

Act would violate the preemption provisions of the Federal Arbitration Act." [16:2 CRLR 12-13]

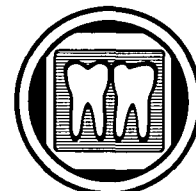
The California Supreme Court is also reviewing the Second District Court of Appeal's decision in *Potvin v. Metropolitan Life Insurance Co.*, 54 Cal. App. 4th 936 (1997). In *Potvin*, the Second District affirmed a physician's right to procedural due process when being terminated by a managed care provider. The issue was whether an independent contractor physician is entitled to notice and opportunity to be

heard before his membership in a mutual insurer provider network may be terminated notwithstanding an at-will provision in the agreement. In April 1997, the Second District reversed a summary judgment in favor of Metropolitan, holding that a physician who is a participating member of a managed health care network provided by an insurance company has a common law right to fair procedure before the insurance company may terminate his membership. [16:2 CRLR 13; 16:1 CRLR 33]

## Dental Board of California

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The Dental Board of California (DBC) is a consumer protection agency within the state Department of Consumer Affairs (DCA). DBC is charged with enforcing the Dental Practice Act, Business and Professions Code section 1600 *et seq.* The Board's regulations are located in Division 10, Title 16 of the California Code of Regulations (CCR).

DBC licenses dentists (DDS/DMD) and all categories of licensed dental auxiliaries, including registered dental assistants (RDA), registered dental assistants in extended functions (RDAEF), registered dental hygienists (RDH), registered dental hygienists in extended functions (RDHEF), and registered dental hygienists in alternative practice (RDHAP). Under Business and Professions Code section 1638 *et seq.*, the Board also issues oral and maxillofacial surgery (OMS) permits to qualified dentists and physicians.

The Board is authorized to establish standards for its approval of dental schools and dental auxiliary training programs; prescribe the subjects in which its licensees should be examined; license applicants who successfully pass the examinations required by the Board; set standards for dental practice; and enforce those standards by taking disciplinary action against licensees as appropriate. DBC is also responsible for registering dental practices (including mobile dental clinics) and corporations; establishing guidelines for continuing education requirements for dentists and dental auxiliaries; issuing special permits to qualified dentists to administer general anesthesia or conscious sedation in their offices; approving radiation safety courses; and administering the Diversion Program for substance-abusing dentists and dental auxiliaries.

DBC's Committee on Dental Auxiliaries (COMDA) was created by the legislature "to permit the full utilization of dental auxiliaries in order to meet the dental care needs of all

the state's citizens." COMDA is part of DBC, and assists the Board in regulating dental auxiliaries. Under Business and Professions Code section 1740 *et seq.*, COMDA has specified functions relating to the Board's approval of (1) dental auxiliary education programs, (2) licensing examinations for the various categories of auxiliaries, and (3) applicants for auxiliary licensure. Additionally, COMDA advises DBC as to needed regulatory changes related to auxiliaries and the appropriate standards of conduct for auxiliaries. COMDA is a separate nine-member panel consisting of three RDHs (at least one of whom is actively employed in a private dental office), three RDAs, one DBC public member, one licensed dentist who is a member of the Board's Examining Committee, and one licensed dentist who is neither a Board nor Examining Committee member.

The Board consists of fourteen members: eight practicing dentists, one RDH, one RDA, and four public members. The Governor appoints twelve of the Board's fourteen members (including all of the dentist members); the Senate Rules Committee and the Assembly Speaker each appoint one public member.

**At its December 3 meeting, the Dental Board is scheduled to entertain a September 9 petition filed by Consumers for Dental Choice, a coalition of several national organizations and individuals concerned about potential health risks associated with the use of mercury amalgams as dental fillings.**

### MAJOR PROJECTS

#### **Consumer Group Petitions Board to Clarify Policies, Obey Law Governing Disclosures on Mercury Amalgam Fillings**

At its December 3 meeting, the Dental Board is scheduled to entertain a September 9 petition filed by Consumers for Dental Choice (CDC), a coalition of several national organizations and individuals concerned about potential health risks associated with the use of mercury amalgams as dental fillings.

# HEALTH CARE REGULATORY AGENCIES

Represented by Washington, D.C. attorney Charles G. Brown, CDC notes that amalgam fillings consist 50% of mercury, a toxic element known to the State of California to cause cancer and/or birth defects. The California Department of Health Services listed mercury as toxic under Proposition 65 in 1990, thus triggering warning requirements under Health and Safety Code section 25249.6. Some studies show that mercury is second in toxicity only to uranium as a human poison. CDC claims that even the American Dental Association (ADA) has warned dentists not to touch the substance unprotected, and that the ADA and some mercury amalgam manufacturers have cautioned dentists not to place mercury amalgams in the teeth of pregnant or nursing women, children, people with kidney disorders, and people allergic to mercury. CDC also cites studies indicating that female dental personnel have both a higher miscarriage rate and a lower fertility rate, and notes that governments in other countries—including Canada—have advised dentists to avoid mercury fillings in vulnerable populations.

In its petition, CDC seeks several actions by the Dental Board:

◆ **Revision of Required Fact Sheet on Dental Restorative Materials.** CDC's petition notes that Business and Professions Code section 1648.10, enacted in 1992 under SB 934 (Watson) (Chapter 801, Statutes of 1992), requires DBC to prepare and distribute a fact sheet comparing the risks and benefits of the most commonly used dental restorative materials; among other things, the fact sheet is required to "encourage discussion between patient and dentist regarding materials and to inform the patient of his or her options." Although the petition acknowledges that the Board approved a fact sheet at its May 1993 meeting [13:2&3 CRLR 66], CDC charges that the fact sheet violates the statute in at least two respects: (1) it fails to advise dentists of the importance of discussing with patients the full range of choices available; and (2) although it discloses that amalgam contains mercury, the fact sheet fails to disclose that mercury was listed as a toxic substance in California three years prior to its preparation, and in fact states (citing no support) that "the preponderance of scientific evidence, to date, fails to show that exposure to mercury from amalgam restoration poses a health risk, except for a small number of allergic and/or sensitive patients." Even the Department of Consumer Affairs found in 1993 that the fact sheet is "probably misleading" in that it "minimizes the controversy over the use of amalgam fillings," and inconsistent with section 1648.10 in that it "fails to compare the risks of the materials. In fact, the risk associated with the use of mercury is dismissed by the sentence quoted above, stating that scientific evidence fails to show exposure to mercury from dental amalgam poses a health risk.....Although most of the scientific evidence currently available does not show that amalgams pose a health risk, there is not a preponderance of conclusive scientific evidence on the subject." [13:4 CRLR 46]

**Even the Department of Consumer Affairs found in 1993 that the fact sheet is "probably misleading" in that it "minimizes the controversy over the use of amalgam fillings."**

Further, CDC charges that, to comply with the letter and spirit of SB 934, the fact sheet should affirmatively notify patients of the full range of options available; remind dentists of their obligation to inquire about mercury sensitivity and/or allergy before placing amalgam fillings (and warn them of their potential legal liability if they fail to do so [16:2 CRLR 21-22]); and require dentists to post Proposition 65 warnings to alert both patients and dental office personnel of their exposure to a toxic substance. This last demand may be somewhat problematical legally; although the U.S. Ninth Circuit Court of Appeals has explicitly ruled that "[t]he State of California has listed mercury as a product which causes reproductive harm. As a result, consumer warnings for dental amalgam are now required," the court did not specify who must provide the warning or in what fashion (see LITIGATION). [16:2 CRLR 20-21]

CDC's petition asks the Board to revise the fact sheet to rid it of misleading language on mercury amalgam; meet all existing statutory requirements under section 1648.10; include in the fact sheet the last six years of research documenting the hazards of mercury amalgam; and provide dentists with guidance on properly warning patients and staff regarding the reproductive toxicity of mercury contained in amalgam.

◆ **Licensing Examination and Continuing Education.** CDC's petition also asks the Board to revise its California law examination to include questions regarding Business and Professions Code section 1648.10, to ensure that dentists know of its requirements. Further, the petition seeks inclusion of required coursework on the hazards of mercury exposure to dental office personnel and patients in California dentists' continuing education requirements.

◆ **Clarification of the Board's Position on "Mercury-Free" Practice.** Finally, CDC asks that the Board clarify its position on the permissibility of advertising and maintaining a "mercury-free" dental practice. This request stems from a recent Board disciplinary action in which CDC attorney Brown represents Ralph Andrew Landerman, a California dentist seeking reinstatement of his license. At a March 1999 public hearing on Landerman's petition

for reinstatement, DBC President Robert Christoffersen, DDS, and two other Board members quizzed Landerman about whether—if reinstated—he would pursue a mercury-free practice. During the course of oral argument, Dr. Christoffersen stated that "an amalgam-free practice does not fit the current practice of dentistry." [16:2 CRLR 22] This statement conflicts with 1993 statements by Board staff to the effect that the Board has "no policy regarding the use of health and safety effects of mercury in dental procedures." [13:4 CRLR 46] Although the Board ultimately denied Landerman's petition on other grounds, Brown has now filed suit to reverse the decision, arguing that the Board's articulated reason for denying the petition is a subterfuge for its "anathema" to

# HEALTH CARE REGULATORY AGENCIES

mercury-free dentistry (see LITIGATION). CDC's petition asks the Board to clarify its position on mercury-free dentistry, and to refrain from taking administrative action against dentists who exercise their first amendment rights to advocate mercury-free dentistry.

## **Ad Hoc Committee on Oral and Maxillofacial Surgery**

At DBC's May 1999 meeting, Board President Robert Christoffersen, DDS, announced his appointment of an Ad Hoc Committee on Oral and Maxillofacial Surgery. The Ad Hoc Committee has been charged with (1) providing DBC with the most current definition of the specialty of oral and maxillofacial surgery (OMS), and (2) identifying specific procedures in which dentists who complete approved OMS educational programs have been trained.

The Board's creation of the Ad Hoc Committee stems from a 1998 DCA legal opinion finding that, for purposes of performing cosmetic surgery, dentists—including dentists with oral and maxillofacial surgery permits under Business and Professions Code section 1638 *et seq.*—are bound by the scope of practice set forth in Business and Professions Code section 1625. Section 1625 restricts the practice of dentistry to regions of the head; further, cosmetic procedures performed on regions of the head by dentists are permitted only insofar as their purpose is to treat or correct a dental condition. While the California Association of Oral and Maxillofacial Surgeons believes that DCA's interpretation and application of section 1625 is overly restrictive and prevents its dentist members from utilizing the full scope of their oral and maxillofacial surgery training, many physician groups believe that dentists holding the OMS permit are exceeding their scope of practice under section 1625 and are actually practicing medicine. Further, the Dental Board has not been enforcing section 1625 against OMS-permitted dentists; instead, DBC has left it to the Medical Board to file unauthorized practice of medicine accusations against OMS-permitted dentists who exceed the parameters of section 1625. [16:2 CRLR 18; 16:1 CRLR 38–39]

The Ad Hoc Committee—composed of dentists, OMSs, and members of both DBC and the California Dental Association (CDA)—met on July 10 and September 18, and on October 22 submitted a report to the Board's Executive Committee. In its report, the Ad Hoc Committee defined the term "dentistry" as "the evaluation, diagnosis, prevention and/or treatment (nonsurgical, surgical or related procedures) of dis-

eases, disorders and/or conditions of the oral cavity, maxillofacial area and/or the adjacent and associated structures and their impact on the human body provided by a dentist, within the scope of his/her education, training and experience, in accordance with the ethics of the profession and applicable law." The Ad Hoc Committee further defined oral and maxillofacial surgery as "the specialty of dentistry which includes the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects involving both the functional and esthetic aspects of the hard and soft tissues of the oral and maxillofacial region." The Ad Hoc Committee also compiled a list of

specific procedures in which dentists completing an OMS program are trained, including procedures to treat traumatic injuries, pathologic conditions, and reconstructive, orthognathic, and cosmetic procedures (including cosmetic surgeries on the nose, face, neck, eyelids, skin, and ears).

At this writing, the Board's Executive Committee is scheduled to meet on November 5 to consider the definitions and list of procedures included in the Ad Hoc Committee's report, and also to review a recent statute enacted in Oregon on the scope of practice of dentists who practice OMS. The Executive Committee will report its recommendation to the full Board at its December 3 meeting.

## **Ad Hoc Committee on DMSOs/IPAs**

At its May 14 meeting, the full Board reviewed an April 21 report of the Ad Hoc Committee on Dental Management Service Organizations (DMSOs) and Independent Practice Associations (IPAs). This committee was created as a result of an October 1998 DCA legal opinion finding that California dentists are not permitted to offer professional services through IPAs or DMSOs. In DCA's opinion, neither business arrangement is lawful under the Dental Practice Act, and legislation is required to legalize either one. [16:2 CRLR 16:1 CRLR 39]

The Ad Hoc Committee's April 21 report suggested that the Board sponsor legislative language to authorize the creation of dental IPAs in California. The draft legislation would add new section 1810 *et seq.* to the Business and Professions Code, to define an IPA as a dental corporation that enters into agreements with participating dentists, which agreements provide that the dentists shall offer their professional services to enrollees of a health care plan or other HMO in accordance with a predetermined compensation schedule established by the IPA. Under the draft language, an IPA would be required to register with the Board (and renew that registration every two

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# HEALTH CARE REGULATORY AGENCIES

years), and submit to the Board its articles of incorporation and any contracts with participating dentists and health plans. Each owner, shareholder, director, officer, manager, and participant in an IPA must be a licensed dentist. The IPA would not offer any form of dental insurance or in any other manner assume financial risk for the provision of professional services by its participating dentists, and each dentist participating in the IPA would retain complete management and control of his/her dental practice. Following discussion, the Board approved the Ad Hoc Committee's recommendation, and agreed to seek legislation to establish dental IPAs during 2000.

Because the range of DMSO activities is perceived to be very broad, the DMSO concept was less easy to address. DMSOs may contract to oversee a very limited aspect of a dentist's practice, or may purchase a practice and hire the former owner to perform dentistry as an employee or independent contractor. While the Committee agreed that current California law does not recognize a DMSO that involves the ownership of a dental practice, it suggested that the Board instruct its legal counsel to prepare an issue paper and authorize it to gather more information on DMSOs before making a recommendation to the Board. DBC approved the Committee's proposal.

## **Board Publishes Regulations Governing Oral Conscious Sedation for Children**

On June 18, DBC published notice of its intent to adopt new sections 1044–1044.5, Title 16 of the CCR, to implement AB 2006 (Keeley) (Chapter 513, Statutes of 1998). Effective January 2000, AB 2006 adds section 1647.10 *et seq.* to the Business and Professions Code; these statutes prohibit a dentist from administering or ordering the administration of oral conscious sedation on an outpatient basis to a patient under the age of 13 unless the dentist holds either a general anesthesia (GA) permit issued by the Board under Business and Professions Code section 1646.1, a conscious sedation (CS) permit from the Board under section 1647.2, or a new "oral conscious sedation certificate" created by the bill. Under section 1647.12(a), dentists who do not possess a GA/CS permit and wish to administer oral conscious sedation to minor patients may qualify for the new AB 2006 oral conscious sedation certificate by registering with the Board and satisfying one of four requirements: (1) satisfactory completion of an approved postgraduate program in oral and maxillofacial surgery, pediatric dentistry, or periodontics; (2) satisfactory completion of a general practice residency or other advanced education in a Board-approved general dentistry program; (3) completion of a DBC-approved educational program on oral medications and sedation; or (4) submission of documentation of ten cases in which the dentist satisfactorily administered oral conscious sedation to patients under 13 years of age. [16:2 CRLR 16; 16:1 CRLR 40]

Proposed regulatory section 1044 would define several terms used in the new statutes, including "outpatient," "physical evaluation," and "sedated." New section 1044.1 would

provide that a dentist is not required to possess an AB 2006 oral conscious sedation certificate if the oral conscious sedation administered to his/her minor patient is directly administered and monitored by a dentist who possesses a GA permit, CS permit, or oral conscious sedation certificate, or by a licensed physician who possesses a GA permit; however, the office in which the oral conscious sedation is administered to minor patients must meet the facilities and equipment standards set forth in section 1044.5 (see below).

For purposes of qualifying for the oral conscious sedation certificate under Business and Professions Code section 1647.12(a)(2), proposed section 1044.2 would state that "a general practice residency or other advanced education in a general dentistry program" is deemed approved by the Board. New section 1044.3 would set forth the components of an acceptable instructional program in oral medications and sedation under Business and Professions Code section 1647.12(a)(3); among other things, the educational program must be in a facility approved by the Board and must consist of satisfactory completion of at least 25 hours of instruction, including a clinical component consisting of an adequate number of cases to demonstrate personal competency in oral conscious sedation of a minor patient. Proposed section 1044.4 would set forth the information required of a dentist who wishes to qualify for the oral conscious sedation certificate by demonstrating that he/she has administered oral conscious sedation to patients under 13 years of age in at least ten cases. New section 1044.5 would set forth detailed facility, equipment, and recordkeeping standards for settings in which dentists administer oral conscious sedation to minor patients under the age of 13.

At its August 20 meeting in San Francisco, the Board held a public hearing on these proposals. Numerous dentists opposed the proposals as being too burdensome on the profession; in response, the Board made a few changes. In particular, the Board modified section 1044.3, applicable to dentists wishing to qualify for the oral conscious sedation certificate by completing a Board-approved educational program in oral medications and sedation, to specify that the program's clinical component need involve "at least one minor patient" (rather than "an adequate number of cases to demonstrate personal competency in oral conscious sedation of a minor patient"). DBC adopted the proposed regulations as modified; at this writing, Board staff is preparing the rulemaking file on these rules for submission to DCA and OAL.

## **Standards for the Advertising of Specialty Training, Credentials, and Practice Specialization**

On July 2, DBC published notice of its intent to adopt new sections 1054–1054.3, Title 16 of the CCR, to implement Business and Professions Code section 651. That statute limits the right of some dentists to advertise their certification by a public or private or agency to those boards or agencies recognized by the Board. In other words, only

# HEALTH CARE REGULATORY AGENCIES

certificants of specialty boards approved by DBC are permitted to advertise their "board-certified" status in California.

For purposes of advertising specialty certification, proposed section 1054 would identify and approve "those dental specialty boards which are affiliated with specialties recognized by the American Dental Association, including: American Board of Dental Public Health; American Board of Endodontics; American Board of Oral Pathology; American Board of Oral and Maxillofacial Surgery; American Board of Orthodontics; American Board of Pediatric Dentistry; American Board of Periodontology; and American Board of Prosthodontics."

Proposed section 1054.1 pertains to the advertising of credentials by dentists. The section would permit a dentist to advertise that he/she has credentials from one of the dental specialty boards recognized by the Board pursuant to section 1054 (see above). Under the proposed regulation, dentists may not advertise credentials granted by a private or public board or parent association which is not recognized pursuant to section 1054 unless: (1) the private or public board or parent association which grants the credentials currently requires (a) the successful completion of a formal advanced education program at or affiliated with an accredited dental or medical school equivalent to at least one academic year beyond the predoctoral curriculum, (b) successful completion of an oral and written examination based on psychometric principles, and (c) training and experience subsequent to successful completion of (a) and (b) above to assure competent practice in the dental discipline as determined by the private or public board or parent association which grants the credentials; (2) any advertisement which references the dentist's credentials includes the following statement: "[name of announced dental discipline] is a discipline not recognized as a dental specialty by the Dental Board of California"; or (3) the dentist discloses that he/she is a "general dentist" in any advertising which references the dentist's credential.

Proposed section 1054.2 would prohibit a dentist from advertising that he/she is a "specialist" unless he/she is certified or eligible for certification by a dental specialty board recognized pursuant to section 1054. Finally, proposed section 1054.3 defines the terms "advertising" and "advertisement" to include "any written or printed communication for the purpose of soliciting, describing, or promoting a dentist's licensed activities, including a brochure, letter, pamphlet, newspaper, telephone listing, periodical, business card, or other writing." Advertising also includes directory listings and radio, television, computer network, or similar airwave or electronic transmissions which solicit or promote the dentist's practice.

At its August 20 meeting, the Board held a public hearing on these proposed regulations. At the hearing, Deputy Attorney General Joel Primes noted that the thrust of the regulations is to prevent misleading dental specialty advertising. He said that some dentists are preying on the elderly by advertising themselves as specialists when they are general dentists and do not have training in dental implants, nor do they have sufficient verifiable experience. He offered a binder of declarations from witnesses who say they were misled by specialty dental advertising. Numerous licensees commented on the proposals; several questioned the constitutionality of limiting the commercial speech rights of dentists.

Following considerable discussion, the Board adopted the proposed rules subject to a few modifications. Among other changes, the Board agreed to add the following statement to

section 1054: "The Board also recognizes those boards that require two or more years of training in a formal advanced education program affiliated with a school of dentistry or medicine that follows educational guidelines developed by the Commission on Dental Accreditation." At this writing, Board staff is preparing the rulemaking file on these regulations for submission to DCA and OAL.

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## Expansion of RDA Functions

On July 2, DBC published notice of its intent to amend section 1086, Title 16 of the CCR, which sets forth the functions that may be performed by a RDA. The Board proposes to add new subsections 1086(d)(12) and (13), to permit RDAs—under the direct supervision of a dentist—to apply and activate bleaching agents to teeth with non-laser light-curing devices. DBC further proposes to amend section 1086(d)(7) to permit a RDA to fabricate temporary crowns under the direct supervision of a dentist. Following a public hearing at its August 20 meeting, DBC approved these changes; at this writing, staff is preparing the rulemaking file on these regulatory changes for submission to DCA and OAL.

In connection with its proposal to expand RDA functions to include fabrication of temporary crowns, on October 15 the Board published notice of its intent to amend section 1081.1, Title 16 of the CCR, which sets forth the required components of the RDA practical exam. To ensure that RDAs are competent to perform this function, the Board proposes to amend section 1081.1 to add fabrication of a temporary crown as a component of the exam. At this writing, the Board is scheduled to hold a public hearing on this proposal at its December 3 meeting in Sacramento.

## Expansion of RDAEF and RDHEF Functions

At its August 20 meeting, the Board considered COMDA's report and recommendations stemming from its

# HEALTH CARE REGULATORY AGENCIES

occupational analysis of RDAEFs and RDHEFs. COMDA recommended that the Board amend sections 1087 and 1089, Title 16 of the CCR, to permit RDAEFs and RDHEFs—under the direct supervision of a dentist—to perform four additional functions: (1) place, condense, and carve amalgams; (2) place composites; (3) remove excess cement from subgingival tooth surfaces with a hand instrument; and (4) apply etchant for bonding restorative materials. Following CDA opposition to proposals (1) and (2) above and considerable discussion, the Board voted to reject COMDA's recommendations to expand the scope of practice of "extended functions" auxiliaries to include (1) and (2) above. Pursuant to Business and Professions Code section 1748, COMDA requested that the Board provide its reasons for rejecting these proposals in writing.

CDA had no objections to functions (3) and (4) above, and the Board approved COMDA's recommendations. On October 15, DBC published notice of its intent to amend sections 1087 and 1089, to permit EF auxiliaries to remove excess cement from subgingival tooth surfaces with a hand instrument, and apply etchant for bonding restorative materials. At this writing, the Board is scheduled to hold a public hearing on the proposed amendments at its December 3 meeting in Sacramento.

## Update on Other Board Rulemaking Proceedings

The following is an update on other DBC rulemaking proceedings described in detail in Volume 16, No. 2 (Summer 1999) of the *California Regulatory Law Reporter*:

◆ **Year 2000 Dental Examination Changes.** At its May 14 meeting, DBC held a public hearing on proposed regulatory changes that implement legislative amendments to Business and Professions Code sections 1632 and 1633.5 made by SB 2239 (Committee on Business and Professions) (Chapter 878, Statutes of 1998). [16:2 CRLR 15-16; 16:1 CRLR 41] Section 1632 requires applicants for licensure to give clinical demonstrations of skill in operative dentistry, prosthetic dentistry, and diagnosis and treatment in periodontics; and provide written demonstrations of judgment in diagnosis-treatment planning, prosthetic dentistry, and endodontics. However, section 1633.5 now provides that passage of the National Board of Dental Examiners' written examination satisfies section 1632's requirement for a written demonstration of judgment in dental diagnosis and treatment planning. These changes effectively eliminate the oral diagnosis and treatment planning (ODTP) portion of the Board's exam. Thus, in March 1999, DBC published notice of its intent to amend sections 1031, 1032, 1032.1, 1032.2, 1032.3, 1032.4, 1033, 1033.1, 1034, and 1035, and adopt new section 1034.5, Title 16 of the CCR, to conform the California Code of Regulations to the new statute. These draft changes eliminate the ODTP component of the Board's examination; additionally, they eliminate the gold cast restoration section of the exam and add a clinical composite resin restoration requirement and a clinical simulated fixed prosthetics section to the examination.

Following the hearing, the Board adopted the proposed changes; OAL approved them on August 25, and they became effective on the same day.

◆ **Minimum Infection Control Standards.** On June 30, OAL approved the Board's amendments to section 1005, Title 16 of the CCR, which sets forth minimum standards for infection control to prevent the transmission of bloodborne pathogens in the dental care setting. The amendments require dental offices to use only disinfectants approved by Cal-EPA, and further require all critical and semi-critical instruments to be packaged, sterilized, and remain sealed until used. [16:2 CRLR 16; 16:1 CRLR 35]

◆ **Clinical Periodontics Examination.** On October 12, OAL approved DBC's amendment to section 1032.3, Title 16 of the CCR. Under the amendment, dental licensure candidates may, at the discretion of the Board, use ultrasonic, sonic, handpiece-drive, or other mechanical scaling devices for scaling during the clinical periodontics examination. [16:2 CRLR 16; 16:1 CRLR 35]

◆ **Continuing Education Requirements for RDAEFs, RDHEFs, and RDHAPs.** On July 21, OAL approved the Board's amendments to section 1017, Title 16 of the CCR, which sets forth the Board's continuing education (CE) requirements for DBC licentiates. The amendments repeal a provision requiring dentists who sponsor, utilize, or employ dental auxiliaries licensed in extended functions to complete at least seven units in the management, supervision, and utilization of such auxiliaries; and require RDAEFs, RDHEFs, or RDHAPs to complete 25 units of approved CE during each two-year license renewal period. [16:2 CRLR 16; 16:1 CRLR 35]

◆ **RDHAP Program Regulations.** On August 17, OAL rejected DBC's August 1998 adoption of new regulations to implement AB 560 (Peralta) (Chapter 753, Statutes of 1997), which created a new category of licensure: the registered dental hygienist in alternative practice (RDHAP). Under Business and Professions Code section 1768 *et seq.*, licensed RDHAPs may practice as an employee of a dentist or of another RDHAP, as an independent contractor, or as a sole proprietor of an alternative dental hygiene practice. A RDHAP may perform duties to be established by DBC in the following settings: residences of the homebound, schools, residential facilities and other institutions, and dental health professional shortage areas certified as such by the Office of Statewide Health Planning and Development. A RDHAP may only perform services for a patient who presents a written prescription for dental hygiene services issued by a licensed dentist or physician who has performed a physical examination and rendered a diagnosis of the patient prior to providing the prescription; the prescription is valid for no more than 15 months from the date it was issued. At its August 1998 meeting, DBC adopted new sections 1073.2, 1073.3, 1079.2, 1079.3, 1090, and 1090.1, Title 16 of the CCR, to implement AB 560. [16:2 CRLR 17]

In its disapproval decision, OAL noted that several provisions of the new regulations failed to meet the "clarity"

## HEALTH CARE REGULATORY AGENCIES

standard in Government Code section 11349.1; further, the Board failed to follow the procedural requirements of the Administrative Procedure Act in several respects. On October 21, the Board published a modified version of the new regulations to meet the deficiencies cited by OAL; at this writing, Board staff is preparing the modified rulemaking record for resubmission to OAL.

Also relating to RDHAPs, the Board held a public hearing on its proposal to amend sections 1067, 1076, and 1083, Title 16 of the CCR, at its May 14 meeting. The amendments to section 1067 would establish the RDHAP as a new category of dental auxiliary in the Board's regulations. Amended section 1076 would require a RDHAP candidate to file a completed application with the Board no later than 30 days prior to the examination for which application is made. Amended section 1083 would mandate that each applicant for RDHAP licensure who attains a grade of at least 75% on the examination shall be considered as having passed the exam. [16:2 CRLR 17] Although the Board approved the proposed amendments and submitted them to OAL, it subsequently withdrew this rulemaking package.

### **Board Continues to Explore "Licensure by Credential"**

On August 21, the Board held an informational hearing on the concept of "licensure by credential," under which qualified dentists licensed in another state could become licensed in California without taking this state's clinical examination. The Board is considering the sponsorship of legislation to create a licensure by credential opportunity for an out-of-state dentist who: (1) has been in clinical practice for at least five years (with a minimum of 1,000 hours in each year) immediately preceding the date of application; (2) has passed Parts I and II of the National Board of Dental Examiners' Examination; (3) has graduated from a dental school accredited by the ADA's Commission on Dental Accreditation, or completed a supplementary predoctoral education program of at least two academic years in an accredited dental school and provides certification by the dental school dean that the candidate has achieved the same level of didactic and clinical competence as expected of a graduate of the school's predoctoral program, or verifies having successfully met the requirements for licensure in another state and holds a valid license to practice dentistry in that state; (4) has passed a state or regional clinical licensure examination; (5) holds a current, valid, active, and unrestricted license in another state; (6) presents verification from each state board where he/she is now, or has ever been, licensed, including the status of any past, pending, or active disciplinary actions; (7) submits releases to DBC allowing disclosure of information from the National Practitioner Data Bank and the Drug Enforcement Administration; (8) has no physical or psychological impairment that would adversely affect the ability to safely deliver dental care; (9) provides documentation of 50 units of continuing education earned in the two years preceding application, including any

courses required by California; (10) successfully passes an examination on California dental law and ethics; (11) has not failed the California Dental Licensure Examination more than once; (12) has not, within the past five years, failed the California Dental Licensure Examination; and (13) provides other information as is normally requested from applicants for licensure (e.g., fingerprints).

At the informational hearing, most witnesses expressed support for the concept. Board members noted that, under licensure by credential, the Board would receive more information about a more experienced dentist than it receives through its normal licensure process about a new applicant for licensure. The Board is expected to take action on the concept of licensure by credential at a future meeting.

### **Board to Study Expansion of RDH Duties**

At its May and August 1999 meetings, the Board discussed several COMDA recommendations for expansion of the RDH scope of practice.

In May, the Board rejected COMDA's suggestion that it amend section 1088, Title 16 of the CCR, to permit RDHs—under the general supervision of a dentist—to place antimicrobial and antibiotic medicaments (including a chlorhexidine chip called the "PerioChip") which need not be subsequently removed. After DBC and members of the public engaged in lengthy discussion about the safety and efficacy of the chip, the Board ultimately rejected COMDA's recommendation that RDHs be permitted to place the chip, even under direct supervision. COMDA requested written clarification of the Board's reasons for rejecting its request. However, in August, Board President Christoffersen stated that by focusing on the chip in rejecting COMDA's recommendation, the Board had essentially disallowed all subgingival irrigation by RDHs. He noted that the Board had received approximately 75 letters stating that RDHs have been using peridex as a rinse or irrigant for eight years, and suggested that the Board reconsider amending section 1088(c) to permit RDHs to irrigate subgingivally with an antimicrobial and/or antibiotic liquid solution. The Board agreed, and instructed staff to publish the proposed change for public comment; at this writing, the proposal has not yet been published in the *California Regulatory Notice Register*.

Also in August, the Board discussed COMDA's recommendation that RDHs be permitted to use a laser in performing curettage. Under current regulation, RDHs may perform periodontal soft tissue curettage under the direct supervision of a dentist; however, the regulation does not specify the tools that may be used. Dental manufacturers are now promoting the use of a laser device, and many hygienists assume that their use of the dental laser to perform curettage is allowed under the Dental Practice Act. After considerable discussion about whether laser curettage is a surgical procedure that should be restricted to dentists, the Board tabled the item and instructed staff to obtain further information and clarification on the precise issues involved.

# HEALTH CARE REGULATORY AGENCIES

## 1998-99 Enforcement Statistics

At its August 20 meeting, the Board reviewed its enforcement statistics for fiscal year 1998-99 (July 1, 1998 through June 30, 1999). During that time period, DBC received 2,997 complaints, opened 447 investigations, referred 123 completed investigations to the Attorney General's Office for the filing of accusations, filed 73 accusations, and took a total of 81 disciplinary decisions (including 13 revocations, 6 voluntary surrenders, 18 probations with suspension, and 38 straight probations). The Board also conducted 130 inspections and issued 46 citations.

Most of these figures are down from the Board's 1997-98 statistical performance. The Board believes that this problem is due in part to a reduction in the number of sworn peace officers it is authorized to employ as investigators: 1997 legislation reduced the number of DBC's sworn investigative staff from seventeen to seven and many left during the 1998-99 fiscal year. AB 900 (Alquist) may alleviate this problem; effective October 8, that bill enables the Board to employ up to ten sworn peace officers as investigators (see LEGISLATION).

## LEGISLATION

**AB 900 (Alquist)**, as amended August 17, is a Board-sponsored urgency bill which allows the DCA Director to designate ten of its investigators as peace officers assigned to Investigations Unit of the Dental Board. This bill supersedes a provision in SB 826 (Greene) (Chapter 704, Statutes of 1997), which prohibited the Board from employing more than seven sworn investigators at any one time. [16:2 CRLR 19; 16:1 CRLR 38] The Governor signed AB 900 on October 8 (Chapter 840, Statutes of 1999).

**AB 552 (Thompson)**, as introduced in February 1999, extends from January 1, 2000 to January 1, 2002, the "sunset" (repeal) date of the current law that authorizes a physician to administer general anesthesia in the office of a licensed dentist if the physician holds a general anesthesia permit issued by DBC. Governor Davis signed this bill on July 26 (Chapter 177, Statutes of 1999).

**SB 1308 (Committee on Business and Professions)**, as amended September 2, is a DCA omnibus bill that changes the Board's name from "Board of Dental Examiners" to "Dental Board of California" and makes multiple changes to the Dental Practice Act, including the following: (1) exempts students in registered dental assistant and dental hygiene programs from licensure if they are practicing in a Board-approved school or externship program; (2) creates a secondary category of limited licenses for dental specialties, such as oral radiology, to allow out-of-state dental faculty to practice their specialty while teaching at a California dental school; (3) provides that dentists who have surrendered their licenses pursuant to a stipulated settlement must wait three years, rather than one year, to petition for reinstatement; (4) reinstates a requirement that dental practices with three or more dentists that wish to operate under a fictitious business name must

obtain a fictitious business name permit from the Board; (5) requires licensed dentists and health care facilities to comply with DBC's requests for the dental records of a patient that are accompanied by the patient's written authorization, and imposes various civil penalties for failure to comply; (6) makes failure to comply with a court order, issued in the enforcement of a subpoena mandating the release of records to the Board, a misdemeanor; (7) clarifies that it is a crime to practice or attempt to practice dentistry, or advertise as a dentist, without a valid license; and (8) allows out-of-state dental experience to be accepted as qualifying experience for RDAs. This bill was signed by the Governor on October 6 (Chapter 655, Statutes of 1999).

**SB 585 (Chesbro)**, as amended May 3, conforms state law to federal regulations by expanding the category of health care professionals who may perform clinical microscopy examinations to include licensed nurse practitioners, licensed physician assistants, certified nurse-midwives, and licensed dentists. This bill was signed on July 6 (Chapter 70, Statutes of 1999).

**SB 856 (Brulte)**, as amended September 7, would have required the Department of Health Services (DHS), which administers the Medi-Cal program, to implement an anti-fraud pilot project in which DHS may require dental care providers to present pretreatment radiographs for patients when requesting reimbursement for restorative services performed on more than six teeth in one visit. The bill would have specified that DHS may also require dental care providers to present pretreatment radiographs when requesting reimbursement for restorative services performed on a patient who has had previous work done on more than ten teeth in the preceding six months; and specified that pretreatment radiographs shall be used solely for the purpose of identifying possible fraudulent patterns of practice and not as a mechanism to deny payment of claims. Governor Davis vetoed SB 856 on October 10, noting that "my administration is already cracking down on Medi-Cal fraud through a broad new \$2.1 million anti-fraud initiative contained in the 1999-2000 budget. This new initiative includes dental anti-fraud activities. If additional resources are necessary for this activity, I will address this issue in the annual budget process."

**AB 1065 (Ducheny)**, as amended June 14, would require DHS, in conjunction with the University of California, to design, implement, and evaluate a pilot project in three counties to increase access to dental services for Medi-Cal eligible infants and children from birth up to five years of age, and to examine the cost-effectiveness of providing preventive and early intervention dental services for children, in accordance with criteria specified in the bill. [S. Appr]

**SB 292 (Figueroa)**, as amended June 24, would require dental insurers and specialized health plans that provide dental benefits to allow an enrollee, an insured, or a participating dentist treating an enrollee or insured to obtain a second opinion from any licensed California dentist of the enrollee's choice, regardless of whether the dentist is a plan participant,



# HEALTH CARE REGULATORY AGENCIES

when a dental care service that would otherwise be a covered benefit under a dental plan contract has been denied, significantly delayed, terminated, or otherwise limited by a decision of the plan, or by one of its contracting providers, based, in whole or in part, on a finding that the service is unnecessary or inappropriate for the enrollee's oral health condition. A dental plan shall only be required to provide one second opinion pursuant to this section per enrollee per year, and only when the fee submitted by the dentist for the disputed benefits exceeds the level of reimbursement, if any, approved by the plan by at least \$250. This bill would also allow a participating dentist who is treating an enrollee or insured to act on behalf of that enrollee or insured in any applicable grievance or appeals process involving a benefit that has been denied, significantly delayed, terminated, or otherwise limited by a decision of the plan or insurer based, in whole or in part, on a finding that the service is inappropriate for the enrollee's or insured's oral health condition. [A. Health]

**SB 1259 (Brulte)**, as introduced in February 1999, would provide that health plans that cover dental benefits are deemed, commencing January 1, 2000, to cover dental services legally rendered by a RDHAP. The bill would prohibit any plan that provides dental benefits from denying membership to RDHAPs if membership is required in order for those services to be covered by the plan. [S. Ins]

**SB 1215 (Perata)**, as introduced in February 1999, would create a Board of Allied Dental Health Professionals, and provide for the licensure and regulation of dental assistants and other auxiliary dental professionals by this new board. The bill would also revise the definition of the practice that may be undertaken by dental hygienists. [S. B&P]

**AB 498 (Longville)**, as introduced in February 1999, would deem it unprofessional conduct for a dentist who owns, operates, or manages a dental office to allow water exiting a dental unit waterline to contain more than 200 colony-forming units per milliliter of aerobic mesophilic heterotrophic bacteria on and after January 1, 2001. This bill is sponsored by the Coalition for Safe Dental Water (Coalition), which describes itself as an alliance of dentists, health care professionals, educators, scientists, corporate entities, and concerned individuals interested in creating public awareness of the widespread and problematic issue of contaminated dental unit water. [A. Health]

## LITIGATION

On May 24, the U.S. Supreme Court issued its decision in *California Dental Association v. Federal Trade Commission*, 526 U.S. 756 (1999), an important case concerning restrictions on professional advertising imposed by a private

trade association. Part of the American Dental Association, CDA is a nonprofit trade association for licensed dentists in California; about 75% of dentists licensed in California belong to CDA. In exchange for membership fees, CDA members are provided with a variety of services, including lobbying, marketing and public relations, seminars on practice management, and continuing education courses. CDA also has several for-profit subsidiaries from which members can obtain liability and other types of insurance, financing for equipment purchases, long distance calling discounts, auto leasing, and home mortgages. As a condition of membership, dentists agree to follow CDA's Code of Ethics, including detailed advertising guidelines which purportedly help members comply with California law.

The Federal Trade Commission (FTC) filed a complaint against CDA, alleging that its application of its advertising guidelines restricts truthful, nondeceptive advertising—a violation of federal antitrust law and the FTC Act. After a trial by an administrative law judge, the Commission found that (1) the FTC has jurisdiction over CDA; (2) CDA's restrictions on

price advertising were unlawful per se, and (3) CDA's non-price advertising guidelines were unlawful under the abbreviated "quick look" rule of reason analysis. The Commission issued a cease and desist order restricting CDA from

enforcing its advertising guidelines. On appeal, the U.S. Ninth Circuit Court of Appeals affirmed the FTC's jurisdiction over CDA, disagreed that CDA's restrictions are unlawful per se, but found them unlawful under the "quick look" rule of reason analysis. [16:2 CRLR 22-23; 16:1 CRLR 42]

In its decision, the Supreme Court upheld the FTC's jurisdiction over CDA, despite the association's vigorous assertion of its nonprofit status. Writing for a unanimous Court on this issue, Justice David Souter noted that the FTC Act, 15 U.S.C.

§ 44, "is at pains to include not only an entity 'organized to carry on business for its own profit,' but also one that carries on business for the profit 'of its members.'...Through for-profit subsidiaries, the CDA provides advantageous insurance

and preferential financing arrangements for its members, and it engages in lobbying, litigation, marketing, and public relations for the benefit of its members' interests. This congeries of activities confers far more than *de minimis* or merely presumed economic benefits on CDA members; the economic benefits conferred upon the CDA's profit-seeking professionals plainly fall within the object of enhancing its members' 'profit,' which the FTC Act makes the jurisdictional touchstone. There is no difficulty in concluding that the Commission has jurisdiction over the CDA."

However, the Court split 5-4 on the propriety of the analysis used by the FTC to conclude that the trade association's

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# HEALTH CARE REGULATORY AGENCIES

restrictions are anticompetitive. Five justices determined that both the Ninth Circuit and the FTC had erred in permitting the use of the “quick look” analysis when evaluating the impact of CDA’s advertising restrictions. According to the majority, that test (a short-cut version of the more extensive “rule of reason” analysis) is permissible only when “an observer with even a rudimentary understanding of economics could conclude that the arrangements in question would have an anticompetitive effect on customers and markets....The case before us fails to present a situation in which the likelihood of anticompetitive effects is comparably obvious.” Thus, the majority remanded the case back to the lower courts and the agency for a fuller analysis of the anticompetitive impacts of CDA’s advertising restrictions. A four-member minority dissented, finding that the FTC had conducted adequate fact-finding and amassed sufficient evidence to rule that the trade association’s advertising restrictions are unlawful; according to dissenting Justice Stephen Breyer, “I should have thought that the anticompetitive tendencies of the three restrictions were obvious.”

Several cases concerning the use of mercury amalgam as dental fillings are still pending in the courts. *Committee of Dental Amalgam Manufacturers and Distributors, et al. v. Stratton*, 92 F.3d 807 (9th Cir. 1996), presents the important issue of whether those who manufacture dental amalgam—a common dental restorative material often referred to as “silver fillings” but which in fact contains mercury—must comply with the warning requirements of Proposition 65, the “Safe Drinking Water and Toxic Enforcement Act” passed by California voters in 1986. The initiative requires that the public be warned about products that contain substances known to pose a risk of cancer or birth defects. The state has compiled a list of such substances, and added mercury to the list in 1990. In 1993, plaintiffs—manufacturers and distributors of mercury amalgam—filed suit in federal court, seeking a declaration that Proposition 65 is preempted by the Medical Device Amendments (MDA) to the federal Food, Drug and Cosmetics Act. Although plaintiffs prevailed in the district court, the Ninth Circuit reversed in 1996, holding that the state initiative is not preempted by federal law. Thus, the Ninth Circuit held that the Proposition 65 warning must be provided; however, it did not specify who must provide the warning or in what fashion, and remanded the case to the district court for further proceedings. At this writing, the parties are in settle-

ment negotiations over the nature of the warning to be provided to consumers that dental amalgam contains mercury. [16:2 CRLR 20-21]

Also pending is a case challenging the Dental Board’s policy on “mercury-free” dental practice. In *Landerman v. California Board of Dental Examiners, et al.*, No. SCV 221662 (Sonoma County Superior Court), plaintiff Landerman contests the Dental Board’s refusal to reinstate his license when petitioned to do so in March 1999. Although the Board denied Landerman’s petition for reinstatement because “he has been away from clinical practice for almost seven years...[and] has done nothing to acquaint himself with what

is going on in the field of dentistry....” Board members Richard Benveniste, Kit Neacy, and Robert Christoffersen quizzed Landerman extensively during oral argument on whether he

would pursue a “mercury-free” practice; during this questioning, Dr. Christoffersen stated: “An amalgam-free practice does not fit the current practice of dentistry.”

Because of the Board’s emphasis on Landerman’s “mercury-free” status, Landerman’s counsel, Charles G. Brown of Washington, D.C., has filed a petition for writ of mandate alleging that DBC’s articulated reason for denying Landerman’s petition is underground rulemaking, contrary to a recent Board decision to reinstate the license of a dentist with “numerous drug and alcohol violations who had been out just as long,” and a subterfuge for the Board’s actual reason: “[Landerman] is a mercury-free dentist, a position that is anathema to the philosophy of Respondents Christoffersen, Neacy, and Benveniste, all of whom attacked Petitioner for simply stating that he intended to use comparable filling that did not contain mercury.” At this writing, Landerman’s petition is pending [16:2 CRLR 22-23]; meanwhile, Brown has filed a petition with the Board seeking clarification of its policy on mercury-free dentistry (see MAJOR PROJECTS).

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## FUTURE MEETINGS

- December 2-3, 1999 in Sacramento.
- January 13-14, 2000 in Los Angeles.
- March 16-17, 2000 in San Francisco.
- May 11-12, 2000 in San Diego.
- August 10-11, 2000 in San Francisco.
- November 16-17, 2000 in Sacramento.