an individual or a group for a referral, the individual is walking down a slippery slope of unethical behavior. This clearly shows that the Dentist does not have the best interest of the patient at hand. Hence, the Dentist will try to sell the patient unwanted treatment or better yet, sell treatment that is not needed for the sake of the almighty dollar. Our profession deserves better and needs to stand up to the unprincipled Dentists. This change in the regulation does two things; it will help ensure that the Board is protecting the public from injury and ensure ethical behavior in our profession. The Board should consider adopting the ADA code of ethics as a model behavior for all Dentists in Virginia. The Board of Dentistry's sworn obligation is to protect the public from harm. By allowing fee splitting to occur in the Commonwealth, the patient is held hostage to the highest bidder and possibly an incompetent Dentist. Fee splitting encourages fraudulent behavior and I know the Board will act appropriately on the petition.

8/21/13 1:27 pm

Commenter: Thomas J. Demayo, DDS *

Fee Splitting

It is the opinion of many (myself included) that Fee Splitting with regard to health care is unethical practice. Hopefully the Virginia Board of Dentistry will be of a similar mindset.

8/21/13 6:06 pm

Commenter: Lanny Levenson, DDS *

fee splitting

It's my belief that the practice of fee splitting or rebates for referrals should be disallowed. The ADA has a paper positioning their stance on ethical guidelines concerning Groupon, Living Social and other arrangements. Monetary incentives for coming in for care often lead to inappropriate care. Please consider what is best for dental citizens and reduce the impact of all forms of fee splitting.

8/22/13 12:44 pm

Commenter: Richard Taliaferro, DDS *

Fee Splitting Prohibition

Fee splitting or paying a third party for patients goes beyond an ethical issue alone. Our patients are degraded when we buy them. They should come into our practice based on an intelligent decision, not because we paid for them. When we pay for a patient, we might have the tendency to seek a return on our investment; possibly resulting in over treatment.

8/22/13 2:08 pm

Commenter: Ted Sherwin, DDS, Virginia Dental Association, President-Elect *

Fee Splitting

The Virginia Dental Association has a Code of Professional Conduct and Ethical Behavior. This is something the VDA takes very seriously. We believe that our member dentists put the interest of their patients first. The VDA works to keep our members aware of and in tune with these beliefs.

Fee Splitting, we believe, is one of those principles that all dentist should abide by, not just members of our Association. Because the VDA has no jurisdiction over non-member dentists, we ask the Board to do its part to "Protect the Public" and create regulations that discourage fee splitting.

8/23/13 8:26 pm

Commenter: DR. ROBERT B. ALLEN *

FEE SPLITTING

Solicitation of patients through any monetary incentives or services provided is a misrepresentation and harmful to the public and reputations of all ethically practicing healthcare providers. This activity should be considered illegal in Virginia and now properly addressed by the Virginia Board of Dentistry.

Respectfully submitted,

ROBERT B ALLEN, DDS

8/25/13 10:12 am

Commenter: Chris Richardson *

Fee splitting

The American Dental Association has a Code of Ethics in place for a reason. It is not simply an "opinion paper" that has been drafted to have language in place that **suggest** dentists have an option of adhering to. Is moral and ethical behavior an option? At this point in time, unfortunately, it is. With no legal grounds to stand on, ethical and legal acts have been put into two distinct categories. In other words, I can choose to be unethical in dentistry, but still be perfectly within the construct of the law. The current rules and regulations of the Virginia Board of Dentistry allow this to take place with regards to fee splitting. Why should the majority of dentists adhere to this Code of Ethics when a few receive a relative slap on the wrist for unethical behavior? This creates a divide within the dental community, when at this point in our profession we need to be doing everything we can to unite it. Please pass the appropriate regulations eliminating these questions by making fee splitting illegal in the Commonwealth of Virginia. This regulation should be written in terms which provide detailed examples as to what is determined to be illegal.

8/27/13 6:23 am

Commenter: Dr. Steven Forte *

Fee Splitting

I agree with the proposal and ask the Board to recognize fee splitting as a unethical practice. Please help to maintain our profession in the highest regard by our members. Thank you for the consideration.

8/27/13 8:57 am

Commenter: Michael S. Morgan, DDS, FAGD *

Fee Splitting

A dental patient is in the position that they must place their full faith in the judgment and ethical principles of their dentist. Anything, such as fee splitting, which may compromise this faith and trust that the patient must have in their dentist is clearly not in the best interest of the dental patient.

8/27/13 11:55 am

Commenter: John W. King DDS *

Strongly Oppose Proposition # 3

I understand the issue with the problem of fee splitting. I don't know anyone who is doing it, but if it is occurring, I'm certainly against it.

The problem I have with Proposition # 3 is that "gifting" has been lumped into this proposition and Proposition # 3 does not differentiate the two.

If this proposition becomes a Board regulation or law, then any "gifting" becomes illegal. At the current time, "gifting" by dentists in Virginia may be at most unethical. I personally give Christmas gifts to my referring doctors during the Holiday. Under the proposed Proposition # 3, this would be against the law and would be board violation. I also give out movie passes and thank you notes to patients and parents for referring patients in the office. In addition, I give out gift cards when these patients actually initiate treatment. All of the above would become illegal acts if this Proposition was adopted by the board as regulations.

When proposing a law or change in the regulations, one must considering all aspects and repercussions of the regulation. Thus, I am opposed to this proposition and would request that the above acts remain as ethical questions not laws or regulations.

8/27/13 1:27 pm

Commenter: Paul W Callahan, D.D.S. *

Dental Care Warranties

I'm concerned that the requirement to warranty dental care will harm the public due to the influences dental warranties will have upon treatment presentation and decision making.

Dentistry is both a profession and a business that we all rely upon to support our families and provide a moderate standard of living. Although a crown may be the ideal standard of care, why would I recommend a crown if I have to warranty it? I may "patch" a filling, that although meets a minimal standard, is a far inferior long term treatment choice. Will I recommend an extraction rather than a crown, knowing that a four Mountain Dew a day habit will destroy any care I provide and therefore be forced to extend a warranty? We face daily less than ideal treat plan situations and discuss openly with our patients the benefits and risks of care when we have less than an ideal prognosis. These discussions lead patients to make decisions of informed consent. Will I continue to do this if it is going to cost me money to replace a crown? Teeth ravaged by decay and the need for endodontics, symptomatic cracked teeth, periodontally involved teeth. Why not just recommend extraction to protect me and my business profit margin? I can't control what a patient does when they leave my office.

We as a profession are ethical and morally bound to provide a standard of care based upon mutually agreed upon treatment plans and informed consent. Leave us alone to do it.

8/27/13 1:33 pm

Commenter: Randy Adams, President- Old Dominion Dental Society *

I oppose proposition #3

8/27/13 2:43 pm

Commenter: Khalid Hussein DDS *

Fee splinting

I think fee splitting is very tricky, and each office should have the right to inform patients about their payment policy.

8/28/13 1:01 am

Commenter: William L. Davenport *

Support Ethical Dentistry-Stop Fee Splitting

It is time for the BOD to take the proper position on ethical practice of dentistry and to prohibit fee splitting and any other schemes that place financial incentives above quality patient care. The ADA Code of Ethics should be the model to guide the regulations that govern advertising and a dentist's self promotion.



COMMONWEALTH OF VIRGINIA

Board of Dentistry

9960 Mayland Drive, Suite 300
Richmond, Virginia 23233-1463

(804) 367-4538 (Tel)
(804) 527-4428 (Fax)

Petition for Rule-making

The Code of Virginia (§ 2.2-4007) and the Public Participation Guidelines of this board require a person who wishes to petition the board to develop a new regulation or amend an existing regulation to provide certain information. Within 14 days of receiving a valid petition, the board will notify the petitioner and send a notice to the Register of Regulations identifying the petitioner, the nature of the request and the plan for responding to the petition. Following publication of the petition in the Register, a 21-day comment period will begin to allow written comment on the petition. Within 90 days after the comment period, the board will issue a written decision on the petition.

Please provide the information requested below. (Print or Type)

Petitioner's full name (Last, First, Middle initial, Suffix,)
Tavakoli, Vahid

Street Address
3046 Mission Square Drive

Area Code and Telephone Number
703-862-9860

City
Fairfax

State
VA

Zip Code
22031

Email Address (optional)

Fax (optional)

Respond to the following questions:

1. What regulation are you petitioning the board to amend? Please state the title of the regulation and the section/sections you want the board to consider amending.

Mandatory five years warranty on Crowns and bridges from the day of installation.

2. Please summarize the substance of the change you are requesting and state the rationale or purpose for the new or amended rule.

All dentists in state of Virginia should give five years warranty on all crowns and bridges from the day they are installed. Insurance companies won't accept any claims on any bridge or crown unless they are at least five years old. This way, customers are protected against another large bill in less than five years. Additionally, this incentivizes dentists to ensure that their work is durable and thorough.

3. State the legal authority of the board to take the action requested. In general, the legal authority for the adoption of regulations by the board is found in § 54.1-2400 of the Code of Virginia. If there is other legal authority for promulgation of a regulation, please provide that Code reference.

Signature: *Vahid Tavakoli*
Date: 6/25/2013

As a faculty member at VCU having conducted over 30 clinical trials in Periodontics and 30 Years of practice I would like to make some comments on the proposed regulations.

Proposed regulation

- 1) To require all dentists to give a five-year warranty on crowns and bridges to ensure work is durable and thorough.

This regulation at best would be very difficult to administer. Bridges and crowns fail for many reasons, many of which are not in the control of the dentist. Periodontal disease, cracked teeth, decay, high caries rates and trauma all can be the reason that a bridge or crown would fail. Determining if these were pre-existing, or after the prosthesis was placed is at best a nightmare to determine in some cases. The word thorough at the end of the regulation could imply that the dentist has anticipated all of these problems whether they existed before or after the prosthesis was placed, making the dentist responsible when they were not. Also what is a failure under this regulation? Would the following be failures: Sensitive teeth, small or large piece of porcelain broken off, recession resulting in compromised esthetics, new decay, cracked teeth, need for a root canal, need for periodontal disease?

In today's world every warranty for any item has pages of small print that define what failures are to be covered, will this be allowed and how will the board determine if the wording is correct?

For these reasons this regulation should not be put in force.

Proposed Regulation

- 3) To specify that a dentist cannot: 1) offer rebates, split fees or commissions for services rendered to a patient to any person other than a partner, employee or employer; nor 2) directly or indirectly receive a fee or other consideration to or from a third party for the referral of a patient or client

How would this impact a clinical trial? If we offer a patient a clinical trial in which there is a reduced fee or no fee or reimbursement for the patient's time would this breach this regulation? i. e. would this be a rebate to a patient who is a person? If a third party web site referred a patient that was paid for by a dentist would this breach this regulation? What is the definition of other consideration?

Again this would be a difficult regulation to administer.

Thank you for considering these opinions

Dr. John C. Gunsolley DDS, MS

Professor of Periodontics

Department of Periodontics

Virginia Commonwealth University

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Part V

Unprofessional Conduct

18VAC60-20-170. Acts constituting unprofessional conduct.

The following practices shall constitute unprofessional conduct within the meaning of § [54.1-2706](#) of the Code of Virginia:

1. Fraudulently obtaining, attempting to obtain or cooperating with others in obtaining payment for services;
2. Performing services for a patient under terms or conditions that are unconscionable. The board shall not consider terms unconscionable where there has been a full and fair disclosure of all terms and where the patient entered the agreement without fraud or duress;
3. Misrepresenting to a patient and the public the materials or methods and techniques the licensee uses or intends to use;
4. Committing any act in violation of the Code of Virginia reasonably related to the practice of dentistry and dental hygiene;
5. Delegating any service or operation that requires the professional competence of a dentist, dental hygienist, or dental assistant II to any person who is not a dentist, dental hygienist, or dental assistant II as authorized by this chapter;
6. Certifying completion of a dental procedure that has not actually been completed;
7. Knowingly or negligently violating any applicable statute or regulation governing ionizing radiation in the Commonwealth of Virginia, including, but not limited to, current regulations promulgated by the Virginia Department of Health;
8. Permitting or condoning the placement or exposure of dental x-ray film by an unlicensed person, except where the unlicensed person has complied with [18VAC60-20-195](#); and
9. Unauthorized use or disclosure of confidential information received from the Prescription Monitoring Program.

Statutory Authority

§ [54.1-2400](#) of the Code of Virginia.

Historical Notes

Derived from VR255-01-1 § 4.3, eff. September 1, 1987; amended, Virginia Register Volume 5, Issue 7, eff. February 1, 1989; Volume 7, Issue 19, eff. July 17, 1991; Volume 9, Issue 19, eff. July 15, 1993; Volume 10, Issue 19, eff. July 13, 1994; Volume 11, Issue 3, eff. April 6, 1995; Volume 11, Issue 9, eff. April 6, 1995; Volume 15, Issue 5, eff. December 23, 1998; Volume 26, Issue 22, eff. August 4, 2010; Volume 27, Issue 11, eff. March 2, 2011.

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Petition Information	
Petition Title	Mandatory warranty on dental crowns and bridges
Date Filed	7/10/2013 [Transmittal Sheet]
Petitioner	Vahid Tavakoli
Petitioner's Request	Require all dentists to give a five-year warranty on crowns and bridges to ensure work is durable and thorough
Agency's Plan	The petition will be published on July 29, 2013 in the <u>Register of Regulations</u> and also posted on the Virginia Regulatory Townhall at www.townhall.virginia.gov to receive public comment ending August 28, 2013. The request to amend regulations and any comments for or against the petition will be considered by the Board at its meeting scheduled for September 13, 2013.

Commenter: Dag Zapatero, DDS *

Five year warrantee on C&B

I am sure the petitioner has good intension to protect the public from bad dentistry, but why only five years? Why not ten, twenty or thirty? I hate to see C&B failures, but I cannot be held accountable for all the failures I have seen in work of any age. What C&B failure data does the Commonwealth have to suggest the need for a change? I would be against any change to current rules since the factors causing early failure of C&B are multifactorial. Who will judge what failures are related to patient host factors, which are related to material or laboratory issues, and which were dentist errors? In the early 1990 I did a bunch of Procera Alumina crown, many of them failed 8-9 years out. I hated to see these fail but we were told by manufactures that these crowns worked and had lifetimes equivalent to PFMs. They were wrong.

Are you asking dentist to be responsible for patient's failure to seek routine dental care, or if they fail to practice proper oral hygiene? What happens if the patient's host oral flora changes due to hospitalization, diseases which lead to immunocompromised states, changes mental status or cognitive abilities, or accidents? How about material failures or poor laboratory workmanship that only show up with time? Will laboratory also be forced to warrantee their work, or will the burden just be borne by the dentist? Medical doctors don't give any warrantees if the surgery fails, cancer comes back or if a patient contracts a nosocomial infection which requires additional treatment and fees. We will be forced to increase our fees to cover this additional liability.

We currently have mechanisms to address patients complaints due to a lack of proper retention and resistance form, incomplete decay removal, bad workmanship and improper fix. Patients can file a complaint with the BOD and an investigation will follow. We have all seen what we consider bad work, but in a court room these are just our opinions and do not represent the standard of care.

It should be left up to the individual dentist to determine his/her office policies. If this were an appliance or electronic equipment the consumer would be allowed to buy an extended warrantee at their discretion. I personally warrantee my work for five years when the C&B is fabricated in the USA and the lab generally covers the replacement crown. When price is the only consideration and off-shore lab is used, we do not have any margins left to offer any warrantee, since those labs done offer one to us. If you are interested in helping the public the BOD should determine what types of failures have occurred and which materials are involved. Maybe a class-action law suit is in order.

Dag Zapatero, DDS, MAGD

7/29/13 4:17 pm

Commenter: Jim Kline *

Unfair to Burden 1/4 of the procedure

How can you possibly make a dentist warranty crowns and bridges for 5 years? You don't require that insurance companies pay dentists whatever the work costs, but rather the state allows insurance companies to dictate to the

practitioner the course of care through various forms of intimidation and pressure. Due to the recent changes in healthcare in America the Federal government is mandating total coverage without any protection of the practitioner which is giving all the power to the insurance companies - don't buy into the fallacy that the insurance companies care about their customers; which happen to be the Dentist's patients.

The practitioner is not the only party involved with a crown or a bridge - the lab, the insurance company, and the patient are also responsible for the longevity and quality of the work. It is an unfair burden to force only 1/4 of the responsible parties to extend a warranty on the work that all 4 are responsible for. If you require a warranty then you must also require the insurance company to pay whatever the cost which will allow the practitioner to select the lab and the materials they want without fear of going bankrupt. Or the State would have to pass a law that says that patients have to pay the difference between reimbursement and actual cost so the Dentist can use the materials and labs they deem best. How can the dentist ensure the patient follows instructions? Will the insurance companies pay for a redo? Are you going to force all labs doing business in Virginia to extend a warranty on their work as well, thus driving labs out of the state too?

Yes, the dentist's work is important and they are the only party in any procedure that has taken an oath to care for the patient. Neither the Labs, the insurance companies, nor the patient have taken an oath and dedicated their lives to Dentistry. Don't further burden the practitioners and further drive the quality Dentists out of Virginia.

7/29/13 7:16 pm

Commenter: Marybeth Fasano DMD *

Unfair burden placed on General Dentists

I read this petition in disbelief. As a general Dentist I am in awe of the one dimensional thinking that happens in our Capital. The idea that a 5 year warrantee on crown and bridge is in any way a method to protect patients is absurd. How can I warrantee something that I have such limited control of? Yes, I can follow through on my responsibilities to ensure that the procedure is done to the high standard that I and the extremely large majority of my fellow colleagues accomplish every day, but it is extremely naive to think that alone ensures the success of treatment. I cannot stop my patients from drinking Monster drinks and Red Bull. I cannot drag them to their prophylaxis appointments, or floss for them. I cannot ensure that they are not immunocompromised in anyway, or guarantee that their family physician does not prescribe medications that cause extreme xerostomia. Even great dentistry will fail given the right mix of circumstances.

7/29/13 10:55 pm

Commenter: David Sarrett, DMD, MS, Virginia Commonwealth University *

Warranty on dental crowns and bridges

Clinical studies on the longevity of dental restorations has shown that the two primary reasons for having to replace a restoration (crowns and bridges, fillings included) are new tooth decay that occurs in the remaining tooth under the restoration, and fracture of the restoration. Fractures tend to take place earlier in the life of the restoration and new tooth decay tends to occur later in the life of the restoration. Tooth decay is the main reason for having to replace a dental restoration with fracture a distance second reason. Tooth decay in a restored tooth is not something the dentists can control since it depends on risk factors that exist in the patient such as past history of tooth decay, strength of the bacteria present in the mouth, dietary use of sugars, saliva amount and content, oral hygiene practices, and use of fluoride toothpaste and rinses. Dentists should talk to patients about these risk factors prior to restoring teeth or replacing missing teeth with bridges so the patient can make an informed decision to proceed with the restorations but there is no way to predict or guarantee when or if the restored tooth may develop new tooth decay.

I have published two review papers that looked at the scientific literature related to the relationship between the fit of restorations to the teeth and the risk of tooth decay. The science does not support a relationship. Dentist should strive to make well fitting restorations but a poor fit does cause tooth decay. Tooth decay is caused by the factors I listed above and cannot be attributed to a poorly fitting restoration.

Fracture of restorations tends to occur more frequently in some patients than others and this risk factors are bite forces and tooth clenching and grinding habits. Certainly the early failure of a restoration due to fracture in a patient without these factors and without a history of breaking restorations, can indicated some problem with manufacture or design of the restoration. In these situations, I typically remake the restoration with out charging and the problem is usually solved.

Forcing dentists to provide a five year warranty on crowns and bridges will only drive up the cost of care for all patients to cover the cost of replacement in patients with risk factors that cause higher failure rates.

Here are the links to the two paper I mentioned earlier.

<http://www.ncbi.nlm.nih.gov/pubmed/18341238>

J Adhes Dent. 2007;9 Suppl 1:117-20.

Prediction of clinical outcomes of a restoration based on in vivo marginal quality evaluation.

Sarrett DC.

<http://www.ncbi.nlm.nih.gov/pubmed/22066463>

J Oral Rehabil. 2012 Apr;39(4):301-18. doi: 10.1111/j.1365-2842.2011.02267.x. Epub 2011 Nov 8.

Prediction and diagnosis of clinical outcomes affecting restoration margins.

Dennison JB, Sarrett DC.

7/30/13 11:56 am

Commenter: David Black,DDS *

Unreasonable expectations of warranty

I do not think there should be a five year warranty. we cannot control a patients level of care that is the biggest determinant of how long dental work will last.

8/1/13 10:16 am

Commenter: Gregory Engel, DMD, MS *

Treatment Warranty

I applaud the comments previously stated from my fellow dentists and agree whole heartedly. But another consideration is this: this rulemaking petition teeters on a very slippery slope. I am gravely concerned about these types of provisions and the subsequent impacts that will follow. As previously stated, there are too many factors to consider - many of which are completely beyond the dentist's control - when determining the longevity of any treatment; crown and bridge or otherwise. Each patient is an individual with individual circumstances that may dictate the predictability and longevity of any treatment (a "crown" for one patient can be and many times is different than a "crown" on another). Not to mention the patient's own treatment desires / choices when given multiple options. I agree that there are existing provisions in place that patients can pursue should a treatment issue arise and that mandating some sort of warranty on treatment is completely unjustified.

8/6/13 1:36 pm

Commenter: Michael J Sims DMD *

warranty period

I could not agree more with my fellow practitioners on the non-feasibility of mandating a "warranty" on crown and bridge prostheses. My colleagues have more than adequately pointed out that there are simply too many

extraneous factors beyond our control to consider this regulation as reasonable. The comments by Dr. Fasano in particular were very pointed and factual and truly reflect the feelings of the vast majority, if not 100%, of all general practitioners in The Commonwealth..

8/10/13 8:38 am

Commenter: Melvin Cruser DDS *

crown and bridge warranty

If there is some sort of defect in a restoration, it will become apparent in the first year, in which case I will happily remake the restoration. There are too many patient related factors over which the dentist has no control to require some sort of across the board warranty. This should be left to the individuals involved, not to the government to decide. We have enough government interference already so lets leave what we can for reasonable people to decide.

8/12/13 9:44 am

Commenter: Marvin Rosman Official Virginia and U.S. consumer and taxpayer *

Proposed C&B warranty

As a consumer, it is not surprising to see that all dentists who responded to date oppose the warranty. I am an 81 year old with some gold crowns that were installed in 1957-58 and still function well. Fifty six years for a crown is pretty good. Of course those were delivered in the days of \$35 gold. I have numerous other crowns and implants. None have failed. My dental hygiene is certainly less than optimal. I believe that my dentists are and have been highly skilled. I recognize that there is a lot of art in making crowns, bridges and implants.

The dental profession must also give consideration to extending a C&B warranty to implants.

We should recognize that reasonable warranties must be subject to *appropriate* restrictions and limitations. I don't have the technical knowledge to draft these limitations, but my reaction is that a failure due to design, workmanship or material breakdown should be covered. A failure due to subsequent decay or related poor dental hygiene would not.

As a consumer, I can not be concerned with related or remote third parties. If an automobile part fails during the warranty period the consumer is not relegated to the supplier to the manufacturer. Presumably the dentist chose the lab and materials. An exception might provide for insurance company liability if the company refused to pay for a material that the dentist appropriately specified..

Some consideration should be given to making the warranty subject to the Virginia Consumer Protection Act.

Type over this text and enter your comments here. You are limited to approximately 3000 words

8/12/13 4:44 pm

Commenter: Thomas J. DeMayo, DDS *

Health Care Warranty

The success vs. failure of a medical procedure is governed by many factors, this also holds true for dental procedures. The patient's biology plays a key role in the success or failure of dental procedure just as it does when a medical procedure is undertaken. As with medical procedures there are rates of success and failure associated with dental procedures and therefore there can be no warranty associated with any dental procedure. Certainly if a patient believes he or she has been misdiagnosed, mistreated or malpracticed, he or she could and should pursue this.

8/12/13 4:48 pm

Commenter: Susan DeMayo *

Crown / Bridge Warranty

When procedures are done by dentists there are a number of reasons why those procedures can fail but biology is often a key factor effecting failure or success. I understand a consumers frustration when any procedure results in failure, but he or she must understand that dentists are physicians of the oral cavity and the treatment of teeth and their supporting structures are comparable to medical treatment done elsewhere in the body. There should be no warranty associated with any medical or dental procedure.

8/13/13 1:10 pm

Commenter: Kirk M. Norbo, D.M.D., Virginia Dental Assoc. President *

Opposed to crown warranty

The Virginia Dental Association and its members abide by a strong Code of Ethics that was written to protect the public. Our member dentists deliver crowns to their patients intending to have these restorations last much longer than 5 years. Unfortunately, diet, poor dental hygiene, medications, and lack of saliva are some of the predisposing factors that lead not only to crown failures but other dental treatment as well. To target crowns or any other dental procedures for warranty periods is simply ill founded. The overwhelming majority of dentists take pride in their ability to provide quality dental care to their patients. Adding additional regulations in the form of warranties would be burdensome to dental practitioners, impossible to monitor and completely unnecessary.

8/13/13 8:49 pm

Commenter: Kristina Staples DDS, Corporate Dental Director CVHS *

Opposed to Crown Warranty

I too, like my colleagues, am opposed to a 5 year C&B warranty. If I'm to provide a warranty on the C&B work what warranty am I given by the patient that they will maintain good oral hygiene, keep a balanced diet, keep their dental recall appointments, stay away from prescriptions that cause dry mouth, monitor any bruxism habits, never have any trauma to the tooth, etc, etc. How about patients that live in nursing homes or retirement communities and have decreased manual dexterity? What about patients that move? Also, what warranty are we getting from the lab that the crowns will last 5 years? We don't make the crowns, and we can't control the patients habits.

I myself have a crown, but if it fails in 5 years, I accept that the failure will likely have little to do with the dentist that seated the crown. Also, if the dentist works for a community health center should the health center have to cover the cost of failed crowns? Could this lead to a decreased rate of crown placement in patients that the dentists feel will not be able to maintain the oral hygiene or protective actions necessary to retain the crown?

8/13/13 9:05 pm

Commenter: Sebastiana G Springmann DDS FAGD *

warranty on dental crowns

I echo and support the comments of my colleagues, especially Dr Norbo of the VDA and Dr Sarrett of VCU. As a dentist with over 20 years in private practice I have seen patients with restorations that have lasted a very short time and those that have lasted 50 years. What is the difference? Perhaps the quality of the materials and work but only in a very few cases. Overwhelmingly the difference between a restoration that succeeds and a restoration that fails is the patient. The patients' medical history, lifestyle, oral habits, health habits, commitment to regular dental care, etc, etc, etc. All factors over which the dentist has no control. To force the dentist to "warranty" such a situation is unreasonable, will place undue regulatory burden on practitioners and only cause the cost of care to rise for all patients.

8/13/13 9:59 pm

Commenter: Dr. Uppasna Chand, D.D.S. *

Warranty disapproval

In a perfect world, it would be great to be able to guarantee all of our dental work we provide. Unfortunately, it's unreal to expect all of our patients to be extremely diligent about not missing a recare appointment. We hear excuses all of the time for why people miss their regular cleanings. If that's the case, how is it fair to the dentist to guarantee work when some patients aren't prioritizing their own dental care.

As dentists, we see so many patients who were once patients of another local dentist. How unfair is it to find decay around a crown which may be 4 years old and send that patient back to the previous dentist to have remade at no cost? The other dentist has no clue how the hygiene has been maintained, etc.

Dr.Chand, D.D.S.

8/13/13 11:05 pm

Commenter: Gail Teuschler, RDH *

Crown and Bridge Warranty?

I have been practicing for 19 years. During seven of those years I worked as a substitute, and saw many different styles of dentistry. I have seen bridges last (patient reported) for thirty years. I have seen (in my opinion) poor margins on some crown and bridge last for many years, because the patients took excellent care of them. I have also seen the opposite. I have seen excellent margins (in my opinion) on some crown and bridge fail, because the patient did not take care of it as they should have. They did not come in for regular dental hygiene appointments, as well as not regularly flossing, and what about using extra fluoride? How can those gauges be implemented? I myself had a crown with excellent margins; I practice excellent hygiene, yet had a crown fail. It happens. Most dentists already offer a 5 year warranty on their work provided that patient practices regular preventive oral hygiene and has regular 6 month (or 3 month if periodontally involved) prophylaxis appointments. I don't believe a blanket statement of requiring dentists to give a five-year warranty on crowns and bridges to ensure work is durable and thorough, there are just too many variables that are beyond the scope of the dentists ability to control.

8/14/13 2:31 pm

Commenter: Gretchen Drees Zelazny DDS *

Disagree with any required Warranty

I agree with the previous comments of my colleagues that this is a BAD idea. It is unrealistic to require a warranty on a dental procedure with "human" factor involved(of variations of non-compliance) with oral care. Dr. Sarrett expressed some succinct comments with research to back it up. I do not support this idea and believe the comments will continue to follow this line of thinking.

8/14/13 4:02 pm

Commenter: William Ossakow, DDS *

Warranty on crowns and bridges

To propose a warranty of 5 years or any amount of time for crowns and bridges is ludicrous. You simply cant paint with such a broad brush in matters relating to dentistry. There are countless factors involved in the success and failure of any restoration, both known and unknown; several studies in the scientific community confirm this.

Would you also have a surgeon warranty that a cancer will not come back after its removal for a specified amount of time? Anytime you are dealing with the human body and a persons individual genetic and behavioral makeup you can't reasonably expect to warranty anything. The human body is not a toaster oven.

Any dentist who does not take his or her craft seriously enough and do all he can to provide quality work that HE or SHE expects to last as long as humanly possible, will be weeded out by both the market place and/or the board of dentistry. Any dentist with a conscience would realize a manufacturing flaw that would lead to breakage, etc. and do the right thing. There is no need for a warranty as that will only create more red tape and more headaches for those who strive to do their best every day they practice dentistry.

8/17/13 11:16 am

Commenter: William J. Bennett, D.D.S. *

Crown guarantee

Many factors out of a dentists control can determine the longevity of a dental restoration of any type. These factors can change over time depending on a patients habits, health and activities. Informed consents for treatment should outline the concerns, limitations and pros & cons for any care to be rendered. All the factors known at the time should be understood and agreed. This is recognized practice and should eliminate misunderstandings on proposed treatment results.

I have no doubts that dentists would like the crowns they provide to last a life time and longer than 5 years. However, to make a legal warranty requirement of dental treatments provided would not be easily regulated or reasonable.

Respectfully submitted,

William J. Bennett,D.D.S.

8/18/13 9:36 pm

Commenter: Bruce R Hutchison, DDS *

Crown Warrantee

While the idea of a 5 year guarantee looks like a nice concept- it is wrought with many flaws. The lifespan of a crown (or any dental restoration) depends on many factors, only some of which are under the dentists control. These factors include quality of laboratory work, quality of procedural work done, condition of the tooth in question to start with, medical condition of the patient, home care performed by the patient, does the patient return regularly for check ups to monitor the restoration and quickly and easily correct small problems before they cause a failure, patient habits (such as never brushing or bruxism) and so on. I will illustrate several situations where a crown may fail due to no fault of the dentist or the laboratory.

1. Trauma- accidental fracture of the restoration or the underlying tooth due to excessive forces of trauma
2. Bruxism- what if a patient refuses a gold crown for a second molar (recommended because it can't break) and chooses a porcelain crown that later breaks because of undue stress from bruxism
3. Root canal therapy- some crowns need root canals after they are completed. A hole must be drilled through the crown to do the root canal- this can weaken the porcelain and cause it to fracture
4. Poor home care and recurrent caries under the crown margin can cause a crown to fail
5. The patient insists on trying to save a tooth that is nearly hopeless, so the dentist does his best, in fact does it perfectly- and it fails after a few years- the patient was informed and knew the crown would likely not last 5 years to start with- and is happy with 2 or 3 years

These are a few situations where, for reasons beyond the control of the dentist, a crown may fail. Some of these are a result of poor decisions on the part of the patient after being informed of options available. In each case, to force a dentist to replace a failed crown would be inappropriate.

Most dentists just do the right thing anyway. If my patient were to have a crown fail within 5 years, we would have a discussion as to why. If I felt there was any fault of mine involved, I would offer a reasonable solution- like replace for free or maybe charge a new lab fee. This is the free market and those who don't stand behind their work will weed themselves out of the mix. You cannot legislate ethical and good behavior- but you can punish the masses for poor behavior of the few. Dentists, for the most part, will do the right thing.

Do not go down this path, it will only lead to confusion, higher costs, and patients not getting what they want. None of these are in the best interests of protecting the public.

8/19/13 1:20 pm

Commenter: Gisela Fashing,DDS *

5 year warranty on crowns and bridges

The vast majority of crowns and bridges endure at least five years and many laboratories provide such a guarantee. Many insurance companies will only reimburse dentists for a new crown 5 years after a crown was placed on a given tooth. However, the laboratory crown guarantee requires that a patient show proof of regular dental visits every 6 months. Even with regular dental cleanings and check-ups every 6 months, a dentist cannot guarantee that tooth decay, periodontal disease or a fracture will not occur to destroy the tooth itself which then causes the crown or bridge to fail. Today's dental patients include many who are taking one of the more than 500 medications known to decrease the flow of saliva which in turn increases the rate of tooth decay. After age 50, the mineral composition of teeth changes and makes teeth more prone to fracture. Periodontal disease can also cause a major periodontal defect within a short period of time which then condemns the tooth to extraction. It is therefore not possible to guarantee anything for any period of time in dentistry. Durability of dental treatment varies with the condition of the tooth when treatment is rendered and with the dietary and oral hygiene habits of the patient. Requiring a 5 year guarantee for all crowns and bridges will foster the unnecessary extraction of slightly questionable teeth and their replacement with implants. This will increase the cost of dentistry to the patient and to society.

8/19/13 1:28 pm

Commenter: Justin Norbo, D.D.S. *

Warranty is unreasonable

It is unreasonable for dentists to have a five year warranty on full coverage crowns. Many factors determine the success of a crown as many people have already listed on this forum. It was commented earlier on this forum that the number one reason why crowns fail is due to decay around crown margins. Decay is a multifactorial issue and certain patients are at higher risk for decay than other patients. This pattern of decay should be discussed during the informed consent of having a full coverage restoration placed. If the patient is informed that they are at higher risk then the situation is analogous to placing a warranty on automotive brake pads for the driver that has his/her foot on the gas and brake pedal at the same time while driving down the highway.

8/19/13 1:32 pm

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that they are at higher risk then the situation is analagous to placing a warranty on automotive brake pads for the driver that has his/her foot on the gas and brake pedal at the same time while driving down the highway.

8/19/13 4:53 pm

Commenter: Thomas Padgett *

What is fair

8/20/13 4:49 pm

Commenter: Catherine Oden Fulton, DDS, PLC *

5 year warranty on crowns

The Virginia Board of Dentistry is made up primary of dentists; therefore, I trust you will deem this request unreasonable. The request for a 5 year warranty on crowns is unreasonable. As an orthodontist, if relapse occurs shortly after retainers are inserted and the patient has been cooperative, I will often retreat for a short duration at no charge. When former patients come back for a touch up, I may give a small discount as a thank you for their loyalty. However, I make no guarantees and certainly not for the entire fee. These courtesy discounts are at my discretion. I do not participate with any insurance that caps fees at discounted rates. However, if I did, I imagine it would be significantly more difficult to extend these courtesies. A crown has many variables for its initial success and longevity. What this petition is asking for is not doable for the vast majority of practices.

8/20/13 5:15 pm

Commenter: Michael J. Link *

petition for warranty on crowns

I believe that a warranty on crowns should be up to each individual Dentist. A mandate from the Government is an intrusion on the patient/doctor relationship. There are too many variables that accompany a warranty on a crown. Currently, most labs guarantee the product (i.e. porcelain and metal) for 5 years as long as the patient is seen every 6 months for an oral exam and prophylaxis. To guarantee total coverage of a crown is ridiculous. The reason most Dentist oppose this petition is for the following reasons: The best fitting crown can fail in 2-3 years with improper oral hygiene. Plus, I have seen a marginal crown survive 15+ years with excellent oral hygiene. A problem with a guarantee is once you give a guarantee, what happens when the patient does not show up for recall appointments? Why should a Dentist be responsible for a patient's neglect? What happens when a patient refuses radiographs? I can tell you that I have seen this in my own practice.

Due to the problems that we as Dentist face, I strongly oppose this request!!

8/20/13 6:39 pm

Commenter: Roger A. Palmer, DDS *

Crown and Bridge is a service not a product, unintended consequences

Crowns, bridges, partial dentures and dentures, etc. are services, not consumer products. Having to warranty not only the crown but all of the associated costs would greatly increase fees to patients.

Also, for those patients with low insurance fee schedules and especially Medicaid patients, access to care would be severely restricted.

The regulations to address all of the possible scenarios involved with crown failures would be hundreds of pages long and in the end will still end up being an ethical decision as to the reason for a failure.

I personally use a lab that guarantees their crowns and bridges for five years against porcelain fracture, etc. providing the patient has been on a regular recall schedule. I have no problem with making crowns over when the problem was not caused by neglect or abuse.

It would be interesting to see how the orthopedic surgeons would feel about an all-inclusive warranty on hip and knee replacement.

8/20/13 9:48 pm

Commenter: Guy Levy, DDS *

5 year warranty

Dental prostheses, including fixed crowns and fixed partial dentures, are fabricated to become a functional part of a patient's anatomy. Although the dentist and patient should have assurance regarding the composition of the prosthetic, which I believe already exists in the VA statutes, assurance regarding the patient's functional anatomy is complicated and dependent upon many factors. Although well meaning, this proposal is impractical given the multitude of variables that contribute to human anatomy and physiology. Respectfully submitted by Guy Levy.

8/21/13 9:19 am

Commenter: Mohamed Attia DDS, FAGD *

strongly oppose

I strongly oppose having a mandatory warranty on any dental prosthesis like crowns, as there's many variables involved in its success, longevity and/ or failure, including biological and biomechanical factors. Warranty and courtesy discounts should be left at the dentist's own judgment and personal discretion and based on case by case evaluation.

8/21/13 4:09 pm

Commenter: Parker Ence, CEO of Dental Warranty Corp. *

Alternative solution

Our company deals directly with this issue on a daily basis. In my opinion, the dentist should not shoulder the full burden for things outside their control as many have stated here.

I do believe, however, that the patient's basic desire behind this rule change request is for better communication and peace-of-mind when faced with the cost of a crown or bridge. Perhaps they had a bad experience with a failed treatment?

At any rate, if patients are demanding a higher level of assurance against life events (which are outside of the dentist's control), an alternative to a state mandated warranty is a third-party warranty or protection plan. For example, our 5 yr protection plan covers the cost of all of the items listed by Dr. Hutchinson above, including trauma or accidents, bruxism, root canal therapy after a crown has been placed, recurrent decay, and others, and also gives the patient nationwide protection if they move. In this way, the dentist doesn't have to take on the added risk and cost of a mandated 5 year warranty, but the patient still has the extra assurance available.

I don't say this to promote our product, but just to point out that there are other ways of solving the issue then adding a regulation.

8/22/13 3:01 pm

Commenter: Brett Dunnill, DDS *

objection to standardized warranty

The problem is this. Every patient and tooth is different. Some people grind their teeth, some people don't brush their teeth, some people don't floss, some people chew ice, some people have a high caries rate due to medical conditions, etc. The long term prognosis for any dental work is different from tooth to tooth. It's like doing a knee replacement on someone who is in perfect health and exercises regularly and doing the same knee replacement on an obese person with uncontrolled diabetes. Two completely different cases with different probabilities of success. The key is patient education and expectations. They need to make informed decisions. Dentists must be beneficent and make case to case determinations on warranties considering all factors. This is in regards to all treatment...not just crowns.

8/22/13 3:28 pm

Commenter: Dr. Ricky J. Rubin *

5-year Crown Warranty

Holding the dentist to a 5-year warranty on crown/bridge is simply wrong. There are numerous variables beyond the dentist's control that cause clinically sound crown/bridge to fail on or before 5 years such as poor oral hygiene, failure to show up for recare appointments, and occlusion issues (a patient with no posterior occlusion needs a crown on an anterior tooth, but cannot afford or is not willing to restore posterior occlusion). A home builder is only required to warranty a new home for 2 years in our state, but there is a call for dentists to warranty crown/bridge for 5-years. There needs to be dual accountability in the dentist-patient relationship, and the responsibility should not only be placed on the dentist.

8/22/13 6:21 pm

Commenter: William Munn DDS *

Warranty work

The problem with attempting to place a warranty on major dental work is that we as dentists don't work in a static environment. Many factors can change the oral condition, some even beyond the patient's control much less the dentist's. Systemic diseases, medications as well as a patient's physical and mental limitations can all produce an oral environment more conducive to decay. And the patient's responsibility can not be negated. Keeping up with regular dental visits to maintain proper care is as important if not more so than the skill of the dentist.

8/23/13 6:24 am

Commenter: Rose Satterfield, DMD *

Mandatory Warranty on Dental Crowns and Bridges

I would oppose this proposed regulation based on clinical research findings on reasons for failure of dental crowns and bridgework. These findings place the most common reasons for failure on patient compliance. Recurrence of decay around these appliances is the major cause of failure and this is caused most often by lack of good hygiene & regular dental care, the individual's oral environment and the general health of the patient. Mechanical failure of the actual appliance is rare. It is very difficult to make a guarantee of patient compliance.

8/23/13 3:34 pm

Commenter: Rod M. Rogge, DDS, PC *

crown warranty

I can't really add much that has not already been said by my colleagues in this Town Hall Forum. I do see this as a poorly conceived concept that is universally rejected by people who understand dentistry. Therefore, why is it even being reviewed by the Board? Why would a citizen propose such a petition if not guided to do so, and why wouldn't the board reject it as ludicrous before putting it into the Forum format?

Is the Board required to put every proposition into this format, regardless of appropriateness? Some editorial comment seems in order. Why does the dental association have to keep on the lookout for ridiculous things like this, so that absurd propositions do not actually develop into lawful requirements? If we can't get the Board to address illegal dentistry issues like tooth bleaching in the mall, or dental "grills" made by jewelers, how do things like this petition get any support to be reviewed?

The Board automatically takes every complaint and turns it into a case for inspection, regardless of validity. They do not tell the complainees that no financial settlement through the Board is possible. The Board also does not tell complainees about the Peer Review Committee of the Virginia Dental Association, which has an amazing success record at satisfying complaints financially and promptly. If anyone wants to make a meaningful petition for the Board, change how the Board answers the phone, and how cases should not be automatically generated.

8/23/13 8:37 pm

Commenter: ROBERT ALLEN DDS *

5 YEAR WARRANTY ON CROWNS

I must agree with Dr. Roggee;

crown warranty

I can't really add much that has not already been said by my colleagues in this Town Hall Forum. I do see this as a poorly conceived concept that is universally rejected by people who understand dentistry. Therefore, why is it even being reviewed by the Board? Why would a citizen propose such a petition if not guided to do so, and why wouldn't the board reject it as ludicrous before putting it into the Forum format?

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8/25/13 10:58 pm

Commenter: Flavio W. Nasr, DDS *

Crowns should not be treated as commodities

This proposal assumes that crowns are commodities like televisions, automobiles or computers. We all know that the success of any medical treatment involves the participation of the patient in this process. As medical professionals, it is our responsibility to educate patients and guide them in showing how their actions can contribute to the success of our treatment. Furthermore, it is our responsibility to provide patients with treatment that follows standard of care. It is also the patient's responsibility to properly follow our instructions in maintaining his/her oral health.

We should have flexibility in dealing with unsuccessful treatment. There are already regulations in place that address failures due to not following standard of care. We should not be burdened by additional inflexible regulations. Should cardiac surgeons warranty bypass surgeries (what if a patient continues to smoke...)? Should plastic surgeons warranty facelifts (what if a patient continues to sunbathe everyday...)?

In conclusion, do not treat crowns as consumer commodities. Thank you.

8/26/13 8:51 am

Commenter: Clark D Fortney DDS *

5 year warranty on fixed prosthodontics

In placing a fixed prosthetic restoration we are dealing with human tissue, human psychology, human behavior, and human host response, all of which are variable in mostly out of the dentist's control. These factors plus others not mentioned influence the clinical life of a prosthesis.

If health care ever gets to the point of warranting how long a patient will live then maybe a 5 year warranty on dental prosthetics may be in line!

A 5 year warranty is an absurd notion.

Can you imagine the litigation and regulation that might result!

8/27/13 12:15 pm

Commenter: Garrett E. Hurt, D.D.S. *

warranty on dental services

It's all been entered by my colleagues already. I can place the best crown or restoration in the world but if the patient does not do their part at home my work is often in vain.

8/27/13 12:15 pm

Commenter: Vandana Sood, D.M.D., LLC *

Warranty on Crown/Bridge

A warranty on crown/bridge is not going to work in my opinion. There are many factors which result in the success and/or failure of a crown. I would say a majority of the cases I do are successful, but there are those cases which patients are non-compliant and don't follow through with regular dental care and follow up. There can be lab errors. What if there was material ie impression used that we later found out to be defective. Do we then go back to the manufacturer and ask them to pay for the patients new crown? How do we monitor what patients do outside of the office ie foods, drinks, habits, oral hygiene; medical factors, medications, etc. Why should I the dentist be penalized for something that is out of my control? I believe if there is a crown that is made, and it is due to an error on the dentist part, then the dentist should remake the crown at no charge to the patient. I strongly believe that it should be left to each dentist to determine the circumstances and try to work something out with the patient on a case by case basis. If you start putting a warranty on crown/bridges then soon after there will be a warranty on all dental procedures. How can you put a warranty on healthcare as it is not a product? I believe most dentist out there try to do their best to serve their patients. I find that insurance sets up these parameters ie 5 years which then set the standard of care when actually the insurance sets these limits based on their profitability not what is in best interest for the patient. I request that you do not put a mandatory warranty on crown/bridge. Thank you for reviewing my opinion.

Dr. Vandana Sood

8/27/13 12:16 pm

Commenter: Tom Gromling, DDS *

Crown warranties

Not to repeat what others have stated about the inability to warranty restorations, but the original tooth failed at some point due to neglect, diet, etc. Was there a warranty with the tooth to begin with?

8/27/13 1:24 pm

Commenter: Daniel F. Babiec, DMD *

Warranties

We already offer a similar warranty. However, there are two issues that need to be addressed, since this only works if there is bilateral responsibility.

Patients must maintain a reasonable oral hygiene and examination protocol.

Trauma and accidents are not covered under the warrantee.

You can't have patients disappear for 5 years and then claim that your dental work failed, for whatever reason. I've dealt with these over the years, and have had no problems with patients who I have been seeing on a regular basis, but have had problems with patients whose dental condition is degrading unsupervised, or have never returned for any followups, or what appears to be a trauma situation, etc.

Another option is to have a sliding scale of "responsibility". The expectation would be different at three months as opposed to 59 months after initial completion. Most true failures will occur sooner rather than later. Later failures tend to be neglect or trauma related.

Failure must also be defined. Does failure of the underlying tooth structure constitute failure of the restoration? Would a slight porcelain chip which doesn't compromise longevity or affect esthetics, and could be smoothed out, constitute failure of the restoration? What about recession? These types of issues must be dealt with beforehand. It gets more involved in the regulatory arena if dealt with after the fact.

8/27/13 1:32 pm

Commenter: Paul W. Callahan, DDS *

Dental Care Warranty

I'm concerned that the requirement to warranty dental care will harm the public due to the influences dental warranties will have upon treatment decision making.

Dentistry is both a profession and a business that we all rely upon to support our families and provide a moderate standard of living. Although a crown may be the ideal standard of care, why would I recommend a crown if I have to warranty it? I may "patch" a filling, that although meets a minimal standard, is a far inferior long term treatment choice. Will I recommend an extraction rather than a crown, knowing that a four Mountain Dew a day habit will destroy any care I provide and therefore be forced to extend a warranty? We face almost daily less than ideal treatment situations and discuss openly with our patients the benefits and risks of care when we have less than an ideal prognosis. These discussions lead patients to make decisions of informed consent. Will I continue to do this if it is going to cost me money to replace a crown? Teeth ravaged by decay and the need for endodontics, symptomatic cracked teeth, periodontally involved teeth. Why not just recommend extraction to protect me and my business profit margin? I can't control what a patient does when they leave my office.

We as a profession are ethical and morally bound to provide a standard of care based upon mutually agreed upon treatment plans. Leave us alone to do it.

8/27/13 1:51 pm

Commenter: John Denison, DDS *

Warrantee of dental work.

I do not believe placing a warrantee on dental work is a good idea. The life expectancy of dental work is dependent on many factors, including a patients personal oral care, diet, alcohol consumption, smoking, hereditary and environmental factors, maintaining regular dental checkups, occlusal habits, to name a few. Foods effect pH of the mouth, the potential for decay and the longevity of dental work. Coffee, even without sugar, sodas with sugar and sugar-free, power drinks, all are very detrimental to natural teeth and dental work. A patient's lack of home dental care also effects the health of the teeth, dental work and periodontal health.

The location of a restoration can also be a factor in its longevity. Patients who grind their teeth weaken and destroy fillings at a faster rate than those who do not. Deeper restorations can have more potential for weakening teeth. Teeth that have decay but are asymptomatic can become symptomatic when treated. The number of restorations in the mouth, the presence of missing teeth, the presence of removable dentures all effect dental work longevity.

In addition, treatments that are recommended by the dentist to preserve dental work and teeth are often not accepted by the patient, or are not done because the treatments are not covered by insurance companies. At present, many dental treatments that are in the best interest of the patient are refused by insurance companies as unnecessary. Were these treatments to be done, the overall health of the dentition and existing restorations would be improved.

There are far too many factors associated with how well dental work will hold up in the oral environment to accurately ascertain the 'life expectancy' of dental work. Trying to regulate such would only serve to create unrealistic expectations and reduced personal responsibility on the part of the patient.

8/27/13 2:39 pm

Commenter: Khalid Hussein DDS *

Warrenty,

I personally believe that no two patients are alike. Some follow their dentist recommendations, others don't. Therefore even though an office may have certain policies regarding re makes, but those should be general guidelines. I have seen crowns placed 40 years ago and still good, others didn't last evens year. There are many factors that affect the long term longevity of crown such as caries risk, perio, poor hygiene.. etc

Therefore I don't think a 5 year warranty should be mandated.

8/27/13 3:38 pm

Commenter: Mohammed Almzayyen, DDS *

Does MD provide any warranty on prosthetic limbs or joints ??

8/27/13 4:43 pm

Commenter: J. Michael Dukes, DDS *

Five year crown and bridge warranty petition

I can only applaud the numerous comments already posted here that show the flawed logic behind this petition. As others have pointed out repeatedly there are many extraneous factors over which we have no control regarding treatment outcomes. We are providing a service, not a commodity when we do anything for our patients. Does any resonable person expect such blanket guaranties from their physicians when the have hips, knees or heart valves replaced? Of course not.

The remarks of Dr. Hutchison are particularly germane. The vast majority of dentists are ethical and will do the right thing by their patients, regardless of whether such a misguided regulation is in place or not.

8/27/13 6:20 pm

Commenter: Paul T. Olenyn DDS+ *

5 year guarantee

Yes, there cases where crowns and bridges have lasted many years. However, there are too many outside factors that influence the longevity. Is the patient compliant with his home care? Does he see his dentist on a routine basis? If their diet is high in acidic foods or beverages the incidence of deay is greater. What if they are a bruxer or ice chewer the porcelain can fracture. There are just too many things that are beyond the dentist's control to guarantee his work if the patent is not doing their part.

Therefore, I am against such an action by the Board.

8/27/13 7:23 pm

Commenter: K. Hyder *

NO WARRANTY!!!!!!

To whom it may concern ,

Certainly dentistry has a lot of technical work involved in it but I and all the dentists including the specialists will tell you that dentistry is a health care profession ! In life when God himself has not guaranteed our life and our parents who created us have not given any warranty on our lives , how do you expect us to give any kind of warranty on anything !! We all are trying our best to provide the best quality of care to everyone and not just patients who need crowns and bridges !! I feel that we are being persecuted for being in this profession !! If this warranty is to take affect then we will all have to stop practicing and providing the best for our patients . I think the board should realize that this kind of petition should not even be discussed since the board was made for us dentists and should support us in this endeavor and prevent this kind of issue to even crop up . I hope and pray that the board accepts our sincere request to void this petition and doesnot allow these kind of petitions to ever come up again .

Thank you so much ,

Sincerely,

K.Hyder

Reen, Sandra (DHP)

From: Reen, Sandra (DHP)
Sent: Tuesday, April 23, 2013 9:13 AM
To: 'rvaughanvt67@comcast.net'
Subject: FW: License
Signed By: Sandra.Reen@DHP.VIRGINIA.GOV

Hi Dr. Vaughan:

Thank you for sharing your view with the Board of Dentistry. Your message will be included as public comment in the Board's agenda materials for its June 7th meeting.

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4437

From: rvaughanvt67@comcast.net [<mailto:rvaughanvt67@comcast.net>]
Sent: Saturday, April 20, 2013 5:39 PM
To: Board of Dentistry
Subject: License

I recently retired and just received a letter from Delta Dental of Virginia saying that my license had expired and they would no longer process any claims. I tried to let the board know that I had retired, and was told that there were no procedures in place to do this. I was told to just let my license expire. After having a license in Virginia for 42 years, it doesn't look too well that I had let my license expire without knowing it was because I had retired. I feel that there should be some way to notify the board of this in the notification of renewal letter. Ronald O. Vaughan 0401oo4174

DHP MAR 29 2013
02:30 PM
Board of Dentistry



Raven Maria Blanco
FOUNDATION, INC.
Protecting Pediatric Dental Patients

March 22, 2013

Virginia Board of Dentistry
Perimeter Center; 99060 Maryland Drive
Suite 300
Richmond VA 23233-1463

To Whom It May Concern:

The Raven Maria Blanco Foundation (RMBF) is a 501(c) 3 charity dedicated to raising awareness in the dental profession and the public regarding the importance of emergency medical preparedness in dental offices. Our organization is named in memory of 8-year-old, Raven, who died in 2007 during a routine dental check-up.

For our 2013 project to recognize National Children's Dental Health month, RMBF conducted a national survey to determine patient expectations and knowledge regarding medical emergency preparedness by their dentist. We surveyed 591 people from across the nation.

Attached, you will find a copy of the raw data. Several key points are noteworthy:

- 1) Dental patients overwhelmingly expect their dentist to be prepared to manage a medical emergency occurring during dental treatment in all of six key areas:
 - ① Ongoing training of the dentist,
 - ② Regular training of the dental staff,
 - ③ Periodically holding mock emergency drills,
 - ④ Having a written medical emergency plan,
 - ⑤ Stocking routine emergency medications, and
 - ⑥ Maintaining appropriate emergency equipment such as oxygen and an automated external defibrillator.
- 2) Most dental patients believe their personal dentist already has all six of these preparations in place.
- 3) Nearly 80% of dental patients would take some type of action against their dentist if they learned there was a deficiency in any area of medical emergency preparation. Over one in three patients would confront their dentist on the matter. An additional 20% would quietly change dentists and nearly a quarter (24%) would report the matter to their state dental board with the expectation of punitive action.

RMBF, INC.
NICOLE CUNHA • EXECUTIVE DIRECTOR
419 S. LYNNHAVEN RD, SUITE 111, VIRGINIA BEACH, VA 23452
Phone: 757.502.8853 • Cell: 757.222.2876 • Web <http://www.rmbfinc.org> • Email: nicole@rmbfinc.org

Based on our communication with numerous dental lecturers on medical emergency preparedness, it is RMBF's position the vast majority of dental offices, including those in your state, are seriously lacking in multiple areas. However, based on the results of our survey, patients have a skewed view of the actual emergency preparedness of their dentist.

We believe medical emergencies occurring during dental treatment are increasing in frequency and severity.

- ① Demographically, dental patients are aging.
- ② Advances in healthcare mean patients with complex medical histories (e.g. elderly or homebound) now receive dental care.
- ③ Dental treatment is becoming more sophisticated and increasingly invasive (e.g. implants and grafts). Given these facts, the public expectations of medical emergency preparedness in the six key areas listed above are both reasonable and appropriate, and should be incorporated into training and emergency preparedness procedures.

As the governmental agency charged solely with protection of your state's population, you are urged to improve the quality of medical emergency preparedness provided by those you license.

Kindly, reply with your board's position on this matter.

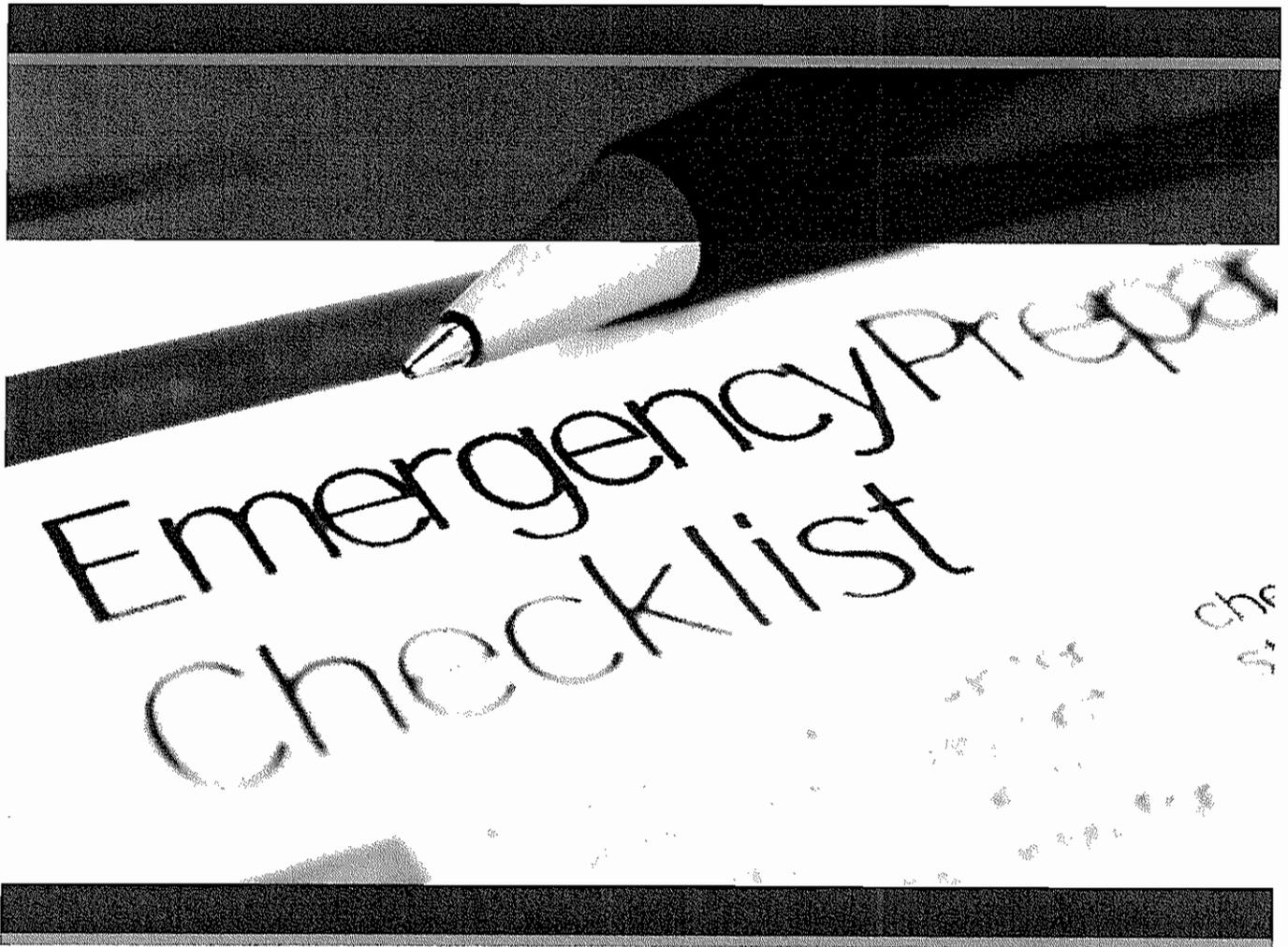
Sincerely,



Nicole Cunha
Executive Director, RMBF

PATIENT EXPECTATION'S on Medical Emergency Preparedness in the DENTAL OFFICE

BY DR. LARRY J. SANGRIK AND NICOLE CUNHA



Raven Maria Blom Foundation, Inc.
4150 Lyndon B. Johnson Freeway, Virginia Beach, VA 23462
www.rmbf.org or 757-461-1133

01 Which best describes you?

Answered: 403 Skipped: 12

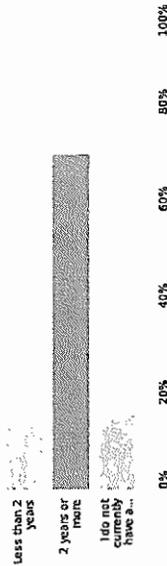


Answer Choices

Answer Choice	Recipients
I see a dentist regularly (check-ups at least once a year)	373
I see a dentist occasionally (check-ups are usually less than once a year)	111
I only go to a dentist for emergency care (when in pain, or for an acute issue)	97
I never go to a dentist (not even in an emergency)	10
Total	591

02 How long have you been a patient of your current general dentist?

Answered: 200 Skipped: 12

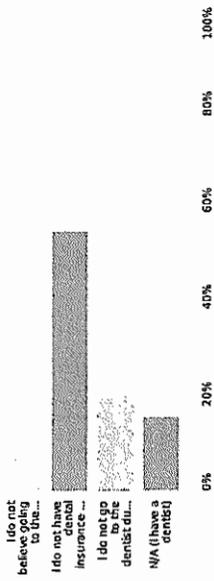


Answer Choices

Answer Choice	Recipients
Less than 2 years	92
2 years or more	401
I do not currently have a general dentist	87
Total	580

Q3 I currently do not have a dentist because?

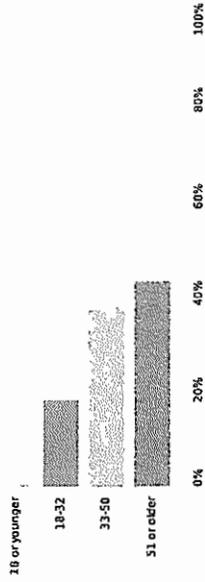
ANSWERS: 10 (53.96%), 46 (53.96%)



Answer Choices	Responses
I do not believe going to the dentist regularly is important	11.63%
I do not have dental insurance and therefore cannot afford treatment	53.96%
I do not go to the dentist due to fear and/or anxiety	19.77%
N/A (I have a dentist)	15.12%
Total	86

Q4 How old are you?

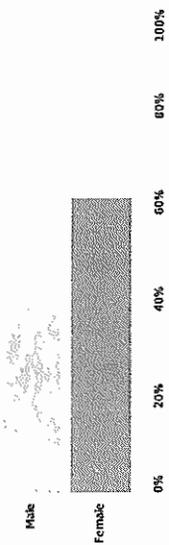
ANSWERS: 15 (2.90%), 90 (17.86%), 185 (36.90%), 213 (42.26%)



Answer Choices	Responses
18 or younger	2.90%
18-32	17.86%
33-50	36.90%
51 or older	42.26%
Total	503

Q5 Are you male or female?

Answers: 504 100%



Answer Choices

Male
 Female
 Total

Response

39.29%
 60.71%

198
 306
 504

Answer Choices

Male
 Female
 Total

Response

78.47%
 21.53%

390
 107
 497

Q6 Is your dentist?

Answers: 497 100%



Answer Choices

Male
 Female
 Total

Response

39.29%
 60.71%

198
 306
 504

Answer Choices

Male
 Female
 Total

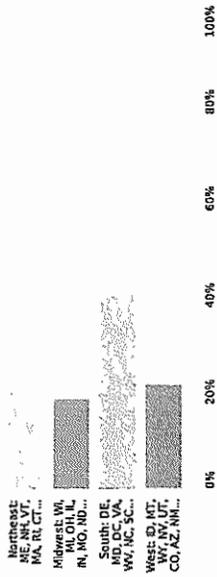
Response

78.47%
 21.53%

390
 107
 497

Q7 In what area of the country does your dentist practice?

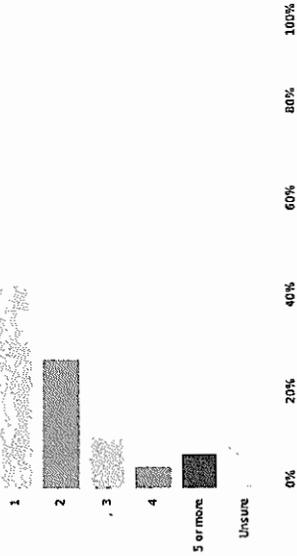
Answered: 174 Skipped: 0



Answer Choices	Responses
Northeast: ME, NH, VT, PA, RI, CT, NY, NJ	92
Midwest: WI, IL, IN, MI, MN, MO, ND, SD, NE, KS, MN, IA	92
South: DE, VA, WV, NC, SC, GA, FL, TN, MS, AL, OK, KY, TX, AR, LA	200
West ID: MT, WY, UT, CO, AZ, NM, AK, OR, CA, HI, WA	106
Total	497

Q8 How many dentists practice in the dental office where you go for treatment?

Answered: 357 Skipped: 0



Answer Choices	Responses
1	211
2	132
3	52
4	21
5 or more	34
Unsure	47
Total	497

Q9 Is the dental practice where you go for treatment:

ANSWERS: 307 Skipped: 0



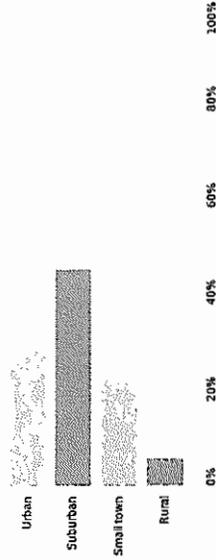
Answer Choices

Answer Choice	Count	Percentage
Privately owned by the dentist(s)	303	77.06%
Corporately-owned	51	12.68%
Unsure	63	12.68%
Total	497	

Responses
77.06%
12.68%
12.68%

Q10 Where is the dental practice located?

ANSWERS: 307 Skipped: 0



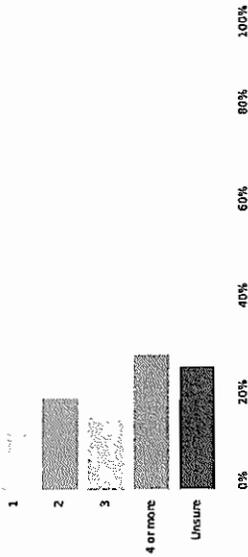
Answer Choices

Answer Choice	Count	Percentage
Urban	139	27.97%
Suburban	222	44.67%
Small town	109	21.83%
Rural	27	5.43%
Total	497	

Responses
27.97%
44.67%
21.83%
5.43%

Q11 How many dental hygienists practice in the dental office where you go for treatment?

Answers: 327 53.36% 91



Answer Choices

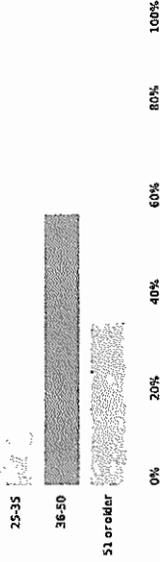
1	60
2	93
3	73
4 or more	137
Unsure	125
Total	407

Responses

1	13.08%
2	18.71%
3	14.05%
4 or more	27.57%
Unsure	25.15%

Q12 In your estimation, how old is your general dentist?

Answers: 657 58.14% 114



Answer Choices

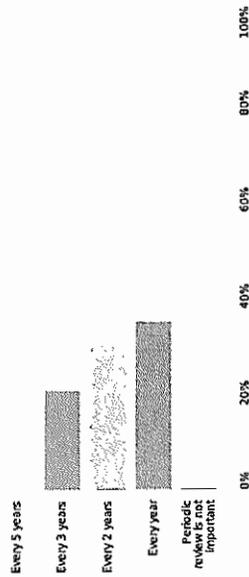
25-35	53
36-50	278
51 or older	166
Total	497

Responses

25-35	10.66%
36-50	55.94%
51 or older	33.40%

Q13 During dental school, all dentists are trained to deal with a wide range of medical emergencies which may occur during treatment. How often do you believe a dentist should review his/her training for a wide range of medical emergencies?

Answers: 103 337842-96

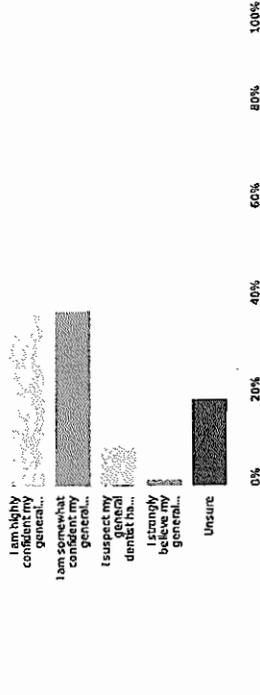


Answer Choices	Responses
Every 5 years	71
Every 3 years	103
Every 2 years	160
Every year	171
Periodic review is not important	1
Total	493

13 / 40

Q14 Based on your answer to the previous question, how confident do you feel your general dentist has received this training within the time period you expected?

Answers: 103 213964-96

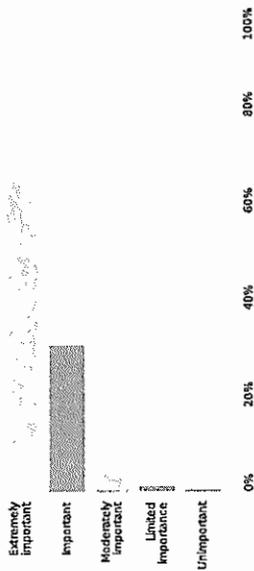


Answer Choices	Responses
I am highly confident my general dentist has done this training	177
I am somewhat confident my general dentist has done this training	178
I suspect my general dentist has not done this training	44
I strongly believe my general dentist has not done this training	6
Unsure	88
Total	493

14 / 40

Q15 How important do you believe it is for your dentist's entire staff to be formally trained to assist in responding to a medical emergency occurring during dental treatment?

Answers: 433 | Selected: 192

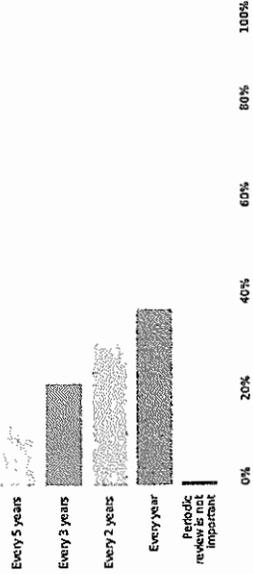


Answer Choices	Responses
Extremely important	318
Important	148
Moderately important	19
Limited importance	5
Unimportant	1
Total	491

15 / 40

Q16 How often do you believe your dentist's entire staff would need to be re-trained to assist in responding to a medical emergency?

Answers: 433 | Selected: 191

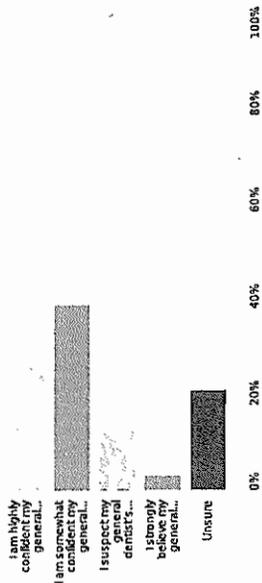


Answer Choices	Responses
Every 5 years	62
Every 3 years	103
Every 2 years	145
Every year	178
Periodic review is not important	3
Total	491

16 / 40

Q17 Based on your answer to the previous question, how confident do you feel your dentist's staff is currently receiving this training within the time period you listed above?

Answers: 333 53.76% (n=1,019)

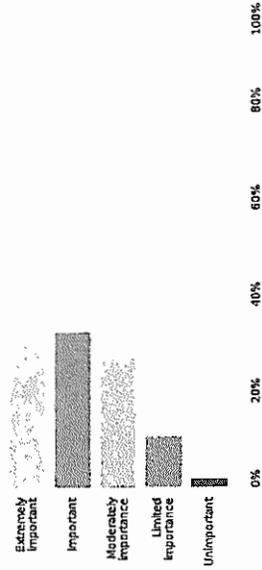


Answer Choices	Responses
I am highly confident my general dentist's staff has done this training	122
I am somewhat confident my general dentist's staff has done this training	157
I suspect my general dentist's staff has not done this training	62
I strongly believe my general dentist's staff has not done this training	14
Unsure	100
Total	491

17 / 40

Q18 Hospitals routinely hold mock drills to prepare for various medical emergencies. How important it is for your dentist to hold mock drills to prepare for a medical emergency occurring during dental treatment?

Answers: 483 83.54% (n=1,019)

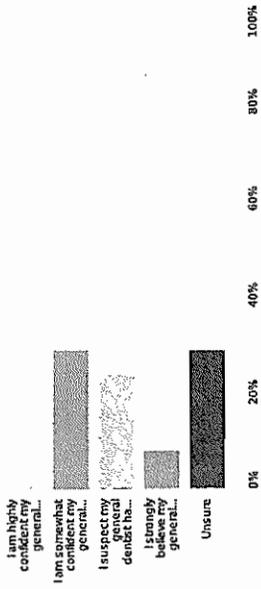


Answer Choices	Responses
Extremely Important	144
Important	156
Moderately Important	130
Limited Importance	50
Unimportant	0
Total	480

18 / 40

Q19 How confident are you that your dentist is currently holding mock drills with his/her staff to prepare for a medical emergency occurring during dental treatment?

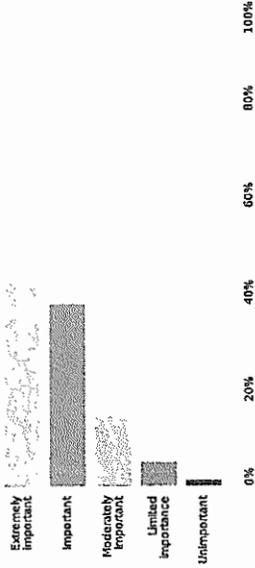
Answers: 100% Skipped: 2 (10%)



Answer Choices	Responses
I am highly confident my general dentist has done this training	54
I am somewhat confident my general dentist has done this training	140
I suspect my general dentist has not done this training	117
I strongly believe my general dentist has not done this training	32
Unsure	139
Total	488

Q20 Hospitals, schools and other entities that deal with the public have written emergency plans to help dictate a specific response and mitigate confusion. How important it is for your dentist to have a written plan specific for his/her office to address a medical emergency occurring during dental treatment?

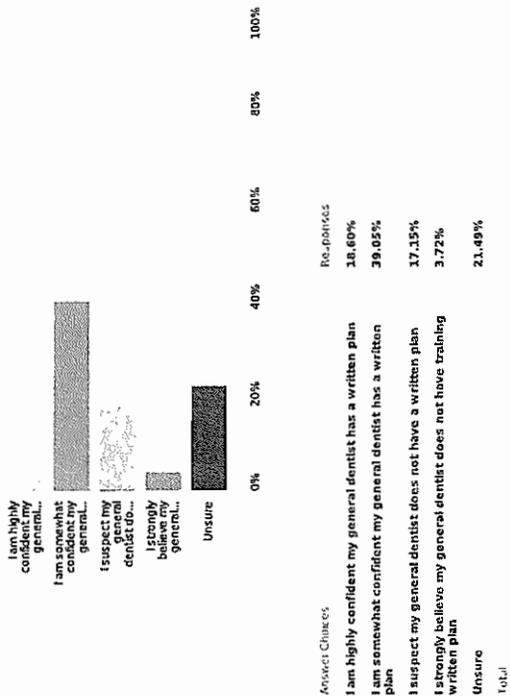
Answers: 100% Skipped: 102



Answer Choices	Responses
Extremely important	205
Important	182
Moderately important	69
Limited importance	23
Unimportant	5
Total	484

Q21. How confident are you that your dentist currently has a written plan?

Answers: 4. 134. Displayed: 107

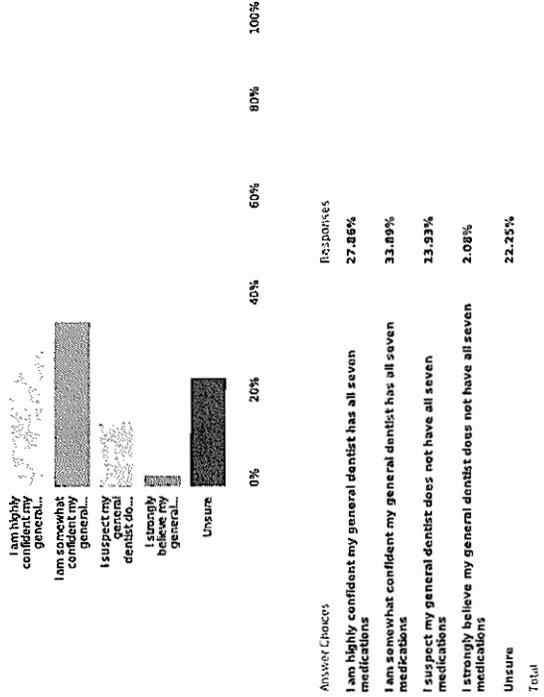


21 / 40

Q22. The American Dental Association recommends dentists stock seven specific medications for use during medical emergencies. However, no state requires a dentist to have them available. How confident do you feel your dentist currently has all seven medications available?

1. Aspirin (blood thinner for heart attacks)
2. An asthma inhaler (Ventolin / Albuterol)
3. Nitroglycerin (used in heart attacks to open coronary arteries)
4. Diphenhydramine (trade name Benedryl, used for minor allergic reactions)
5. Epinephrine (used in asthma, cardiac arrest and anaphylactic shock)
6. Ammonia inhalants (fainting)
7. Glucose (low blood sugar)

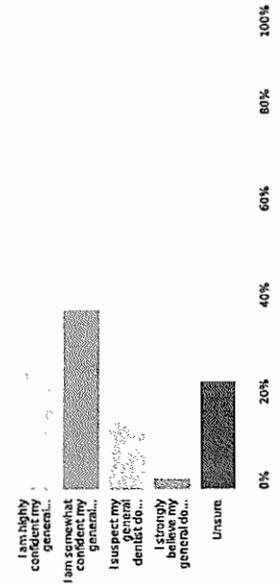
Answers: 401. Displayed: 110



22 / 40

Q23 At least three sizes of blood pressure cuffs to accommodate all sizes of patients

Answers: 12 / 477 (2.5%)

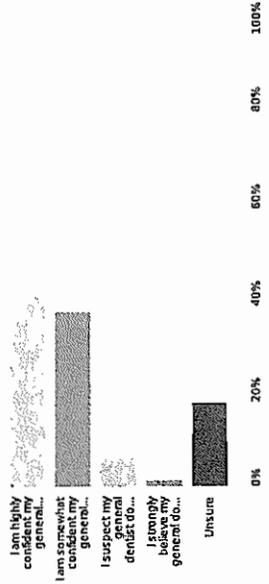


Answer Choices

Answer Choice	Responses
I am highly confident my general dentist has these devices	25.16%
I am somewhat confident my general dentist has these devices	36.90%
I suspect my general dentist does not have these devices	13.63%
I strongly believe my general dentist does not have these devices	2.10%
Unsure	22.22%
Total	477

Q24 A method of providing extra oxygen for breathing patients

Answers: 4 / 477 (0.8%)

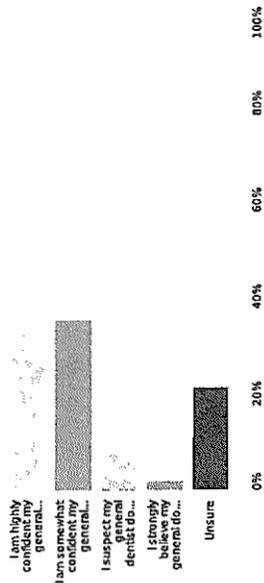


Answer Choices

Answer Choice	Responses
I am highly confident my general dentist has this device	39.83%
I am somewhat confident my general dentist has this device	36.06%
I suspect my general dentist does not have this device	5.07%
I strongly believe my general dentist does not have this device	1.05%
Unsure	17.19%
Total	477

Q25 A method of providing extra oxygen for a patient that has stopped breathing

Answers: 477 Responses: 153



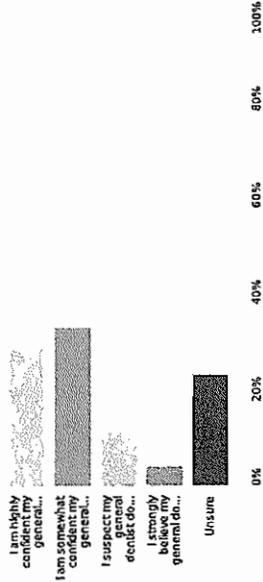
Answer Choices:

- I am highly confident my general dentist does not have this device
- I am somewhat confident my general dentist does not have this device
- I suspect my general dentist does not have this device
- I strongly believe my general dentist does not have this device
- Unsure

Total: 477

Q26 An automatic external defibrillator (AED), a device to electrically start a non-beating heart

Answers: 477 Responses: 156



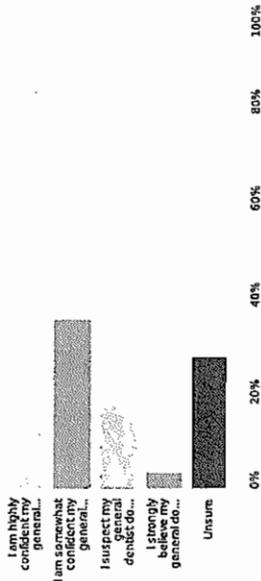
Answer Choices:

- I am highly confident my general dentist has this device
- I am somewhat confident my general dentist has this device
- I suspect my general dentist has this device
- I strongly believe my general dentist has this device
- Unsure

Total: 477

Q27 A glucose monitor (a device to measure the level of sugar in the blood)

Answers: 477 Responses: 112

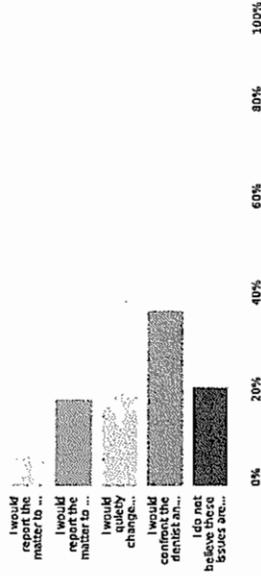


Answer Choice	Responses
I am highly confident my general dentist has this device	17.61%
I am somewhat confident my general dentist has this device	34.00%
I suspect my general dentist does not have this device	17.40%
I strongly believe my general dentist does not have this device	3.14%
Unsure	27.04%
Total	

27 / 40

Q28 Based on your expectations, if you learned your dentist's office was deficient in any area, what would you likely do?

Answers: 475 Responses: 116



Answer Choice	Responses
I would report the matter to the authorities (my state's dental board) and expect the dentist's license to be suspended for a specified period of time.	6.53%
I would report the matter to the authorities (my state's dental board) and expect the dentist's license to be suspended until all areas are corrected.	17.69%
I would quietly change dentists.	19.56%
I would confront the dentist and not continue treatment at that office until I felt circumstances were changed.	36%
I do not believe these issues are an important when choosing a dentist. I would continue to remain a patient.	20.21%
Total	

28 / 40

Q29 Oral surgeons? Specialists in extractions, wisdom teeth, facial surgery and general anesthesia

Answered 467 (100%)

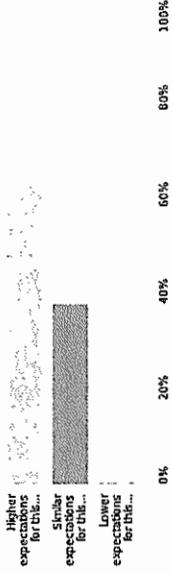


ANSWER CHOICES

Answer Choices	Responses
Higher expectations for this specialist than a general dentist	365
Similar expectations for this specialist and a general dentist	101
Lower expectations for this specialist than a general dentist	1
Total	467

Q30 Endodontists? Specialists in root canal therapy

Answered 467 (100%)

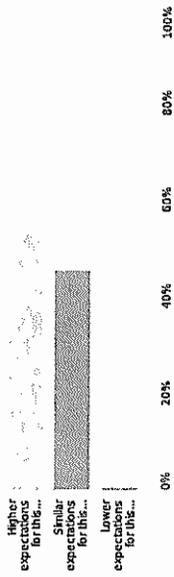


ANSWER CHOICES

Answer Choices	Responses
Higher expectations for this specialist than a general dentist	292
Similar expectations for this specialist and a general dentist	174
Lower expectations for this specialist than a general dentist	1
Total	467

Q33 Pediatric dentists? Specialists in dentistry for children

Received 37 / Skipped 174

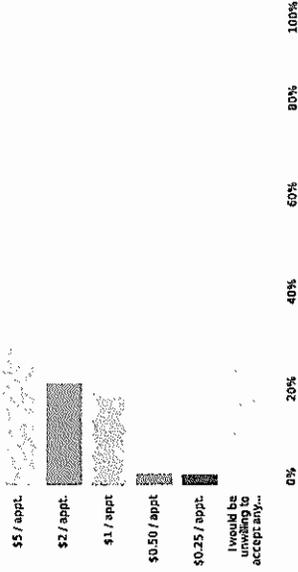


Answer Choices

Answer Choices	Responses
Higher expectations for this specialist than a general dentist	53.53%
Similar expectations for this specialist and a general dentist	45.18%
Lower expectations for this specialist than a general dentist	1.28%
Total	

Q34 Currently, state dental boards have very few requirements for medical emergency preparedness. Eight states have no requirements. Preparing dental offices in all six areas of medical emergency preparedness will take time and money. How much would you be willing to pay out-of-pocket, per appointment, to cover the costs of increasing medical emergency preparedness in your dentist's office?

Received 167 / Skipped 111

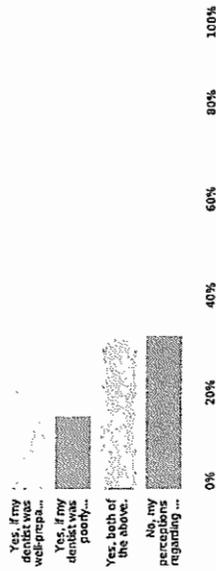


Answer Choices

Answer Choices	Responses
\$5 / appt.	30.19%
\$2 / appt.	26.99%
\$1 / appt.	19.06%
\$0.50 / appt.	2.14%
\$0.25 / appt.	1.93%
I would be unwilling to pay anything... medical emergency preparedness in my dentist's office.	25.70%
Total	

Q35 Would your positive or negative perceptions of your dentist's overall preparedness for a medical emergency occurring during your dental treatment influence your decision to speak to an attorney regarding possible litigation, if a medical event occurred?

ANSWERED 367 (100%)

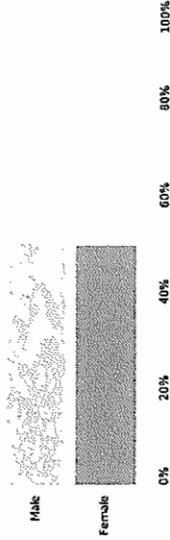


Answer Choices

Response	Count
Yes, if my dentist was well-prepared, I would be less inclined to speak to an attorney.	103
Yes, if my dentist was poorly prepared, I would be more inclined to speak to an attorney.	70
No, my perceptions regarding my dentist's preparation for an emergency would not influence my decision to speak to an attorney.	137
Total	467

Q36 Gender

ANSWERED 346 (100%)



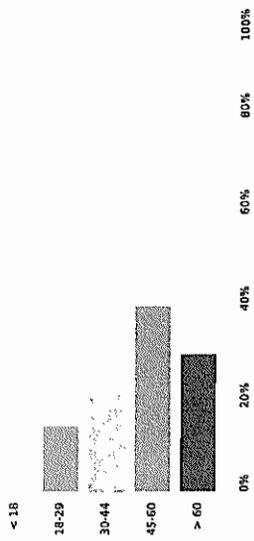
Answer Choices

Response	Count
Male	176
Female	170
Total	346

Patent Expectation Survey

37 Age

Answers: 3, 327 (93.80%)

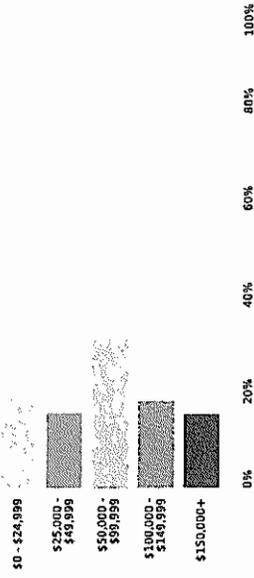


Answer Choices	Responses
< 18	0%
18-29	13.48%
30-44	19.84%
45-60	38.20%
> 60	28.37%
Total	356

Patent Expectation Survey

38 Household Income

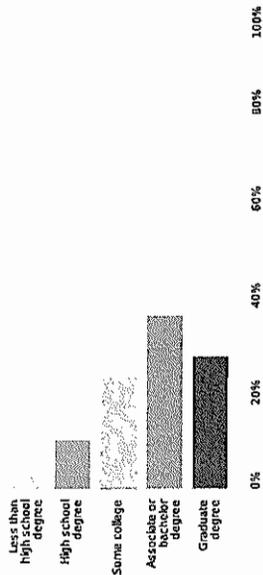
Answers: 3, 327 (93.80%)



Answer Choices	Responses
\$0 - \$24,999	0
\$25,000 - \$49,999	48
\$50,000 - \$99,999	71
\$100,000 - \$149,999	136
\$150,000+	101
Total	356

Q39 Education

As Percent of 326 Respondents



Answer Choices

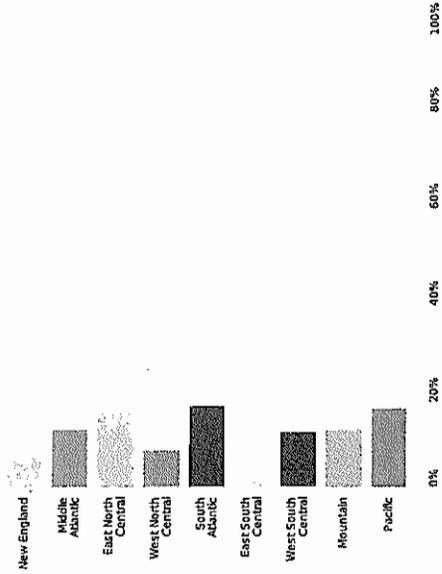
- Less than high school degree
- High school degree
- Some college
- Associate or bachelor degree
- Graduate degree

Responses

Less than high school degree	3.37%	12
High school degree	10.11%	36
Some college	23.00%	84
Associate or bachelor degree	35.67%	127
Graduate degree	27.25%	97
Total		356

Q40 Location (Census Region)

As Percent of 351 Respondents



Answer Choices

- New England
- Middle Atlantic
- East North Central
- West North Central
- South Atlantic
- East South Central
- West South Central
- Mountain
- Pacific
- Total

Responses

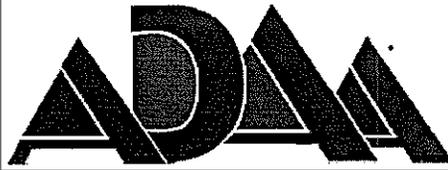
New England	6.55%	23
Middle Atlantic	11.68%	41
East North Central	15.67%	55
West North Central	7.41%	26
South Atlantic	16.52%	58
East South Central	3.42%	12
West South Central	11.11%	39
Mountain	11.68%	41
Pacific	15.95%	56
Total		351



CONTACT: ADAA
Phone: 312.541.1550

FOR IMMEDIATE RELEASE

For many years, dental assistants have worked tirelessly within individual states to introduce and urge legislation regarding the preparation and credentialing of dental assistants to assure patient safety. Although some safeguards and requirements have been implemented in certain states, very few if any requirements exist for entry into dental assisting. With the recent publicity of several most unfortunate incidents regarding breaches in infection control and seemingly unqualified individuals performing tasks associated with patient care, the American Dental Assistants Association (ADAA) has issued a position statement regarding the education and credentialing of dental assistants.



**American Dental Assistants Association (ADAA)
Education and Credentialing of Dental Assistants**

ADAA is the voice of dental assistants to the public and to all professional communities of interest. ADAA in collaboration with other notable professional organizations is working to advance and promote initiatives for quality care and patient protection in meeting the current and changing needs of the dental community. Our ability to be flexible and open-minded in adapting to the evolving health care environment is critical to our future as allied dental professionals and to our ability to best serve the public.

The ADAA is focused on two major themes: standardized credentialing and education of dental assistants to assure competency and safeguard the welfare of the public; and the need for enhanced recognition of the critical role dental assistants play in the provision of quality care as vital members of the dental health team. From the first “Lady in Attendance” or female attendant in the dental office to the dental assistant of the present, the scope of practice and responsibilities delegated to dental assistants has changed drastically over the years. Depending upon the state in which one is employed, there are a variety of significant intraoral procedures performed by chairside dental assistants on patients on a daily basis.

In order to appropriately prepare to enter a highly demanding yet rewarding allied health career in dental assisting, interested individuals should be required to attend a formal dental assisting program as there are many critical areas in which individuals should achieve a sound knowledge base prior to employment in any dental practice setting. Mastery of pertinent information will allow dental assistants to translate background information into sound clinical practice protocols to assure high standards of quality patient care and public protection. In addition to finely honed business/front office, laboratory, radiology and chair side skills, the role of dental assistants also includes community outreach. Therefore, dental assistants also need to provide oral hygiene instruction, nutritional counseling and overall general health information to members of the community to enhance their well-being. The initiatives of the American Dental Assistants Association (ADAA) include but are not limited to: promoting formal education and credentialing of all dental assistants nationally and assuring adequate preparation and clinical competency of all dental assistants as part of best practices in dentistry for patient protection.

Multiple unfortunate cases have arisen in several areas across the country in which unqualified individuals performed tasks for which they were not adequately prepared. These cases serve as a reminder that all dental professionals must understand the guidelines and regulations related to infection control, radiology, health history information and intraoral functions and all other critical areas in dentistry for public protection. Every dental healthcare professional should periodically review infection control procedures and have those procedures in writing for reference.

Communication between team members is also essential to ensure team members understand their role in the infection control processes. At least an annual review of written protocols should

be conducted which includes all team members. References should be made to scientific literature and other resources, such as the Center for Disease Control (CDC), Organization for Safety and Asepsis (OSAP) and the American Dental Association (ADA), so that all dental professionals may review available references for updates and any changes in recommendations.

On-the-job trained dental assistants are highly regarded, as they are the backbone of our profession. However, as our role has changed, so too must requirements for entry into the field of dental assisting. Therefore, it is important for dental assistants to not only complete an appropriate academic program in dental assisting but to also pursue continuing professional education after graduating from a formal dental assisting course of study. By doing so, dental assistants may continue to enhance both personal and professional development as highly valuable members of the dental health team. Whether as part of a requirement for credential renewal or as a part of enhancement as an allied dental professional, it is critical for dental assistants to continue to build upon the fundamental background they received as dental assisting students and as part of life-long learning.

Dental assistants must work with colleagues in encouraging legislators and state boards of dentistry to recognize the skills required of dental assistants in performing the wide variety of chairside, clinical and intraoral functions on patients, so that policies will be enacted in all states to require mandatory education and credentialing of all dental assistants nationally. In that dentistry and dental hygiene are both regulated professions, and considering the tremendous expansion of the scope of practice of dental assistants over recent years, it is appropriate that dental assistants also be required to meet certain benchmark standards prior to providing direct patient care services in order to protect the welfare of the public and the patients we serve.

According to the Raven Maria Blanco Foundation (RMBF) in 2013, a national survey was conducted to determine patient expectations and knowledge regarding medical emergency preparedness by their dentist. According to the Foundation, dental patients overwhelmingly expect their dentist to be prepared to manage a medical emergency occurring during dental treatment in all areas: ongoing training of the dentist; regular training of the dental staff; periodic mock emergency drills; written medical emergency plan; stocking routine emergency medications, and maintaining appropriate emergency equipment such as oxygen and an automated external defibrillator. The Foundation also believes that medical emergencies occurring during dental treatment are increasing in frequency and severity due to demographics, aging of dental patients, and patients with complex medical histories. As dental treatment is becoming more sophisticated and increasingly invasive (e.g. implants and grafts), public expectations of medical emergency preparedness are reasonable and appropriate and should be incorporated into training and emergency preparedness procedures.

There are many quality dental assistant training programs nationally. Unfortunately, there are no national or state requirements for dental assistants to complete formal dental assisting education prior to employment in various dental employment settings. The issue is one of social responsibility from within the profession for patient protection. Many states require no formal education or accountability requirements for dental assistants. Dental assistants can be on-the-job trained, so there is a lack of incentive to obtain formal dental assisting education.

The American Dental Association (ADA) Commission on Dental Accreditation (CODA) is recognized by the United States Department of Education (USDE). CODA has been recognized since 1952 and requires adherence to criteria and operational policies and procedures. ADA-CODA focuses on process fairness and consistency. Accreditation is a process involving self-review and peer assessment by which an agency uses experts in a particular field of interest or discipline to define standards of acceptable operation/performance of education programs and evaluates compliance with those standards for education programs. The roles and responsibilities of CODA are to establish standards that define quality of education, evaluate and monitor programs for compliance with standards and establish policies & procedures to guide evaluation and decision process.

The ADA supports ADA-CODA accredited education to promote innovation in education, training and supervision. ADA-CODA also promotes a scope of practice that ensures the protection of the public. Through CODA, public perception of the profession increases as CODA establishes a high standard and level of respect for the dental assisting profession.

In this day and age, formal education is essential for preparing dental assistants to perform intraoral functions, infection control, radiography and a variety of additional critical procedures performed routinely by dental assistants. An appropriate education includes didactic, lab, preclinical and clinical practice components. The educational setting must provide adequate resources and qualified faculty.

Based on the best interests of the patient, public safety, education, training and credentialing, valid research should support intraoral functions based on the State Dental Practice Acts. Duties listed should specify education and training requirements to assure quality and public protection. Under the supervision of the dentist, the functions performed by dental assistants require background knowledge, manual dexterity, coordination and proficiency of multiple significant skills. Individuals interested in careers in dental assisting need to be adequately prepared to take their place in the profession with their peers. Although delegable functions outlined in state dental practice acts vary, the following is a partial listing of procedures dental assistants routinely perform on patients: preliminary impressions; placement and removal of rubber dams; placement and removal of matrices; placement and removal of arch wires and ligatures; placement of amalgam; removal of excess cement; cementation of temporary crowns; removal of sutures; placement of sealants; administration of topical fluoride; placement of topical anesthetics; patient education; and placement and removal of periodontal and surgical dressings. Some states also allow dental assistants to perform coronal polishing, radiographic exposures and placement of permanent restorations. However, there are a few states that require specific education and credentialing to legally perform the expanded functions referenced. These and other notable services provided by the dental assistant contribute directly to the oral health of the public.

As critical members of the dental workforce, we need to carefully examine the breadth of the role of the dental assistant in patient care and value the role of the dental assistant as part of the dental team. Most importantly, the contributions that dental assistants make to the health and welfare of the patients who come under their care must be noted and regarded by the dental community.

Professionalism is defined as: “The conduct, aims, or qualities that mark a profession or a professional person.” The essence of a profession or professionalism is a commitment to patient welfare, ethics, high ideals and desirable characteristics. An important aspect of being a professional is portraying behavior that is considered appropriate and ethical by colleagues and the public. In fulfilling daily responsibilities, dental assistants need to be mindful of the following, which assist in guiding appropriate ethical behavior. Prior to taking action, an assessment may be conducted to determine if pending actions will comply with rules, regulations and guidelines, and be compatible with organizational values.

As documented, a profession is distinguished by a body of knowledge that is constantly expanded, updated and documented in the literature; continual improvement in the quality of service to the public; specific academic preparation in specialized institutions; lifelong commitment to continuing education; self-regulation and a code of ethics developed by the profession. In carefully examining the characteristics of a profession, we can safely indicate that dental assisting meets several of those outlined. However, there are still multiple aspects of truly being recognized as a profession that dental assistants and ADAA must continue to address and toward which dental assistants and legislators must work.

The public in each state should have some assurance that those individuals providing care and assisting with care in the dental office have adequate education and understanding of their responsibilities. This includes all members of the dental team: dentist, hygienist and assistant. Dental assistants are a valuable member of the team and should be afforded the opportunity to be recognized for their level of knowledge through required credentialing. This can provide greater assurance to the public. Patients assume that the individuals assisting the dentist are highly educated and licensed or registered as required by the state. But for many dental assistants, this is not the case as some states view it as the dentist’s responsibility to ensure their staff is performing procedures correctly. Often the behind-the-scenes expertise is left to the uneducated clinical dental assistant.

The American Dental Assistants Association (ADAA) believes that dental assistants have a responsibility to monitor themselves and inform their patients about the importance of licensed or registered dental assistants as part of the dental team. Unfortunately, many trained-on-the-job assistants can be taught improper sterilization techniques by others who were also improperly trained. A means to address this issue is for strict guidelines and training to be implemented, which should be applied equally in ALL states and not just a few.

ADAA is working hard to develop collaborations with other notable national organizations to explore and outline initiatives to address the need for specific academic preparation in public protection and to assure quality care. The American Dental Assistants Association (ADAA) speaks for approximately 300,000 dental assistants in the United States and is America’s oldest and largest dental assisting association. ADAA is dedicated to the development and recognition of professionalism through education, membership services and public awareness programs. The ADAA is a strong advocate for legislation mandating required academic preparation and credentialing.

ADAA supports education and credentialing of dental assistants nationwide in order to assure that dental assistants have a comprehensive understanding of state dental practice acts containing legally delegated responsibilities for dental assistants, as well as a thorough knowledge of infection control and appropriate treatment protocols and knowledge of many other critical aspects of dental assisting responsibilities related to high standard quality care and patient protection.

State requirements:

CA: State course required after four months

MN: CPR certificate

MS: CPR certificate within 180 days

MT:OJT or CODA program grad

NC: No education or training unless involved with N/O

OH: Specific training by the dentist required

SD: High school diploma

UT: CPR Certificate

VT: Emergency procedures training within 180 days of hiring

WA: 7-hour AIDS course



DATE: August 14, 2013

TO: Presidents/Chairmen, State Dental Boards
President, American Dental Association
President, American Dental Education Association
President, American Student Dental Association
President, American Dental Hygienists' Association

FROM: Dr. Mark Christensen, Chair, AADB Committee to Develop Guidelines on Standards of Conduct and Ethics for State Boards and Board Members

SUBJECT: Call for Comments Regarding Draft "Guidelines on Standards of Conduct and Ethics for State Boards and Board Members"

The American Association of Dental Committee to Develop Guidelines on Standards of Conduct and Ethics for State Boards and Board Members met by conference call several times in 2012-2013. The purpose of the Committee was to develop a position paper to assist agencies that regulate dentistry.

The Committee directed that notification be sent to the communities of interest calling for comment. Comments on the draft document should be submitted to the AADB Central Office, 211 East Chicago Avenue, Chicago, IL 60611, no later than September 16, 2013. Please direct your comments to the attention of Mr. James Tarrant, Executive Director, AADB. It is anticipated that the Committee will forward the final document to the 2013 AADB General Assembly at the 130th AABE Annual Meeting, October 30-31, 2013 for consideration.

The Committee appreciates your input and looks forward to receiving your comments.

Enclosures

cc: Executive Director, State Dental Boards
Executive Director, American Dental Association
Executive Director, American Dental Education Association
Executive Director, American Student Dental Association
Executive Director, American Dental Hygienists' Association
Members, AADB Executive Council
Members, Committee to Develop Guidelines on Standards of Conduct and Ethics for State Boards and Board Members

American Association of Dental Boards
Guidelines on Standards of Conduct and
Ethics for State Boards and Board Members



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Standards of Conduct and Ethics for State Boards and Board Members

“The graduation of knowledgeable and skilled clinicians in dentistry is a necessary, but not sufficient, condition for ensuring quality oral health care. The further requirement is the commitment of graduates applying their abilities with integrity that is, providing quality care in their patient’s interest. Ultimately, good dentistry depends on individuals committed to treating society and their patients fairly, that is, ethically.” D.A. Nash, D.M.D.

SECTION I: INTRODUCTION

This document, *Standards of Conduct and Ethics for State Boards and Board Members*, provides guidelines incorporating best practices for state boards and guidance for the personal conduct of individual members of these boards. State dental board members may be appointed or selected as required by the individual state. Appointment to the state dental board brings with it certain obligations. Foremost among these is an obligation to protect the safety and well-being of the public. Informed, unbiased participation and decision-making is required to fulfill this obligation. Understanding and incorporating the principles and recommendations in this document should assist boards and their members to discharge their duty to the public.

The definitions, principles, concepts and recommendations presented are not intended to be exhaustive, but rather provide a framework and guide for reference by state boards and their individual members. Dental boards are encouraged to seek additional counsel in instances where the guidance of this document is insufficient. This document is not intended to provide legal advice or the basis for any conclusion that may conflict with any relevant statute or rule.

SECTION II: CORE PRINCIPLES

Core principles provide a foundation for standards of conduct defining ethical board behavior and are based on shared human values. The following core principles incorporate characteristics and values that can be associated with good character and ethical behavior. Additional information about these concepts can be found in resources identified in Appendix A of this document.

- **Accountability:** obligation or willingness to accept responsibility for actions, decisions, and policies.
- **Beneficence:** duty to act for the benefit of others.
- **Dignity:** respect for individuals and the knowledge and contributions brought to the decision-making process.

- **Ethical conduct:** behavior that promotes the well-being of oneself or others while maintaining high standards of competence and integrity. Ethical conduct is observed in individual behaviors and as a member of a collective body.
- **Fidelity:** loyalty, keeping one's promise to fulfill attendant charges and responsibilities.
- **Integrity:** honesty and moral courage; appropriate use of authority.
- **Justice:** duty to be fair in all interactions; objectivity.
- **Nonmaleficence:** to protect from harm.
- **Transparency:** action in all matters that is characterized by open and readily available for scrutiny.
- **Veracity:** honesty and trustworthiness.

SECTION III: CONFLICT OF INTEREST

A conflict of interest occurs when a vested interest may influence or be perceived to influence an individual's decision or action. Avoiding a conflict of interest or the appearance of having a conflict of interest is the responsibility of each board member. Board member actions should be transparent. Board members should disclose any conflict of interest and recuse themselves from deliberation and voting if a conflict of interest exists. A board member should identify any unrecognized conflict of interest that may exist for any other board member and strictly follow board policy with regard to recognizing and addressing such conflicts.

A board member is expected to make decisions that serve the interest of the public. Board members must recognize this responsibility, deliberate accordingly and act in an appropriate manner. Depending on the issue or the parties involved, there may be an occasion when a conflict of interest arises due to a board member's concurrent roles or responsibilities in professional associations, societies or organizations. On those occasions, it may be appropriate for board members to seek advice and guidance about recusing themselves from the deliberations.

SECTION IV: ETHICAL CONSIDERATIONS FOR BOARDS

The Role and Responsibility of the Board

A primary goal of a board is to protect the general public by licensing individuals who demonstrate an acceptable standard of competency in a regulated field. Licensing boards are responsible for issuing licenses to qualified candidates, determining whether licenses should be renewed, setting standards for license renewal, investigating complaints about the performance of licensees and promulgating rules to enforce legislative directives and intent. A board may also be responsible for establishing and enforcing standards of practice. Additional

responsibilities may include enforcing licensure laws against fraudulent, unethical or illegal practices. The authority and actions of a regulatory board are collective.

A board is most effective when all members are engaged and actively participate. Individual states define the composition of a board and provide guidelines for board member qualification, term of office, authority, and responsibilities.

This document provides information on best practices and guidelines for consideration that can assist boards and board members to discharge their ethical responsibilities

A State Board should:

- **Conduct an orientation for new board members.** The orientation program for new board members should be structured and comprehensive. Included within the orientation process should be an emphasis on board members' ethical responsibility and obligation to protect the public.
- **Provide ongoing updates for current members.** The board should provide resources for current members to enhance their knowledge and understanding of changes in protocol, legislation or statute and best practices. Updates of information about board processes and procedures should occur in a timely manner and on a regular basis.
- **Maintain a Policy and Procedures Manual** or comparable document unless all detail regarding board operation and protocol is specified in statute and rule. The composition of the board changes, board member terms mature and new members are appointed on a regular basis. Therefore, the board should incorporate a process that periodically verifies that all board members are informed regarding the board's policy and procedures manual and location of the information that guides operation of the board. The board should create a system or process that verifies that all members have reviewed or accessed this information. The board should have a schedule and protocol for systematically reviewing and updating its Policy and Procedures Manual or source(s) of information that guides its operation.
- **Model appropriate behavior.** In the conduct of its meetings, a board should adhere to published meeting protocol as appropriate. The board should follow the administrative rules under which it operates or, in the absence of specific guidelines, should operate in a manner that affords transparency, fairness, clear communication, adequate notice of meetings, acceptance of public testimony and other practices that potentially impact the success and effectiveness of its actions.
- **Provide information pertaining to licensing requirements.** A board should provide guidance on how to obtain information about licensees, report violations or make inquiries,

- **Provide information for licensees and other interested parties** regarding how they can receive appropriate notification of changes in rules and regulations that govern the profession.

SECTION V: ETHICAL CONSIDERATIONS FOR BOARD MEMBERS

The Role of the Board Member

A board member's primary responsibility is to view any issue from the perspective that protects the interest and safety of the public. In any deliberation or interaction, a board member may have a responsibility to several groups. These may include, for example, licensees, potential licensees, board member colleagues, and other professional groups. The board member's preeminent concern, however, should always be that of the public consumer.

The public expects board members to have experience that supports thoughtful and deliberate decision-making in all circumstances. The board member also has an obligation to ensure that during the decision making process the impact on all parties involved will be considered; including the effect for the licensee and the public.

Board members have an obligation, within the structure of the board, to monitor the profession in a manner that maintains the public's confidence. In this role, each member, regardless of his or her professional designation, has a responsibility to function as a team member and support decisions made by the board as a group. Although comprised of individual members, boards are viewed as one voice by the general public.

Board Member Conduct and Responsibility

These standards of conduct apply to all members of the board including dentists, dental hygienists, dental assistants and public members. The statements about board conduct and responsibility are intended to assist board members in fulfilling their duties as board members and in their interactions with colleagues, non-dental professionals, the general public, and other professional organizations. Commentary is provided to enhance clarity for the statements.

- **Lead by example.** A board member should dedicate himself/herself to upholding ethical and professional standards while serving the public and the board. (Dignity)
- **Exercise caution in personal communication, whether written, verbal or electronic.** Written and electronic communication should maintain the confidentiality of board business or decisions. Board members should not criticize collective board actions or offer opinions that might harm public trust in the regulatory process. Board members should not communicate in a manner that disparages any member of the board. All personal and professional interaction

should be respectful and courteous. Board members should accept feedback or mentoring in a gracious and professional matter. (Integrity)

- **Collaborate as a team.** Board members should conduct themselves in a manner that promotes cooperation and trust among members as well as with other associated entities. (Transparency and integrity)

- **Be familiar with board policy and procedure.** Board members should familiarize themselves with board policy and procedure at the time of initial appointment and remain knowledgeable as policy changes or new procedures are instituted. Board members should recognize budget and financial implications of board function and board actions. (Accountability)

- **Attend meetings and actively participate.** Board members should attend and participate in board meetings including deliberation and voting. Absence and lack of participation, especially when opinions differ, negatively impacts the quality of proceedings and outcomes. (Accountability)

- **Recognize personal and professional bias and refrain from allowing such bias to influence decision making or voting.** In making decisions, board members should consider the interest of the public they serve and not be influenced by personal or professional bias. (Justice)

- **Act independently in decision making and voting.** Board members should seek accurate information. Board members should not allow themselves to be bribed, coerced or unduly influenced by any individual, lobby group, or personal or professional affiliation. (Integrity)

- **Place the mission of the board ahead of personal agendas.** Membership on the board should not be sought or maintained for personal, professional association or political gain. Board work and board decisions should consistently serve the interest of the public. (Accountability)

- **Act in a professional manner.** Board members represent the board and should dress, speak and act in a professional manner during board meetings or in circumstances in which they are representing the board. (Dignity)

- **Pursue excellence in fulfilling one's duties.** Board members should consistently endeavor to increase their abilities and understanding as required or recommended. (Accountability)

- **Model professional integrity.** To sustain public confidence, the conduct of members should be above all suspicion and criticism. Integrity also requires members to observe principles of independence and objectivity and maintain unimpeachable standards of professional conduct. (Integrity)

- **Decisions of the board.** Board members should refrain from engaging in divisive behavior that undermines the authority of the board or confidence in its decisions. Board members should refrain from attempting to influence or pressure other members of the board, novice or experienced. (Fidelity)
- **Interpret and enforce board policies consistently and fairly.** Board members should be cognizant of historical patterns of action, seek information about precedent, and otherwise interpret and apply law and policy in a consistent manner. (Justice)
- **Maintain confidentiality.** Each member of the Board is expected to uphold the strict confidentiality of meetings held in executive session as directed by state laws governing such meetings. A board member should not share, reproduce, transmit, divulge or otherwise disclose any confidential information related to the affairs of the board or confidential patient records. Upon termination of public service to the board, each member should promptly return documents, electronic and physical files, reference materials and other property entrusted to the member for the purpose of fulfilling board responsibilities. The return of these items does not abrogate the retiring board member from his or her continuing obligation of confidentiality with respect to information acquired as a consequence of tenure on the board. (Nonmaleficence)
- **Understand board organizational structure and its position within the licensing and regulatory agency structure of the state.** Knowledge of organizational structure and respect for protocol and procedure is critical for a board member to function effectively. (Beneficence)

Appendix A: Resources

1. American Association of Dental Boards (AADB): <http://www.dentalboards.org>
2. American College of Dentists (ACD):
[http://www.acd.org/PDF/Ethics_Handbook_for_Dentists_\(s\).pdf](http://www.acd.org/PDF/Ethics_Handbook_for_Dentists_(s).pdf) The American College of Dentists developed and manages Courses Online Dental Ethics (CODE), a series of online courses in dental ethics and related resources at <http://www.dentaethics.org>.
3. American Dental Assistants Association (ADAA):
Policy on Principles and Ethics and Code of Professional Conduct
http://www.dentalassistant.org/content/details/ADAA_Code_of_Professional_Conduct.pdf
4. American Dental Association (ADA):
Principles of Ethics and Code of Professional Responsibility:
http://www.ada.org/sections/about/pdfs/code_of_ethics_2012.pdf
5. American Dental Hygienists' Association (ADHA):
Code of Ethics: www.adha.org/bylaws-ethics
6. American Student Dental Association (ASDA):
<http://www.asdanet.org/codeofethics.aspx>
7. International Association of Dental Research (IADR):
Code of Ethics: <http://www.iadr.com/i4a/pages/index.cfm?pageid=3562>
8. State or local dental, dental hygiene or dental assisting societies may also have resources or educational materials available for use.

Appendix B: Potential Constituencies and Stakeholders

As a result of their role and responsibility, board members may interact with various individuals, constituencies or stakeholders. Following is an outline listing some of these groups. This list is not intended to be comprehensive.

- Candidates for licensure
- Licensed oral health professionals
- Organized dental, allied and educational groups/members
 - American Association of Dental Boards
 - American Dental Association
 - o Council and Commission members
 - o State and local component society representatives
 - National Dental Association
 - Hispanic Dental Association
 - Native American Dental Association
 - American Dental Hygienists' Association
 - American Dental Assistants Association
 - American Dental Education Association
 - American Student Dental Association
 - Dental Laboratory Technology
 - Dental Specialty Organizations
- Dental professionals
- Board member colleagues
- General public
- Complainants
- Testing agencies and their representatives
- Government agency supervisors or government employee staff
- Non-dental professionals and personnel, including but not limited to:
 - Attorneys
 - Medical professionals (physicians, psychologists, addiction counselors, nurses)
 - Legislators, public officials and law enforcement representatives
 - Drug enforcement agency personnel
 - Child welfare personnel
- Public health personnel/departments
- Industry representatives and vendors
- Continuing education sponsors

Appendix C: Sample Code of Ethics

This template for a Code of Ethics is provided for guidance. Sections and language provided in the template may not be applicable in all situations. A Board may consider creating a Code of Ethics to provide guidance to its members. This template is only provided for guidance and should not be deemed as required for state dental boards by the American Association of Dental Boards. Reprinted with permission from the Texas State Board of Dental Examiners.

[STATE] = Name of State

[Dental Board] = Dental Board; Board of Dental Examiners, etc.

SAMPLE ETHICS POLICY

I. Purpose.

Pursuant to [Section] [STATE] [Government Code], the [STATE] [Dental Board] promulgates the following Ethics Policy addressing the ethical responsibilities of the [STATE] [DENTAL BOARD] Members and employees. This Ethics Policy adds to the ethical responsibilities and obligations [required by state law] of Board Members and state employees. This Ethics Policy is not an exclusive and complete statement of legal and ethical responsibilities and its provisions are not the only statements of legal and ethical responsibility that may apply in a particular situation. This Policy does not supersede any applicable federal or [STATE] law or administrative rule. All Dental Board Members and employees must familiarize themselves with this ethics policy. All State Board of Dental Examiners' employees must abide by all applicable federal and [STATE] laws, administrative rules, and Dental Board conduct policies, including this Policy. A [Dental Board]' employee who violates any provision of the Agency's conduct policies is subject to termination of the employee's state employment or another employment-related sanction. A [Dental Board]' employee or Board Member who violates any applicable federal or [STATE] law or rule may be subject to civil or criminal penalties.

II. Definitions. The following definitions apply to this Ethics Policy, unless the context clearly indicates otherwise:

1. "Agency" or "Board" means the [STATE] [Dental Board].
2. "Business entity" means any entity recognized by law through which business for profit is conducted, including a sole proprietorship, partnership, firm, corporation, holding company, joint stock company, receivership, or trust. [state] [definition reference]
3. "Confidential information" means any non-public information of the Board, including but not limited to information as described by the [state] [definition reference].

4. "Conflict of interest" means any professional, personal, or private relationship or interest that an individual has and of which the individual is actually aware, that could reasonably be expected to diminish or appear to diminish the individual's independence of judgment in the performance of his or her duties, obligations, or responsibilities to the Board.
5. "General Counsel" means the General Counsel of the [STATE] [Dental Board].
6. "Member" means a member of the [STATE] [Dental Board].
7. "Participated" means to have taken action through decision, approval, disapproval, recommendation, giving advice, investigation, or similar action. [STATE] [definition reference].
8. "Particular Matter" means a specific investigation, application, request for a ruling or determination, rulemaking proceeding, contract, claim, accusation, charge, arrest, or judicial or other proceeding. [STATE] [definition reference].
9. "Policy" means Ethics Policy.
10. "Staff" or "employee" means an individual or individuals employed by the Board.

III. Code of Ethics. When conducting personal or professional activities, Board members and employees are governed by this Policy and all applicable state statutes.

- A. **General Ethical Responsibilities.** A [Dental Board]' employee or board member shall:
 1. exercise his or her duties with the highest degree of honesty;
 2. avoid actions and relationships that could discredit the board in the eyes of the public or adversely affect the public's confidence in the board;
 3. avoid actions and relationships that could create the appearance of impropriety or wrongdoing; and
 4. comply with all applicable laws, rules, and policies. (See Appendix A for a partial list) [CLICK HERE TO VIEW APPENDIX A](#)
- B. **Gifts, Benefits, or Favors.** A [Dental Board]' employee or board member shall not:
 1. accept or solicit any gift, favor, or service that might reasonably tend to influence the employee or board member in the discharge of official duties, or that the individual knows or should know is being offered with the intent to influence the individual's official conduct; or
 2. Intentionally or knowingly solicit, accept, or agree to accept any benefit for having exercised his or her official powers or performed his or her official duties in favor of another. An association or organization of employees of the dental board may not solicit, accept, or agree to accept anything of value from a

business entity regulated by the dental board and from which the business entity must obtain a permit to operate that business in this state or from an individual directly or indirectly connected with that business entity.

- C. **Confidentiality.** A [Dental Board]' employee or board member shall not disclose confidential information, information that is excepted from public disclosure under the [STATE] [Public Information Act] [state] [code], or information that has been ordered sealed by a court, that was acquired by reason of the individual's official position, or accept other employment, including self-employment, or engage in a business, charity, nonprofit organization, or professional activity that the employee might reasonably expect would require or induce the employee to disclose confidential information, information that is excepted from public disclosure under the [STATE][Public Information Act], or information that has been ordered sealed by a court, that was acquired by reason of the employee's official position.
- D. **Employment.** A [Dental Board]' employee or board member shall not accept other employment, including self-employment, or compensation or engage in a business, charity, nonprofit organization, or professional activity that could reasonably be expected to impair the individual's independence of judgment in the performance of the individual's official duties.
- E. **Investments.** A [Dental Board]' employee or board member shall not make personal investments, or have a personal or financial interest, that could reasonably be expected to create a substantial conflict between the individual's private interest and the public interest.
- F. **Use of State Resources.** A [Dental Board]' employee or board member shall not utilize state time, property, facilities, or equipment for any purpose other than official state business, unless such use is reasonable and incidental and does not result in any direct cost to the state or [STATE] [Dental Board], interfere with the individual's official duties, and interfere with [Dental Board]' functions.
- G. **Improper use of official position or state issued items.** A [Dental Board]' employee or board member shall not utilize his or her official position, or state issued items, such as a badge, indicating such position for financial gain, obtaining privileges, or avoiding consequences of illegal acts.

- H. **Misleading Statements.** A [Dental Board]' employee or board member shall not knowingly make misleading statements, either oral or written, or provide false information, in the course of official state business.
- I. **Use of state time or resources for political activity.** A [Dental Board]' employee or board member shall not engage in any political activity while on state time or utilize state resources for any political activity.
- J. **A [Dental Board]' board member shall not, unless required for the disposition of an ex parte matter authorized by law, communicate, directly or indirectly, with any party or representative of the party in connection with any matter before the board, except on notice and opportunity for all parties to participate.**
- K. **Former Employees.** A former employee of the [Dental Board], who was compensated, as of the last date of state employment shall not represent any person or entity, or receive compensation for services rendered on behalf of any person or entity, regarding a particular matter in which the former employee participated during the period of state service or employment, either through personal involvement or because the case or proceeding was a matter within the employee's official responsibility.
- L. **A [Dental Board]' employee and board member shall:**
 - (1) perform his or her official duties in a lawful, professional, and ethical manner befitting the state and [STATE] [Dental Board]; and
 - (2) report any conduct or activity that the employee believes to be in violation of this ethics policy to the Executive Director[administrator] or General Counsel.
- M. **A [Dental Board]' member shall not serve as an expert witness in a suit involving a health care liability claim against a dentist for injury to or death of a patient unless the member receives approval from the board or an executive committee of the board to serve as an expert witness.**

This position statement was approved by the [Dental Board] on [DATE].

Click [HERE](#) to return to the main directory of Policy Statements.

Click [HERE](#) to review or order a copy of the Dental Practice Act ([STATE] [Code]).

Click [HERE](#) to return to the directory of Rules and Regulations.

APPENDIX A – LAWS APPLICABLE TO BOARD MEMBERS AND STAFF Board members and employees must comply with all applicable laws and be aware of the following statutes. The omission of any applicable statute from this list, however, does not excuse a violation of its provisions:

GENERAL STANDARDS OF CONDUCT

- [STATE] Government Code (Prohibition Against Solicitation or Acceptance of Certain Gifts, Favors, Services or Other Financial Benefits) • [STATE] Penal Code (Prohibition Against Bribery and Corrupt Influence) • [STATE] Penal Code (Prohibition Against Abuse of Official Capacity; Prohibition Against Official Oppression of Any Person)

DISCLOSURE OF CONFLICTS OF INTEREST

- [STATE] Government Code (Requirement of Disclosure by Board Member of Private Interest in Measure or Decision Pending Before the Board; Removal from Office for Violation)

CONFIDENTIAL INFORMATION

- [STATE] Government Code (Prohibition Against Distribution or Misuse of Confidential Information) • [STATE] Penal Code (Prohibition Against Misuse of Official Non-Public Information) Other

GIFTS AND ENTERTAINMENT

- [STATE] Government Code (Prohibits acceptance of gifts, favors, or services that may “reasonably tend to influence” or that the Employee “knows or should know are intended to influence his official conduct”) • [STATE] Penal Code (Prohibits Bribery) • [STATE] Penal Code (Prohibits gifts to public servants. For purposes of [STATE] Penal Code § 36.08, a gift does not include an item with a value of less than \$50.00, excluding cash or a negotiable instrument as described by [STATE] Business and Commerce Code, and certain other exceptions contained in [STATE] Penal Code .

LOBBYING PROHIBITION

- [STATE] Government Code (Representation by Former Officer or Employee of Regulatory Agency Restricted for Two Years)

EX PARTE PROHIBITION

- [STATE] Government Code (Prohibition against ex parte communication)

8.12.13

Disciplinary Board Report for September 13, 2013

Today's report reviews 2013 calendar year case activity then addresses the Board's disciplinary case actions for the fourth quarter of fiscal year 2013 which includes the dates of April 1, 2013, to June 30, 2013.

Before I get into the numbers, I wanted to give you a refresher of what it takes from Board staff and Board members to get the numbers I will give you. The Boards have an agency directive of investigating and processing 90% of patient care cases within 250 work days. Here are a few examples of how patient care is defined: **impairment due to use of alcohol or drugs; dispensing drugs to patients for non medicinal purposes, excessive prescribing, dispensing without a practitioner/patient relationship; sexual assault; inappropriate termination of practitioner/patient relationship; improper/unnecessary performance of treatment; failure to diagnose; practicing beyond the scope of dentistry; practicing on a revoked, suspended, lapsed license, and aiding and abetting unlicensed activity; falsification/alteration of patient records; and disciplinary action by another state when the underlying conduct is a patient care case.**

As you can see from the previous description, the majority of our cases are patient care cases (approximately 73%).

What this means is that from the time a complaint is docketed with the Enforcement Division, to the time it is resolved, only 250 work days should pass before closing a patient care case. The Enforcement Division is allotted 100 work days to conduct an investigation (about 3 ½ months), the Board is allotted 120 work days (about 4 ½ months) and the Administrative Proceedings Division is allotted 30 work days (about 1 month).

Regrettably, we often don't receive cases from the Enforcement division until well after 100 days into the timeline. Or we often receive 10-12 cases in a week, since there are approximately 50 investigators.

Factored into the time a case spends with the Board is how long it takes before a case can be scanned or mailed to a Board member for probable cause review, how long a case is with a Board member, how long it takes for Board staff to process the probable cause review to send to the Administrative Proceedings Division and the time a case waits at Board level if a Confidential Consent Order, Pre-hearing Consent Order, or Notice is requested. The Respondent is provided at least 30 days notice for an informal conference and/or Pre-hearing Consent Order, or provided 45 days to return a Confidential Consent Agreement. That doesn't take into account if a continuance of an informal conference is requested by the Respondent, or the fact that a case may be scheduled 4 or 5 months out because a Committee's docket is full for the next few months. This is why we have such a short turn-around time for Board members to return probable cause reviews.

Calendar Year 2013

The table below includes all cases that were received for Board action since January 1, 2013 through August 21, 2013.

Calendar 2013	Cases Received	Cases Closed No/Violation	Cases Closed W/Violation	Total Cases Closed
Jan. 2013	46	13	4	17
Feb. 2013	28	4	2	6
March 2013	34	40	7	47
April 2013	36	14	7	21
May 2013	39	12	4	16
June 2013	27	52	17	69
July 2013	36	15	6	21
Aug. 21, 2013	23	15	6	21
Totals	269	165	53	218

Q4 FY 2013

For the fourth quarter, the Board received a total of 66 patient care cases. A total of 75 patient care cases were closed for a 114% clearance rate. The current pending caseload of patient care cases older than 250 days is 24% (60 cases). This number should be no more than 25%. The Board closed 79% (56 cases) of patient care cases within 250 days. The number should be at least 90%. Although the Board met the clearance rate performance measure and the age of pending caseload performance measure, we have still not been able to process 90% of patient care cases within 250 work days.

Solutions?

Given all of the information contained in this report, in order to meet the key performance measures that the agency has set for us, Board staff is suggesting the following solutions:

1. If you, as a Board member, are assigned a case that you are not going to be able to complete within the fifteen day window because you are going to be out of town for an extended time period, please let Board staff know immediately, so the case can be reassigned.
2. When you are assigned a case that you briefly review it upon receipt to determine if you have a conflict of interest or if you believe another Board member with a certain area of expertise would be better suited for review. Sometimes Board members will wait until the 15 day window is almost over to take a first look at cases they have been

assigned and realize the case needs to be assigned to another Board member. We have now lost that time on our ticking clock!

3. Board staff has decided to send out Priority C cases containing only one patient record to Board members without initial staff review.

4. We will also be making an effort to follow up with Board members, by email, who have not returned probable cause review forms after 15 days.

5. Ensure that when you are filling out the probable cause review form you are to be as explicit as possible as to why the conduct of the Respondent is a violation of the laws and regulations. Even if a case is being closed "no violation" or "undetermined," please also be explicit in that reasoning. Although it does not seem significant, a few days of emails and phone calls back and forth between Board staff and Board members, as well as the discussions among Board staff as to findings and appropriateness of sanctions often adds an additional week or two of time.

License Suspensions

Between April 1, 2013 and August 21, 2013, the Board summarily suspended and by Consent Order accepted the voluntary permanent surrender of the privilege to renew or reinstate the license of one dentist. Further, the Department of Health Professions mandatorily suspended the license of one dentist.

*The Agency's Key Performance Measures.

- We will achieve a 100% clearance rate of allegations of misconduct by the end of FY 2009 and maintain 100% through the end of FY 2010.
- We will ensure that, by the end of FY 2010, no more than 25% of all open patient care cases are older than 250 business days.
- We will investigate and process 90% of patient care cases within 250 work days.

Reen, Sandra (DHP)

From: Casway, Howard [HCasway@oag.state.va.us]
Sent: Friday, March 15, 2013 11:44 AM
To: Douglas, Jay P. (DHP); Reen, Sandra (DHP); Chappell, Catherine (DHP); Juran, Caroline (DHP)
Subject: FW: Off Duty Scrutiny

Interesting discussion. I think something you may want to share with Board members and/or have a discussion.

Off duty, under scrutiny: How much off-the-clock behavior can the state regulate?

[View Larger](#)

KCDB
Then-Texas Tech University Health Science Center professor Rodney Hicks was disciplined by state nursing regulators when the content of a private computer chat he was participating in from his home was mistakenly viewed by a single student.

[View Larger](#)

Terri Mann-Dye
The Texas Board of Nursing moved to suspend the license of Terri Mann-Dye (then known as Terri Dye) after she drew her gun on a man she said had aggressively approached her in a parking lot.

By [Eric Dexheimer](#)

American-Statesman Staff

Three years ago, while on his computer at home one evening, professor Rodney Hicks clicked the wrong button. After digitally recording a lesson for his graduate nursing students at Texas Tech University, he accidentally reduced the screen instead of completely exiting out of it. Then he logged onto a private chat room. Because he hadn't closed the window, the program continued to capture screen shots of his sexually explicit session.

Hicks, who holds a doctorate in his field and taught under an endowed professorship, had earned high reviews as both a nurse and an academic. Months earlier, the Texas Tech University Health Science Center's School of Nursing had named him "Outstanding Teacher of the Year." In more than 30 years of nursing practice he'd never had a patient complaint filed against him, court records say. Colleagues praised his high ethical standards.

But when the single college student who saw the mistakenly posted graphic discussion reported it, none of that mattered. Hicks said he left his university job under pressure in 2011.

The Austin-based state Board of Nursing also moved to suspend or revoke the professional license essential to his livelihood. Even though he was never charged with any crime, the board asserted Hicks had nevertheless engaged in "unprofessional or dishonorable conduct" that threatened patient and public safety.

It's not an isolated case. In recent years, Texas boards that oversee the growing number of state-regulated occupations have punished licensed professionals not for on-the-job missteps that imperil the public, but for legal behavior that occurs outside of work hours — often saying the incidents dishonor the profession or indicate character failings that might seep into their work.

Legal critics say the cases are based on an unproven connection between off-duty behavior and acceptable work performance, and that they distract licensing boards from attending to genuine public threats. Once regulators begin linking professional licenses to personal behavior that, while perhaps objectionable is not against the law, they say it's hard to know where to stop.

“Should we take away the license of a cardiologist who smokes cigarettes?” asked Adam Slote, a San Francisco lawyer considered an expert in the field through his representation of nurses in several high-profile California cases. “Or the nurse who doesn’t vaccinate her children, or the Realtor who goes into foreclosure because he paid too much for his own home?”

Civil libertarians fear such broad reach can overstep the government’s authority. “I don’t think that when people get an occupational license they should be giving up their privacy,” said Marc Levin, an analyst with the conservative Texas Public Policy Foundation.

Board of Nursing Executive Director Katherine Thomas stressed that regulators must act aggressively on behalf of patients who in many instances can’t look out for themselves. “If you are a nurse, you are caring for the most vulnerable people — unconscious, elderly, children — who are putting their entire trust in you,” she said. “You need to uphold standards to where that trust is deserved.” She added that it is uncommon for nurses to be sanctioned for their legal off-duty actions.

Yet the board also has taken the official position that a licensed nurse may be judged on his or her behavior 24 hours a day, regardless of whether he or she is on the clock.

In 2009, after nurse Terri Dye reached into her car and drew a handgun on an unfamiliar man advancing aggressively on her in a Lubbock hospital parking lot, a jury may or may not have concluded she acted in self-defense; the man, a process server in her divorce, never filed a complaint. But that didn’t stop the nursing board from moving in 2011 to suspend her license.

Never mind that Dye hadn’t yet checked in at work, where her nursing skills were not in question: In legal filings, regulators contended the parking lot incident had grave — if theoretical — implications for patients. While none had actually witnessed the incident, a board expert testified that if they had, they might have been frightened by the gun.

Dye’s behavior “did not conform to the minimum standards of nursing practice [because] Dye did not appropriately assess the situation,” the board’s legal filings explained. “If a nurse reacts without appropriately assessing a situation, it could cause an unsafe environment.”

“It was ‘could’ve, could’ve, could’ve,’” recalled Dye, who now lives in Amarillo.

At the judge’s recommendation, the board eventually decided not to punish Dye for the incident. But its final order in the matter stressed its authority: “The Board reiterates that a nurse may be subject to disciplinary action for unprofessional or dishonorable conduct whether such conduct occurs while the nurse is ‘on duty or on call’ or not.”

Casting wide net

Other state-regulated professions have seen similar cases. In July 2011, the Texas Education Agency revoked the license of a teacher who’d had a sexual relationship with a high school student. Yet Plano teacher Robert Lange didn’t know the 18-year-old from his classes; she was enrolled in a different school district in a different county.

The two had met in a non-school activity and the legally adult woman “fully consented” to the relationship, court documents show. No charges were filed because no laws were broken. The agency nevertheless found Lange “unworthy to instruct” and permanently revoked his license.

Lange, 56, who taught for 30 years, is appealing the decision. “When all you have in play is lawful personal behavior — not relevant to the license in any way — how do you get to ‘unworthy to instruct?’” asked his Austin attorney, Kevin Lungwitz.

The answer is that some regulators have adopted rules that allow for broad interpretation. Texas’s description of “unworthy to teach,” for example, has been defined in a key court case as essentially undefinable: “What qualities or lack of qualities should render one unworthy would be difficult for legislative enumeration.”

That allows licensers to cast a wide net. In 2006, Houston school teacher Carmelita Anderson decided she wanted to teach her then-10-year-old foster son a vivid lesson. The boy had been in trouble — stealing, lying

and smoking — so Anderson, who had also worked with prisoners and emotionally disturbed youth, decided to offer a quick “homeless” lesson that they’d discussed in the past, court records show.

She let the boy off on a street a few minutes from their home and drove off, keeping an eye on him in the mirror. She said she drove 500 feet, performed two u-turns, and picked him up. “You were out here less than a minute,” she said as they debriefed in the car. “Imagine your life like this forever.”

Two Houston police officers had observed the incident, however, and Anderson was charged with child endangerment for leaving the boy alone on the side of a busy road at dusk. Prosecutors declined to pursue the charges. Child Protective Services and the school district both investigated and dropped the matter.

But the state moved to suspend Anderson’s teaching certificate anyway. While she had earned glowing job evaluations working as a teacher, the out-of-school incident proved she “lacks fitness” to instruct children, the regulatory board said. It eventually voted to reprimand Anderson.

Similarly, the nursing board can discipline licensees for any conduct that might hurt not just patients, but also “the public.” It doesn’t have to prove actual harm to pursue disciplinary proceedings.

In 2010, when Ollie Traylor was found asleep on the couch at the house of her Houston home health patient, the state nursing board moved to revoke her license. The judge concluded her conduct wasn’t serious; there was no evidence it had happened repeatedly, for example, or that Traylor’s nap harmed, or was likely to harm, the patient. He recommended dropping the case.

The board disagreed, contending it only had to show there was potential for patient harm. Last July, it overrode the judge’s recommendation and revoked Traylor’s license.

The nursing board’s definition of “patient,” too, has been expansive. Hospice nurse Lori Jan Vazquez cared for a man dying of cardiac disease in Austin for two months in late 2007. The two stayed in touch afterwards, and he gave Vazquez and her children several gifts before he died.

In 2010, when regulators sought to reprimand Vazquez for violating “the professional boundaries of the nurse/patient relationship” for accepting the gifts, she noted their professional relationship had ended. Before he’d died, the patient testified he gave her the gifts as a friend.

But an expert for the board recommended a penalty because a nurse’s duties “don’t just end when the nurse stops caring for a patient.” The expert testified there were no definitive rules when the relationship ended, so “the nurse/patient relationship may extend ad infinitum.”

Such interpretations suggest “the nursing board is taking an extraordinarily broad interpretation of the law,” said Baylor University law professor Ron Beal, who teaches and practices administrative law. Other attorneys agreed the nursing board had an aggressive approach to off-duty behavior, though it wasn’t unique.

“The dirty little secret is when you become a health care professional you can’t make the mistakes Joe Blow down the street does,” said Austin’s Jon Porter, who worked as an investigator for the Texas Medical Board before entering practice defending licensees. “And when you make that mistake, it puts your license at risk.”

Legislating morality?

State-issued licenses — Texas currently has more than 500 occupations overseen by state regulators, representing about a third of its total workforce — are considered a government privilege that can be removed or restricted for reasons including “moral turpitude.” Often these are cases in which a licensee has been convicted of a crime relevant to his or her profession.

Few would argue that a teacher who has sexually assaulted a child or a stockbroker convicted of swindling investors should be allowed to continue in those professions. But other crimes are more of a stretch.

Following a rough patch, San Antonio licensed vocational nurse Tammy Spence qualified for food stamps and Medicaid assistance for her son for an 18-month period in 2007 and 2008. Picking up some extra shifts later put her over the income limit, which she didn’t report.

In 2009 she was charged with welfare fraud. After she explained what happened, prosecutors agreed to a deferred prosecution; the charge would eventually be dropped after she paid back the more than \$12,000 in total benefits she'd received.

She did. Meanwhile, in 2010 the Board of Nursing moved to revoke her license — even though Spence had practiced without incident for more than a decade. “They said it was a crime of moral turpitude,” Spence said. “That if I deliberately got welfare benefits I wasn’t entitled to, it would hurt patient safety.”

Spence settled, agreeing to be supervised by another nurse for a year. Thomas, of the nursing board, said the crime could hint at professional problems: “If they have engaged in behavior that violated the public trust outside of work, it could speak to their behavior at work.”

Yet Elizabeth Higginbotham of San Antonio, a registered nurse and lawyer who represents nurses in licensing disputes, said that approach means “anything you could do at any point could be considered unprofessional. They really do believe they have the ability to legislate morality.”

Slote, the San Francisco lawyer, said occupational boards increasingly are feeling pressure to take aggressive action as a legal shield. “It’s really the fear that if they don’t act, and then something happens, they’ll be blamed,” he said. “There’s this concept of, ‘We’re trying to prevent future conduct.’”

One of the few researchers to study the issue in detail, Loyola University Chicago School of Law professor Nadia Sawicki, concluded in a 2010 law review article that state medical boards “often focus on character-related misconduct, including criminal misconduct, that bears only a tangential relation to clinical quality and patient care.”

Even among doctors who have encountered personal or certain legal tangles, Sawicki added, there is slim evidence it predicts trouble in their clinical work. Very little research shows what personal behavior reveals future professional problems.

And the connection isn’t always obvious. In 2008, a nurse from Magnolia attempted suicide after a series of personal setbacks. Following a four-day hospital stay, psychiatric treatment and on-going counseling, the woman, who’d been a nurse for 16 years, returned to work, according to court documents.

Since then she’d been a stellar worker, testimony showed, earning the highest evaluation from her employer in 2010 and 2011. At a recent hearing, a quadriplegic patient she cared for in his home four days a week said she often stayed late to help him, and he rated her care 9.99 out of 10. She’d also been a foster mother to medically fragile children.

But the nursing board contended the woman’s suicide attempt had demonstrated poor judgment that placed patients at risk, so she should practice only under the supervision of another nurse. “An attempted suicide speaks to a person’s competency to act rationally,” Dusty Johnston, the nursing board’s general counsel, said in an interview.

Last September, an administrative judge recommended only a warning. “There was no evidence (the nurse) has ever placed a patient at risk of harm,” the judge wrote. “Indeed, the record demonstrates that she is an extraordinary person who ably cares for her patients.” The case is pending.

‘Reckless behavior’

The computer error by Hicks, the nursing professor, wasn’t discovered for a month. The single graduate nursing student who saw the explicit screen-grabs immediately reported it to the university. She later described her reaction as “shock and disgust,” though conceded she continued reading even after realizing the chat was private and had been posted mistakenly.

The only other person to view the graphic content was Chandice Covington, the dean of Texas Tech University Health Sciences Center, who immediately initiated a review of all of Hicks’s patient contacts. It found no evidence of misbehavior or complaints.

The dean also lodged a complaint with the Board of Nursing, and in early 2011, the board formally charged Hicks with engaging in unprofessional or dishonorable conduct. It also asserted the “obscene” content of the chat demonstrated he was mentally unfit to practice.

A battery of psychological tests given or interpreted by five experts was inconclusive. Although the chat had veered from adults to underaged subjects, several experts testified there was nothing to indicate that he was any more likely to engage in — versus fantasize or talk about online — deviant sexual behavior than anyone else.

Last March, Judge Penny Wilkov agreed Hicks had no mental disabilities. “Dr. Hicks had a pattern of accolades, success, and promotions that would not be expected of a person with a personality disorder,” she wrote in her opinion. “By all accounts, his record as a nurse is exemplary.”

But the judge did find Hicks’s at-home behavior had harmed the nursing student. “To conduct private graphic chats just minutes (after preparing a lesson) was reckless behavior,” she wrote. “Had he kept his work life and private life completely separate, he would have ensured a safe environment for his students to learn without the possibility of viewing explicit material.”

Wilkov recommended Hicks work only under the supervision of another nurse for a year. Hicks has appealed to district court, arguing that he has never acted unprofessionally while working.

“The nursing board regulates nursing practice; they don’t regulate nurses,” he said from California, where he now teaches nursing. “Where are my privacy rights? The board can’t regulate what goes on in your own home.”

COMMISSION ON DENTAL ACCREDITATION

F. RECIPROCAL AGREEMENT WITH THE COMMISSION ON DENTAL ACCREDITATION OF CANADA

The reciprocal accreditation arrangement between the Commission on Dental Accreditation and the Commission on Dental Accreditation of Canada (CDAC) has been maintained and expanded since its adoption in 1956. Under the reciprocal agreement, each Commission recognizes the accreditation of educational programs in specified categories accredited by the other agency. Under this arrangement, the Commissions agree that the educational programs accredited by the other agency are equivalent to their own and no further education is required for eligibility for licensure. Commissioners and staff of the accrediting agencies will regularly attend the meetings of the other agency and its standing committees. In addition, Commissioners and/or staff will participate annually in at least one site visit conducted by the other agency. The Commissions believe that this cross-participation is important in maintaining an understanding of the accreditation processes in each country and in ensuring that the accreditation processes in each country continue to be equivalent.

The following educational programs are included in the scope of the reciprocal agreement.

- Predoctoral dental education
- Dental hygiene
- Level II dental assisting
- All nine (9) ADA recognized advanced specialty education programs

The following statement is used in each issue of the List of Accredited Advanced Education Programs and in each issue of the List of Accredited Dental Education Programs:

Canadian Programs

By reciprocal agreement, programs that are accredited by the Commission on Dental Accreditation of Canada are recognized by the Commission on Dental Accreditation of the American Dental Association. However, individuals attending dental programs in one country and planning to practice in another country should carefully investigate the requirements of the licensing jurisdiction where they wish to practice.

By reciprocal agreement, Level II Dental Assisting and Dental Hygiene programs that are accredited by the Commission on Dental Accreditation of Canada are recognized by the Commission on Dental Accreditation of the American Dental Association.

Reaffirmed: 8/12, 8/10, 7/07, 1/03, 7/01; Updated: 7/91; CODA: 1/97:03, 1/94:4-5

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Accreditation Notices

Accreditation Status Definitions

DDS/DMD Programs - Canada.

US Programs

By reciprocal agreement, programs that are accredited by the Commission on Dental Accreditation of Canada are recognized by the Commission on Dental Accreditation of the American Dental Association. However, individuals attending dental programs in one country and planning to practice in another country should carefully investigate the requirements of the licensing jurisdiction where they wish to practice.

For additional information, please visit the Canadian Dental Association website at <http://www.cda-adc.ca/cdacweb/en/>.



211 East Chicago Ave
Chicago, IL 60611-2678
312 - 440 - 2500

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Home > International Professionals

International Professionals

The Commission on Dental Accreditation of Canada (CDAC) is responsible for accrediting dental, dental hygiene and dental assisting education programs in Canada

For the purpose of certification and licensure in Canada, only programs that are accredited by either CDAC or the American Dental Association's Commission on Dental Accreditation (CODA) are considered accredited.

In addition, the following general dentistry programs are also considered accredited:

Effective March 30, 2010, general dentistry programs accredited by CDAC or the Australian Dental Council (ADC).

Effective December 15, 2011, general dentistry programs accredited by CDAC or the Dental Council of New Zealand (DCNZ).

Effective December 5, 2012, general dentistry programs accredited by CDAC or the Irish Dental Council.

For more information on any of the following, follow the link to contact the appropriate agency or organization:

- The American Dental Association's Commission on Dental Accreditation (CODA), via the American Dental Association's website at www.ade.org
- The Australian Dental Council website at www.adc.org.au.
- The Dental Council of New Zealand website at www.dcnz.org.nz.
- The Irish Dental Council website at www.dentalcouncil.ie/contactus.php.
- Certification and licensure for dentistry in Canada, via the Canadian Dental Association's website at www.cda-adc.ca.
- Specific information on certification for dentistry, via the National Dental Examining Board of Canada's website at www.ndeb.ca.
- Specific information on certification for dental hygiene, via the National Dental Hygiene Certification Board's website at www.ndhcb.ca.
- Specific information on certification for dental assisting, via the National Dental Assisting Examining Board's website at www.ndaeb.ca
- For specific information on licensure, contact the regulatory authority in your province of practice.

A list of [dental regulatory authorities](#) is available on the Canadian Dental Association's website at www.cda-adc.ca. A list of dental hygiene regulatory authorities is available on the Canadian Dental Hygienists Association's website at www.cdha.ca and a list of dental assisting regulatory authorities is available on the Canadian Dental Assistants Association's website at www.cdaa.ca.

Reen, Sandra (DHP)

From: DR JOHN L HARRIS III [jlharrisiii@cox.net]
Sent: Monday, August 12, 2013 4:40 PM
To: Reen, Sandra (DHP)
Cc: Dr. James D. Watkins; Jeff Levin; David C Sarrett
Subject: Re: SCDDE 2014 DUES & INFORMATION

Sandy,

I have no doubt regarding what you have related to me regarding the Board minutes is true. I do know, however, that there have been Board members and Dental School representatives that have attended in the past, but may not have communicated information to their respective institutions. At this point, it is not necessary, nor is it productive to take a look back at the attendance lists of past meetings, so I will not go there.

All elected positions of SCDDE are voted on at the annual Business meeting, the day following the Executive Committee meeting, at which time the Nomination slate is approved, which the minutes reflect. Those newly elected take office at the close of that business meeting. There is only one meeting per year and that is in January of each year. The sequence has been continuous and in consecutive order, with a few exceptions, since the organization began, close to 60 years ago. Each year the member representative (s) of the school and boards who attend are invited to participate at the EC meeting, in order to get a heads-up of how things are done and an opportunity to have discussions with others present. I have generally included in the meeting distributed materials, a past President's list that shows the name of the school, board, Dean, and year served, etc.

The Boards have always taken a second seat, in a sense, to the schools since they do not have CE department resources that generally develop and implement the meeting programs, along with input from the Board. The Boards have "always" been elected and represented as the Vice-President of SCDDE and have participated in the program, as a co-host, to my knowledge, and as the minutes reflect. Each attendee, including schools and board, except for speakers, are expected to register and pay associated fees. The school(s) or board may also do this on their member's behalf. Since the emphasis has been with the schools, and less emphasis on the boards, most contact through SCDDE is associated with the schools. I have always asked the schools to be in touch with the boards, and have encouraged both institutions to attend our early meetings, especially those prior to their respective turn as host.

For instance, I do know that, Kentucky schools & board will co-host in January 2015, and they were in attendance for the January 2013 meeting. I believe that Mississippi follows and will be contacted soon, for 2016. Generally, the Boards have also changed faster than the Deans. If I am responsible for letting things drop through the cracks, I do apologize, but that was not intended.

I hope that you will be able to continue our tradition, as this is what the SCDDE has always done, and with no expense to either the schools or boards. Regardless, of the way that the Virginia Board of Dentistry is mandated to do an be represented in name, by co-host, member, etc. at this conference, I hope that someone from the Board will represent our state at this meeting. Virginia Board of Dentistry President is the current Vice president of SCDDE, according to our election. If a new Board President occurs prior to the January SCDDE, then he/she is Vice President of SCDDE.

I am sorry that things have come to this type of situation, but I understand that changes in law and perception create differing perspectives which are to be respected and implemented.

Thank you for your time; I hope that things will work out for VBD.

Take care, and keep me informed of your decisions, and how to proceed. I will not use those "terms" that you requested not be used, again for VBD, as I conveyed to you last week in telephone conversation. I would ask that you try to expedite the determination on this issue as registration materials for the January SCDDE will go out this Fall, from VCU.

John

----- Original Message -----

From: Reen, Sandra (DHP)

To: DR JOHN L HARRIS III

Cc: David C Sarrett ; Jeff Levin

Sent: Monday, August 12, 2013 2:06 PM

Subject: RE: SCDDE 2014 DUES & INFORMATION

John:

Thank you for your follow-up message and phone call and for explaining the practices of SCDDE regarding the rotation of its annual meeting and officers. I understand that the designation of the Board as a co-host is essentially honorary and that you notify a state's representatives 2 years in advance of a state's turn to host. To the best of my knowledge, the Virginia Board of Dentistry (Board) did not get that notice. I looked back through our travel records and found that no one from the Virginia Board of Dentistry (Board) was able to attend the 2012 and 2013 SCDDE meetings. I also looked back at the Board's March 2009, 2010 and 2011 minutes to see what the Board's representatives reported on the SCDDE meetings held in those years. I did not find any note made regarding when Virginia would come up in the rotation.

I have checked with Dr. Reynolds-Cane, the Director of the Department of Health Professions, about any requirements or policies a board would need to address before hosting/sponsoring a meeting. She said that the Board would need to have approval from the Secretary of Health and Human Resources in order to be recognized generally or specifically as a host, sponsor or supporter of a meeting/conference.

Since the Board has not discussed co-hosting the SCDDE and has not obtained the required approval to undertake this role, I am again asking you not to refer to the Board as a co-host, sponsor or supporter of the 2014 SDDE meeting in any future correspondence about the meeting.

Thank you,
Sandy

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4437

From: DR JOHN L HARRIS III [mailto:jlharrisiii@cox.net]

Sent: Thursday, August 08, 2013 6:34 PM

To: Reen, Sandra (DHP)

Subject: Re: SCDDE 2014 DUES & INFORMATION

Sandy,

Virginia Board of Dentistry has always been a member of SCDDE and has co-hosted the conference at all meetings in the state since the organization has been formed. This cost the state nothing and has not been a problem in the past. As the conference rotates each year from state to state, the President of SCDDE is the Dean(s) of the Dental School(s), and the Vice President of SCDDE is the President of the state Board of Dentistry.

Let's talk tomorrow, if possible, to iron out and discuss any problems. You may want to speak with Drs. Watkins and Levin as they probably know the history of SCDDE better than most on the Board at this time, and have attended in the past.

Thank you...will call you in the morning.

John

----- Original Message -----

From: Reen, Sandra (DHP)

To: DR JOHN L HARRIS III

Cc: David C Sarrett ; Jeff Levin

Sent: Thursday, August 08, 2013 5:00 PM

Subject: RE: SCDDE 2014 DUES & INFORMATION

Hi John:

I may have inadvertently given you the wrong impression in our recent telephone conversation. I only recall saying that I was participating on the planning committee that Dr. Sarrett convened and never meant to imply in any way that the Virginia Board of Dentistry is co-hosting the SCDDE meeting. The Board has not undertaken this task. I apologize for any misunderstanding I may have caused and request that the Board not be referred to as a co-sponsor in future correspondence about the meeting. To the best of my knowledge the VCU School of Dentistry is the only host and should be given full credit for the event.

With sincere apologies,

Sandy

Sandra K. Reen, Executive Director

Virginia Board of Dentistry

804-367-4437

From: DR JOHN L HARRIS III [<mailto:jlharrisiii@cox.net>]

Sent: Thursday, August 08, 2013 2:57 PM

To: Dr. Michael S. Reddy; Dr. D. Gregory Chadwick; Dr. Teresa Dolan; Dr. Francis Gerald Serio; Dr. Connie Drisko; Dr. Leo Rouse; Dr. Sharon P. Turner; Dr. Robert F. Hirsch; Dr. Henry A. Gremillion; Dr. John J. Sauk; Dr. Janet H. Sutherland; Dr. Gary W. Reeves; Dr. Jane Weintraub; Dr. Robert Uchin; Dr. Humberto J. Villa; Dr. John J. Sanders; Dr. Timothy L. Hottel; Dr. David Sarrett; Dr. David A. Felton; Ms. Susan F. Wilhelm; Ms. Donna Cobb; Ms. Bonnie Rampersaud; Ms. Sue Foster; Ms. Tanja D. Battle; Mr. David Beyer; Mr. Peyton Burkhalter; Ms. Leah Diane Howell; Mr. Bobby White; Ms. Magda E. Bouet; Ms. Kate Cox; Ms. Dea Smith; Reen, Sandra (DHP); Ms. Deborah Richardson; Dr. Richard D. Smith

Cc: Dr. John L. Harris III

Subject: SCDDE 2014 DUES & INFORMATION

Greetings from the Southern Conference of Dental Deans and Examiners (SCDDE). On January 24- 26, 2014, Virginia Commonwealth University and the Virginia Board of Dentistry will co-host the 59th meeting of the SCDDE at the Omni Richmond Hotel In Richmond, Virginia. The purpose of this conference is to explore *Ethics and Professionalism in Dental Education and Licensure- Putting Patients First.*

We welcome all current state board members and educational faculty as well as former board members and faculty that are interested in topics involving dental issues between the educational and examination perspectives of licensure boards and educational institutions. The current membership includes 19 Dental Schools & 15 Dental Boards.

Please see the enclosures: 1) SCDDE institutional dues statement of \$200.00 for the fiscal year 2013/2014, and 2) the W-9 Taxpayer ID & Certification. Dues were reinstated via vote at the last business meeting of the SCDDE in January 2013.

Registration materials will be sent this Fall, however, online registration will also be available as handled by VCU Department of Continuing Education, Contact information: Ms. Pamela Flynn, pflynn@vcu.edu or (804) 828-0869.

This event is a great opportunity to renew relationships with educators and examiners, dental professionals and other parties of interest; while exchanging ideas, visiting the vendor sponsor tables, obtaining continuing education credits for conference attendance, and discussing the relevant issues in the forefront of dentistry today. Needless to say, Richmond also has much to offer for the spouse/guest and the registrant, including a tour of the DentSim Lab and a Spouse Program.

There will also be opportunities for other dental groups to interact as several will have meetings prior to and after the SCDDE at the same location.

Thank you for your cooperation and attention to paying your dues (via check to "SCDDE") at the address below upon receipt of the statement; and attending one of the first regional conferences of the 2014 New Year. Take care, enjoy the rest of the summer, and we hope to see you in Richmond in January.

Sincerely yours,

John L. Harris III, MS, DDS
SCDDE: SECRETARY/TREASURER
5423 MEDMONT CIRCLE
ROANOKE, VA 24018-1135
EMAIL: JLHARRISIII@COX.NET
Cell: 540-556-2718
H: 540-774-7209

August 08, 2013

Reen, Sandra (DHP)

From: Reen, Sandra (DHP)
Sent: Monday, May 13, 2013 5:17 PM
To: mmagid@lynchburgoralsurgery.com
Subject: AAOMS Credential
Signed By: Sandra.Reen@DHP.VIRGINIA.GOV

Importance: Low

Hi Dr. Magid:

I understood your questions to be:

Does the AAOMS certificate option (in lieu of obtaining a permit from the Board) travel with an OMS who provides sedation and general anesthesia on an itinerant basis to other dental practices? Or, does the AAOMS certificate option only apply in the practice that is subject to the AAOMS examination?

Please let me know if my understanding of your inquiry is correct because I will need to ask the Board for guidance on the response at its June 7, 2013 meeting. This circumstance and the circumstance of having more than one office were not considered during the development of the Emergency Regulations.

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4437

Reen, Sandra (DHP)

From: Laura Givens [Givens@vadental.org]
Sent: Thursday, April 11, 2013 4:53 PM
To: Reen, Sandra (DHP)
Subject: RE: AAOMS Exam Question

Hi Sandy,

Thank you very much for clarifying that for me. As we discussed, I thought that would be the case, but now it is good to know for sure in moving forward.

As always, I appreciate your help!

Laura

Laura Givens
Executive Secretary
Virginia Society of Oral & Maxillofacial Surgeons
3460 Mayland Ct., Ste. 110
Richmond, VA 23233
(P) 804-523-2185
(F) 804-288-1880

From: Reen, Sandra (DHP) [<mailto:Sandra.Reen@DHP.VIRGINIA.GOV>]
Sent: Thursday, April 11, 2013 4:46 PM
To: Laura Givens
Subject: RE: AAOMS Exam Question
Importance: Low

Hi Laura:

I did discuss this with Board Counsel. He and I agreed that the permit exemption for OMSs only applies when the AAOMS office examinations are conducted on offices in VA. The Board of Dentistry established the exemption because it was willing to accept AAMOS results instead of conducting our own inspections of practices in VA.

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4437

From: Laura Givens [<mailto:Givens@vadental.org>]
Sent: Tuesday, April 09, 2013 1:10 PM
To: Reen, Sandra (DHP)
Subject: AAOMS Exam Question

Hi Sandy,

I left you a voicemail and thought I'd email you as well. I have had a few OMSs ask me for clarification on their requirements to be exempt from the sedation permit requirement. Several AAOMS members are members in Maryland so are examined through the Maryland Society of OMS. They have satellite offices in Virginia so VSOMS would not normally evaluate their office since the AAOMS exam has been done through Maryland. My question is, must the doctor also be examined at their Virginia office through VSOMS? In the past, we have not required them to do so since

they are members with Maryland and that state organization has taken care of their AAOMS exam. I just want to make sure that continues to be valid.

I appreciate your assistance in clarifying this situation!

Laura

Laura Givens
Executive Secretary
Virginia Society of Oral & Maxillofacial Surgeons
3460 Mayland Ct., Ste. 110
Richmond, VA 23233
(P) 804-523-2185
(F) 804-288-1880

Reen, Sandra (DHP)

From: DENNIS CLARK [dlibsdden@mt.gov]
Sent: Thursday, August 01, 2013 11:52 AM
To: Reen, Sandra (DHP)
Subject: Re: Inspections

*This message has been forwarded to you from the **AADA Message Board**.
[Click here to reply to this message.](#)*

Anesthesia

Re: Inspections

From: DENNIS CLARK
To: marshall shragg
Attachments: None

08/01/13
10:52:19 AM
3UG0NAVZ8 

In Minnesota, we have an inspection requirement for those holding a sedation or anesthesia permit. Since we implemented the inspections several years ago, we've been accepting the AAMOS inspections completed by and for their members as equivalent to our inspections. That practice has come under discussion, in no small part to the Oklahoma incident.

So... does your state accept the AAMOS inspections for your oral surgeons, or do you require a separate Board inspection?

Thank you.

---Marshall

Hi from Montana,

Due to the requirements in statute and rule, the board contracts with qualified licensed Dentists in Montana to provide the inspections for Moderate Sedation and Deep Sedation/General Anesthesia permits.

My understanding is the AAMOS will accept our inspections as equivalent to theirs for their members.

Best,

Dennis

*This message has been forwarded to you from the **AADA Message Board**.
[Click here to reply to this message.](#)*

Reen, Sandra (DHP)

From: Susan Miller [susan.miller@isbd.idaho.gov]
Sent: Thursday, August 01, 2013 10:29 AM
To: Reen, Sandra (DHP)
Subject: Re: Inspections

*This message has been forwarded to you from the **AADA Message Board**.
[Click here to reply to this message.](#)*

Anesthesia

Re: Inspections

From: Susan Miller
To: marshall shragg
Attachments: None

08/01/13
09:28:37 AM
3UG0KB9DK 

Idaho is just the opposite, our Board inspections are accepted by AAOMS.

-Susan

In Minnesota, we have an inspection requirement for those holding a sedation or anesthesia permit. Since we implemented the inspections several years ago, we've been accepting the AAMOS inspections completed by and for their members as equivalent to our inspections. That practice has come under discussion, in no small part to the Oklahoma incident.

So... does your state accept the AAMOS inspections for your oral surgeons, or do you require a separate Board inspection?

Thank you.

---Marshall

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PROPOSED REVISION

Virginia Board of Dentistry
 Policy on
CCAs/CONFIDENTIAL CONSENT AGREEMENTS (CCAs)
 Adopted July 11, 2003

Excerpts of Applicable Law, Regulation and Guidance

- CCAs may be entered into only in cases involving minor misconduct where there is little or no injury to a patient or the public and little likelihood of repetition by the practitioner, §54.1-2400(14)
- A licensed practitioner who has entered into two CCAs involving a standard of care violation, within the ten year period immediately preceding a board's receipt of the most recent report or complaint being considered, shall receive public discipline for any subsequent violation within the 10 year period unless...§54.1-2400(14)

Probable Cause Decisions

- ~~1. Intake Investigations/offline cases are reviewed by the president for a decision regarding:

 - ❖ closure
 - ❖ further investigation or
 - ❖ assignment to a Special Conference Committee (SCC) for probable cause review.~~
2. 1. Consideration of CCAs will shall be addressed in probable cause reviews conducted by Special Conference Committees.
- ~~3. Staff will implement the SCC decisions when at least 2 of the 3 members agree or will discuss with the committee chair the action to be taken when there are 3 different responses.~~
4. 2. SCCs Reviewers may use CCAs to address one or more minor or technical violations to include:
 - advertising
 - CE*
 - recordkeeping
 - terms of probation
 - inadequate communication with patient
 - standard of care findings when there was little or no injury
 - ~~unintentional practicing with a lapsed license~~ up to 90 days**
 - failure to post required license, credential or certificate
 - failure to filing file and maintaining OMS profile
 - OHS standards
 - expired drug stock
 - releasing records
5. 3. The offered CCA shall include a finding that a violation occurred, shall direct that the licensee institute or cease a certain practice and may require continuing education.
4. A proposal from a respondent for a CCA will only be considered during probable cause review stage and shall not be considered once a notice is executed.
5. Upon receipt of a decision to offer a CCA in which standard of care violations are to be addressed, staff shall review the licensee's history to determine if two such CCAs have been entered. If a licensee already has 2 CCAs addressing standard of care violations, staff will confer with the Reviewer on the action to be taken.

* As addressed in Guidance Document: 60-5

** As addressed in Guidance Document: 60-6

PROPOSED REVISION**Virginia Board of Dentistry****Policy on Sanctioning for
Practicing with an Expired License**Excerpts of Applicable Law, Regulation and Guidance

- No person shall practice dentistry unless he possesses a current valid license, §54.1-2709.A
- No person shall practice dental hygiene unless he possesses a current valid license, §54.1-2722.A
- Licenses must be renewed annually, 18 VAC 60-20-20.A
- Practicing with an expired license may subject the licensee to disciplinary action and additional fines, 18 VAC 60-20-20.C.2
- Confidential Consent Agreements may be used to address ~~an unintentional practicing with a lapsed license~~ up to 90 days, Guidance Document: 60-1
- Licensees shall provide the board with current addresses and notice is validly given by the board when mailed to the latest address given, 18 VAC 60-20-16
- If a disciplinary proceeding will not be instituted, a board may send an advisory letter to the subject of a complaint or report, § 54.1-2400.2.F

Reporting

1. On a semi-annual basis during the months of October and April, the Board will generate a report to identify licensees who renew their license after the annual deadline for renewal but within the twelve month late period.
2. Board staff will sort the licensees in groups according to the length of time the license was lapsed to determine which action will be taken by the Board.
3. Cases where the license was lapsed for 30 days or less will be assigned a case number by Board staff and will not be referred to Enforcement.
4. Cases where the license was lapsed for more than 30 days but was renewed within the 365 day late period will be sent to Enforcement for an investigation to determine if the licensee was practicing in Virginia during the period the license was lapsed and to determine if the address of record is current.

Probable Cause Decision

1. Cases where the license was lapsed for 30 days or less will be closed without investigation by Board staff with an advisory letter unless there are other grounds for disciplinary action.
2. Cases where the license was lapsed for more that 30 days will be reviewed by either a Board member or staff (the reviewer) to determine if evidence exists that the licensee was practicing during the period the license was lapsed.

PROPOSED REVISION**A. Guidelines for Offering a Confidential Consent Agreement**

1. The reviewer shall only offer a CCA for a first offense.
2. The reviewer shall offer a CCA to a licensee in a case where there is only one finding of probable cause and that finding is that his license was expired for 31 to 90 days.
3. The reviewer shall offer a CCA to a licensee in a case where there are only two findings of probable cause and those findings are that (1) his license was expired for 31 to 90 days, and (2) he failed to provide a current address.
4. In cases where there are findings of probable cause for violations in addition to an expired license for 90 days or less and an address not being kept current, ~~a SCC~~ the reviewer may offer a CCA consistent with Guidance Document 60-1.
5. The offered CCA shall include a finding that a violation occurred and shall request the licensee's agreement to henceforth keep his license and address current.

B. Guidelines for Imposing Disciplinary Sanctions

1. The reviewer shall offer a Pre-Hearing Consent Order (PHCO) to a licensee for a second and for subsequent offenses where there is a finding of probable cause and that finding is that his license was expired for 90 days or less.
2. The reviewer shall offer a Pre-Hearing Consent Order (PHCO) to a licensee in a case where there is only one finding of probable cause and that finding is that his license was expired for a period longer than 90 days but less than 365 days.
3. The reviewer shall offer a PHCO to a licensee in a case where there are only two findings of probable cause and those findings are that (1) his license was expired for a period longer than 90 days but less than 365 days and (2) he failed to provide a current address.
4. In cases where there are findings of probable cause for violations in addition to an expired license and an address not being kept current, The reviewer may offer a PHCO or ~~hold~~ refer for an informal fact finding conference.
5. The reviewer shall consider the following sanctioning guidelines for a PHCO:
 - a. For a license expired for less than 180 days – First Offense – Reprimand
 - b. For a license expired for less than 180 days – Subsequent Offences – Reprimand and a \$500 monetary penalty
 - c. For a license expired for more than 180 days but less than 365 – First Offense - Reprimand and \$500 monetary penalty
 - d. For a license expired for more than 180 days but less than 365 – Subsequent Offences - Reprimand and \$1000 monetary penalty
 - e. For an address not being kept current – \$500 monetary penalty

PROPOSED REVISION**Virginia Board of Dentistry
Policy on Recovery of Disciplinary Costs****Applicable Law and Regulations**

- §54.1-2708.2 of the Code of Virginia.
The Board of Dentistry (the Board) may recover from any licensee against whom disciplinary action has been imposed reasonable administrative costs associated with investigating and monitoring such licensee and confirming compliance with any terms and conditions imposed upon the licensee as set forth in the order imposing disciplinary action. Such recovery shall not exceed a total of \$5,000. All administrative costs recovered pursuant to this section shall be paid by the licensee to the Board. Such administrative costs shall be deposited into the account of the Board and shall not constitute a fine or penalty.

- 18VAC60-20-18 of the Regulations Governing Dental Practice. The Board may assess:
 - the hourly costs to investigate the case,
 - the costs for hiring an expert witness, and
 - the costs of monitoring a licensee's compliance with the specific terms and conditions imposedup to \$5000, consistent with the Board's published guidance document on costs. The costs being imposed on a licensee shall be included in the order agreed to by the parties or issued by the Board.

Policy

In addition to the sanctions to be imposed which might include a monetary penalty, the Board will specify the costs to be recovered from a licensee in each pre-hearing consent order offered and in each order entered following an administrative proceeding. The amount to be recovered will be calculated using the assessment of costs specified below and will be recorded on a Disciplinary Cost Recovery Worksheet (the worksheet). All applicable costs will be assessed as set forth in this guidance document. Board staff shall complete the worksheet and assure that the cost to be assessed is included in Board orders. The completed worksheets shall be maintained in the case file. Assessed costs shall be paid within 45 days of the effective date of the Order.

Assessment of Costs

Based on the expenditures incurred in the state's fiscal year which ended on June 30, ~~2011~~ 2012, the following costs will be used to calculate the amount of funds to be specified in a board order for recovery from a licensee being disciplined by the Board:

- ~~\$403~~ 105 per hour for an investigation multiplied by the number of hours the DHP Enforcement Division reports having expended to investigate and report case findings to the Board.
- ~~\$403~~ 101 per hour for an inspection conducted during the course of an investigation multiplied by the number of hours the DHP Enforcement Division reports having expended to inspect the dental practice and report case findings to the Board.
- The applicable administrative costs for monitoring compliance with an order as follows:

PROPOSED REVISION

- ~~\$110~~ 127.25 Base cost to open, review and close a compliance case
 - ~~62~~ 70.25 For each continuing education course ordered
 - ~~16.25~~ 152 For passing the Virginia Dental Law Exam
 - ~~16.25~~ 19 For each monetary penalty and cost assessment payment
 - ~~16.25~~ 19 For each practice inspection ordered
 - ~~32.50~~ 38 For each records audit ordered
 - ~~32.50~~ 38 For passing a clinical examination
 - ~~91.50~~ 102.50 For each practice restriction ordered, and
 - ~~75.25~~ 83.50 For each report required.
- The amount billed by an expert upon acceptance by the Board of his expert report.

Inspection Fee

In addition to the assessment of administrative costs addressed above, a licensee shall be charged \$350 for each Board ordered inspection of his practice as permitted by 18VAC60-20-30 of the **Regulations Governing Dental Practice**.

Virginia Board of Dentistry
Calculation of Costs for Recovery
Based on FY13 Expenditures

COMPLIANCE WITH SANCTIONS	Compliance Case Manager (CCM)	Executive Director (ED)	Combined Costs	FY13 PROPOSED CHARGE
Base cost to open, review and close a compliance case (\$ per hr * 1.25 hrs) - CCM (\$ per hr * .25 hr) - ED	76.00	129.00	\$127.25	\$127.25
For each continuing education course ordered (\$ per hr * .5) - CCM (\$ per hr * .25) - ED	76.00	129.00	\$70.25	\$70.25
For passing the Virginia Dental Law Exam (\$ per hr * 2) - CCM only	76.00			\$152.00
For each monetary penalty and cost assessment payment (\$ per hr * .25) - CCM only	76.00			\$19.00
For each practice inspection ordered (\$ per hr * .25) - CCM only	76.00			\$19.00
For each records audit ordered (\$ per hr * .5) - CCM only	76.00			\$38.00
For passing a clinical examination (\$ per hr * 1.5) - CCM only	76.00			\$114.00
For each practice restriction ordered (\$ per hr * .5) - CCM (\$ per hr * .05) - ED	76.00	129.00	\$102.50	\$102.50
For each report required (\$ per hr * .25) - CCM (\$ per hr * .5) - ED	76.00	129.00	\$83.50	\$83.50