managed care entity for damages proximately caused by the entity’s failure to exercise ordinary care when making a health care treatment decision. In addition, the law provides that these entities may be held liable for substandard health care treatment decisions made by their employees, agents, or representatives. The Act also established an independent review process for adverse benefit determinations, and requires an insured or enrollee to submit his/her claim to a review by an independent review organization if such review is requested by the managed care entity. [16:1 CRLR 33-34]" "Rather, plaintiffs are medical service providers to ERISA plans and their members.” The court also rejected plaintiffs’ other arguments that the liability provision “relates to,” “refers to,” and “is connected with” ERISA plans—finding essentially that the statute applies to managed care entities’ treatment decisions “regardless of whether the commercial coverage or membership therein is ultimately secured by a ERISA plan.” The court concluded that ERISA does not preempt a state law claim challenging the quality of a benefit (because ERISA “simply says nothing about the quality of benefits received”), such that “the Act does not constitute an improper imposition of state law liability on the enumerated entities.” Aetna Liability Casualty Company is appealing this portion of the holding.

However, Judge Gilmore struck down the Act’s independent review organization (IRO) provision and other provisions “that address specific responsibilities of an HMO and further explain and define the procedure for independent review of an adverse benefit determination by an IRO.” Plaintiffs argued that these provisions are preempted by ERISA because they “mandate employee benefit structures or their administration,” citing New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co., 514 U.S. 645 (1995). On this claim, the court agreed with plaintiffs, finding that such provisions are connected with ERISA plans and are precisely the kind of state-based procedures that Congress intended to preempt when it enacted ERISA. Texas Attorney General Dan Morales has appealed this portion of Judge Gilmore’s ruling.

Board of Dental Examiners

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**COMDA—Executive Officer: Karen R. Wyant ♦ (916) 263-2595 ♦ Internet: www.comda.ca.gov/**

The Board of Dental Examiners (BDE) is a consumer protection agency within the state Department of Consumer Affairs (DCA). BDE 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).

BDE 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).

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.

BDE 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.

BDE’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 BDE, 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 dental auxiliary education programs, licensing examinations for the various categories of auxiliaries, and applicants for auxiliary...
licensure. Additionally, it advises BDE 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 BDE 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. The Board recently welcomed Mark Goldenberg, DDS, and public members Llewellyn Chin and Kathy Holladay, and has its full complement of fourteen members.

**MAJOR PROJECTS**

**Board Exploring “Licensure by Credential”**

Currently, dentists who are licensed in another state and who wish to practice in California must pass the California Clinical Dental Licensure Examination, even if they have passed a similar clinical examination in their home state of licensure. Over the past several years, the Board has explored 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. Although the licensure by credential concept has been controversial and was traditionally opposed by the California Dental Association (CDA), 33 licensing agencies in the United States are now authorized to grant licenses to dentists who are licensed in another jurisdiction without further theoretical and clinical examinations. The American Dental Association (ADA) has supported the concept for 19 years, and CDA recently shifted position and has agreed to support licensure by credential under certain conditions.

At its March 18 meeting, BDE considered a recommendation by its Examination Committee that the Board sponsor 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 supplementary pre-doctoral 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 pre-doctoral 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 BDE 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 current mandatory 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).

Following extensive discussion at its March 18 meeting, the Board agreed that the criteria recommended by the Examination Committee are feasible, and set the matter for an informational hearing which, at this writing, is scheduled for August 21. Also at its March 18 meeting, BDE agreed that its Strategic Plan should include the goal of studying the feasibility, by December 31, 2001, of licensure by credential for dental auxiliaries.

**Year 2000 Dental Examination Changes**

Currently, all applicants for dental licensure must take and pass, in addition to Parts I and II of the examination of the National Board of Dental Examiners, the California Clinical Dental Licensure Examination, which consists of amalgam restoration, gold cast restoration, periodontics, endodontics, removable prosthodontics, and oral diagnosis and treatment planning (ODTP).

During the spring of 1999, the Board developed regulatory changes to 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). [16:1 CRLR 41] Section 1632 requires applicants for licensure to give a clinical demonstration of his/her skill in operative dentistry, prosthetic dentistry, and diagnosis and treatment and periodontics; and provide a written demonstration of his/her 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. The changes effectively eliminate the ODTP portion of the Board’s exam.

Thus, the Board’s Examination Committee developed draft changes to sections 1031, 1032, 1032.1, 1032.2, 1032.3, 1032.4, 1033, 1033.1, 1034, and 1035, and new section 1034.5, Title 16 of the CCR, to conform the California Code of Regulations to statute. These draft changes would eliminate the ODTP component of the Board’s examination; additionally, they would eliminate the gold cast restoration section of the exam and add a clinical composite resin restoration requirement and a clinical simulated fixed prosthodontics section to the examination.

The Board published notice of its intent to adopt these regulatory changes on March 19, and opened a 45-day written comment period ending on May 11; at this writing, BDE is scheduled to hold a public hearing on its proposed regulatory amendments on May 14.

**Oral Conscious Sedation Permit Regulations**

Effective January 1, 2000, no dentist may administer or order 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 permit, a conscious sedation permit, or an oral conscious sedation permit newly created by AB 2006 (Keeley) (Chapter 513, Statutes of 1998). [16:1 CRLR 40]

Dentists may qualify for the AB 2006 permit in three ways: (1) successful completion of a postgraduate program in oral and maxillofacial surgery, pediatric dentistry, periodontics, or general dentistry practice; (2) completion of a BDE-approved program in oral conscious sedation of minor patients; or (3) detailed documentation of ten cases in which the dentist administered oral conscious sedation for patients under 13 years of age. BDE is currently developing regulations to define an approved educational program; the regulations are expected to require that the course be offered in a facility approved by the Board and include at least 25 hours of instruction in safe and effective ways to administer oral pharmacological agents to minors. The regulations will define how courses and course providers are approved, specify the standards for equipment and facilities in which oral conscious sedation is administered to minor patients, detail the records that must be maintained by such facilities, and flesh out other provisions of AB 2006.

At this writing, BDE hopes to finalize the language of its AB 2006 regulations and schedule a public hearing on the proposed rules to occur at its August 20 meeting in San Francisco.

**Update on Other Board Rulemaking Proceedings**

The following is an update on recent BDE rulemaking proceedings described in detail in Volume 16, No. 1 (Winter 1999) of the California Regulatory Law Reporter:

- **Minimum Infection Control Standards.** At its January 22 meeting, BDE amended section 1005, Title 16 of the CCR, which sets forth its 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 that all critical and semi-critical instruments be packaged, sterilized, and remain sealed until used. [16:1 CRLR 35] At this writing, Board staff is preparing the rulemaking file on these changes for submission to the Office of Administrative Law (OAL).

- **Clinical Periodontics Examination.** Also on January 22, BDE approved a proposed amendment to section 1032.4, 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. [16:1 CRLR 35] At this writing, Board staff is preparing the rulemaking file on these changes for submission to OAL.

- **Continuing Education Requirements for RDAEFs, RDHEFs, and RDHAPs.** Also on January 22, the Board amended section 1017, Title 16 of the CCR, which sets forth the Board’s continuing education (CE) requirements for BDE licensees, to repeal a provision requiring dentists who intend to 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. [16:1 CRLR 35] At this writing, Board staff is preparing the rulemaking file on these changes for submission to OAL.

- **Electronic CE Courses.** On February 2, OAL approved the Board’s amendments to section 1017, Title 16 of the CCR, which authorizes full CE credit for Board-approved interactive instruction courses via computers, telephone conferencing, video conferencing, or other electronic mediums. [16:1 CRLR 35]

- **Patient Acceptability Standards for Dentist and Auxiliary Clinical Examinations.** On March 26, OAL approved BDE’s amendments to sections 1033.1, 1080.1, 1081.2, and 1082.2, Title 16 of the CCR. These sections set forth the Board’s clinical examination requirements for dentists (section 1033.1), dental auxiliaries (section 1080.1),
RDAEs (section 1081.2), and RDHEFs (section 1082.2), and require examinees to furnish patients, instruments, engines, and materials necessary for the clinical examination. However, the regulations were not consistent regarding patient acceptability. The Board’s amendments make consistent patient acceptability standards for dental and dental auxiliary examinations, incorporate current guidelines into regulations for the RDAEF and RDHEF examinations, and eliminate redundant language.

- **Time Allotment for RDAEF and RDHEF Examination.** At its November 1998 meeting, BDE amended sections 1081.2 and 1082.2, Title 16 of the CCR, to reduce the time period allowed for RDAEF and RDHEF applicants to complete the endodontic portion of the licensure examination from two and one-half hours to one and one-half hours. [16:1 CRLR 35] At this writing, staff is preparing the rulemaking file for submission to OAL.

- **RDH Clinical Examination Requirements.** On April 29, OAL approved BDE’s amendment to section 1082.1, Title 16 of the CCR, which requires applicants taking the RDH clinical examination to complete the scaling of one or two quadrants and root planing. Scaling and root planing includes, but is not limited to, complete removal of calculus, soft deposits, and plaque, and smoothing of the unattached tooth surfaces; section 1082.1 previously prohibited candidates from using any ultrasonic, handpiece-drive or other mechanical scaling device during the examination. BDE’s amendment permits RDH candidates, at the Board’s discretion, to use ultrasonic, handpiece-drive or other mechanical scaling devices to complete the scaling and root planing procedure during the examination.

- **RDHAP Program Regulations.** At its August 1998 meeting, BDE adopted 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 sections 1768 et seq., licensed RDHs who have been engaged in clinical practice as a dental hygienist for a minimum of 2,000 hours during the immediately preceding 36 months, possess a bachelor’s degree or its equivalent, complete 150 hours of BDE-approved coursework, and pass a written examination prescribed by the Board may be issued an RDHAP license. Once licensed, an RDHAP 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. An RDHAP may perform duties to be established by BDE in the following settings: residences of the homebound, schools, residential facilities and other institutions, and dental health professional shortage areas as certified by the Office of Statewide Health Planning and Development. An 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 a prescription; the prescription is valid for no more than 15 months from the date it was issued.

At its August meeting, BDE adopted new sections 1073.2, 1073.3, 1079.2, 1079.3, 1090, and 1090.1, Title 16 of the CCR. New section 1073.2 would set forth general requirements for the Board’s approval of RDHAP educational programs, and new section 1073.3 would set forth specific requirements which must be met by an RDHAP educational program in order to be approved by the Board. New section 1079.2 would specify application requirements for those seeking licensure as an RDHAP, and new section 1079.3 would set forth the examination requirements for RDHAP licensure. New section 1090 would set forth the duties and settings in which an RDHAP may perform; under this section, an RDHAP may, upon the prescription of a California-licensed dentist or physician, perform the duties assigned to a registered dental hygienist by section 1088(c), Title 16 of the CCR, including root planing, polish and contour restorations, oral exfoliative cytology, application of pit and fissure sealants, and specified functions relating to the preliminary examination of a patient. Section 1090 also sets forth procedures that an RDHAP may not undertake, including diagnosing and treatment planning; surgical or cutting procedures on hard or soft tissue; fitting and adjusting of correctional and prosthetic appliances; prescribing medication; placing, condensing, carving, or removing permanent restorations, including final cementation procedures; and administering local or general anesthesia or oral or parenteral conscious sedation. Finally, section 1090 specifies the required contents of the written prescription from the dentist or physician to the RDHAP. New section 1090.1 would require an RDHAP, prior to establishing an independent practice, to provide to BDE documentation of an existing relationship with at least one dentist for referral, consultation, and emergency services, on a form specified by the Board. At this writing, staff is preparing the rulemaking record on these regulations for submission to OAL.

Also relating to RDHAPs, the Board has announced its intent to amend sections 1067, 1076, and 1083, Title 16 of the CCR. 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 an RDHAP candidate to file a completed application with the Board no later than 30 days prior to the examination for which application is made; and amended section 1083 would state 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. At this writing, the Board has not scheduled a public hearing on these proposed regulatory changes, but is accepting written comments until May 11.

**Board Adopts “Precedent Decision”**

At its March 18 meeting, BDE adopted a portion of a recent disciplinary decision as a “precedent decision” under Government Code section 11425.60. Under that relatively new provision of the Administrative Procedure Act, an agency may
HEALTH CARE REGULATORY AGENCIES

designate as a precedent decision all or part of a decision “that contains a significant legal or policy determination of general application that is likely to recur.” Under the statute, designation of a decision as a precedent is not rulemaking, and the rule of the case is not codified in the California Code of Regulations. However, agencies must maintain an index of significant legal and policy determinations made in precedent decisions; the index must be updated at least annually and made available to the public by subscription.

The Board designated pages 1-3 of In Re Lorenz F. DeJulien, OAH No. 1998010174 (April 30, 1998), as a precedent decision. In this matter, respondent DeJulien—who has been licensed by BDE for 45 years and is semi-retired—was a part-time attending dentist and instructor at the Oral and Maxillofacial Surgery Clinic in the Loma Linda University School of Dentistry; on November 1, 1996, he supervised resident David Gilbert in performing minor reconstructive surgery on a patient. Seven minutes after surgery, the patient suffered extreme complications and died. Respondent immediately prepared morbidity reports which were submitted to the hospital, but not to the Board; the Board did not find out about the patient’s death until July 1997. The Board cited respondent and issued him a fine for failure to report the death of a patient during the performance of a dental procedure under Business and Professions Code section 1680(z), which provides that “failure to report to the Board in writing within seven days...the death of his or her patient during the performance of any dental procedure....”

Respondent contended that the provision is inapplicable because he was performing as an instructor of a dental student at the time the patient died. Respondent relied on Business and Professions Code section 1626(b), which exempts from the Dental Practice Act’s licensure requirement “[t]he operations by bona fide students of dentistry or dental hygiene in the clinical departments or the laboratory of a reputable dental college approved by the Board of Dental Examiners....” Although the Board agreed that the student was exempt from the licensure requirement, it also held that “the clear intent is for someone who acts as an instructor to be licensed....In an operation used for teaching purposes, if the student cannot be held to the standards of licensed dentists which are imposed through a system of licensing, then the instructor/supervising dentist is the only one left who can be held to those standards. To exempt the instructor/supervising dentist in a teaching situation from the requirements of licensing and the attending standards of practice would leave the patient with no one who he or she could hold responsible if something went wrong....The only reasonable interpretation of section 1626(b) is that it does not exempt instructors/supervising dentists from the requirements imposed by the Dental Practice Act.”

BDE Appoints Ad Hoc Committees to Explore Controversial Issues

Last fall, the Department of Consumer Affairs issued two legal opinions on issues of interest to BDE and dentists, and the Board has now appointed ad hoc committees to explore the ramifications of these opinions.

In September 1998, DCA opined 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 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. This opinion upset the California Association of Oral and Maxillofacial Surgeons (CAOMS), which believes that section 1625 prevents its members from utilizing the full scope of their oral and maxillofacial surgery training. For several years, BDE has taken a hands-off approach to the entire issue, advising CAOMS that if it wants an expanded scope of practice for permitted OMSs, it should approach the legislature directly; and leaving enforcement of its permit program essentially to the Medical Board (which could press charges of unauthorized practice of medicine). [16:1 CRLR 38-39]

At BDE’s January 22 meeting, Board President Robert Christoffersen, DDS, appointed the Executive Committee (himself, Board Vice-President Roger Simonian, DDS, and Board Secretary Kit Neacy, DDS) to an ad hoc committee to research these complex issues. Dr. Christoffersen announced that the Executive Committee would be joined by one appointed public member and an advisory panel of experts representing CAOMS, OMS programs, hospitals, single- and dual-degreed OMSs, and a CDA representative; collectively, this committee will educate itself on current procedures within the scope of oral and maxillofacial surgery, as well as procedures taught under current accreditation standards and within OMS programs and continuing education courses designed for physicians who are permitted by BDE as oral and maxillofacial surgeons. At this writing, the Ad Hoc Committee is scheduled to hold a public hearing on July 10 in San Francisco.

In October 1998, DCA issued another document reiterating its opinion that California dentists are not permitted to offer professional services through independent practice associations (IPAs) or dental management service organizations (DMSOs). [16:1 CRLR 39] In DCA’s opinion, neither business arrangement is lawful under the Dental Practice Act. At the Board’s January 21 meeting, Board President Christoffersen appointed Board Vice-President Simonian to chair the Ad Hoc Committee on Dental Management Service Organizations and Independent Practice Associations.

The Ad Hoc Committee met on April 21 in Sacramento, and discussed draft legislative language which would authorize the creation of dental IPAs in California. An IPA is defined as a dental corporation which 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 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. The Ad Hoc Committee approved the draft legislative language and, at this writing, is scheduled to present it to the full Board at its May 14 meeting.

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. Committee participants agreed that the term "management" must be defined and restricted, and that more research is required before making any recommendation to the Board. The Committee did agree, however, that California law does not recognize a DMSO that involves the ownership of a dental practice; this recommendation will be presented to the full Board at a future meeting.

**DCA Website Displays Information on BDE Licensees**

**SB 492 (Rosenthal) (Chapter 661, Statutes of 1997)** requires eleven occupational licensing boards within DCA—including BDE—to post licensing and disciplinary information on their licensees on the Internet. Under Business and Professions Code section 27, the information to be provided must include "information on suspensions and revocations issued by a board and other related enforcement action taken by a board relative to persons, businesses, or facilities subject to licensure or regulation by a board." Beginning in April, consumers may verify the status of a dental license through DCA's website at <www.dca.ca.gov>.

**LEGISLATION**

**AB 900 (Alquist),** as amended April 13, is a Board-sponsored bill which would allow BDE to designate an unlimited number of its investigators as sworn peace officers. This bill would supersede a provision in SB 826 (Greene) (Chapter 704, Statutes of 1997), which prohibits the Board from employing more than seven sworn investigators at any one time. [16:1 CRLR 38] Prior to the restriction imposed by SB 826, the Board designated 17 of its investigators as peace officers. [A. Appr]

**AB 552 (Thompson),** as introduced February 18, would extend 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 BDE. [A. Floor]

**SB 1215 (Perata),** as introduced February 26, 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]

**SB 1308 (Committee on Business and Professions),** as amended April 14, is a DCA omnibus bill that would change the Board's name to "Dental Board of California" and make multiple changes to the Dental Practice Act, including the following: (1) exempt from the DPA's licensure requirements operations by bona fide students of registered dental assisting, registered dental assisting in extended functions, and registered dental hygiene in extended functions in the clinical departments or the laboratory of an educational program or school approved by the Board; (2) revise existing provisions relating to special permits issued by BDE to entitle every person to whom a special permit is issued to practice in the specialty or discipline in which he/she has been examined by the Board at the dental college at which he/she is employed and its affiliated institutions; (3) authorize a person whose license, certificate, or permit was surrendered pursuant to a stipulated settlement as a condition to avoid a disciplinary administrative hearing to petition for reinstatement or modification of penalty after three years; (4) permit individual dentists or pairs of dentists to practice under fictitious names approved by the Board, and reinstate the 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) require licensed dentists and health care facilities to comply with BDE's requests for the dental records of a patient that are accompanied by the patient's written authorization, and impose various civil penalties for failure to comply; (6) make 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) clarify that any person who willfully, under circumstances or conditions which cause or create risk of specified physical or mental harm or death, practices or attempts to practice or advertises or holds him/herself out as practicing dentistry without a valid license to practice dentistry is guilty of a crime; and (8) allow out-of-state dental experience to be accepted as qualifying experience for RDAs. [S. Appr]

**SB 292 (Figueroa),** as amended April 5, would require every dental plan and disability insurer that issues policies providing dental benefits to provide an enrollee or insured with the opportunity to seek independent review whenever dental care services have been denied, significantly delayed, terminated, or otherwise limited by the plan or by one of its contracting providers. Beginning January 1, 2001, this bill would establish a Dental Independent Review System in the Department of Corporations and in the Department of Insurance, whereby enrollee or insured grievances involving a disputed dental care service or other adverse decision may
be resolved by independent review organizations. The bill would set forth the duties and responsibilities of the departments, dental plans, disability insurers, and enrollees and insureds with respect to the system. It would provide that Medi-Cal and Medicare beneficiaries shall not be excluded from the system, to the extent that their participation is not preempted by federal law. SB 292 would also require the Corporations Commissioner and the Insurance Commissioner to contract with a private, nonprofit accrediting organization to accredit the independent review organizations, and would further require the adoption of related regulations. This bill would require the departments to contract with independent expert entities to undertake evaluations of the dental independent review systems; and require the evaluators to provide their evaluation to the departments on or before January 1, 2003, a copy of which would be required to be made available to the public. This bill would require reviews to be conducted by an individual California dentist, subject to strict conflict of interest provisions, and whose decision will be binding upon the dental plan or insurer; the costs of such review, as provided by the bill, shall be borne by the dental plans. [S. Jud]

SB 856 (Brulte), as amended April 26, would require the Department of Health Services (DHS), which administers the Medi-Cal program, to implement a pilot project in which DHS may require any Medi-Cal provider of dental services, when the provider requests reimbursement for restorative dental services performed on an unspecified number of teeth during one visit for a specific beneficiary, to include documentation in the form of pretreatment radiographs for that beneficiary with the posttreatment claim. The bill also provides that, with implementation of the pilot project, the DHS Director may require any Medi-Cal provider of dental services to provide pretreatment radiographs with the posttreatment claim when the provider requests reimbursement for restorative dental services for a beneficiary who had previous restorative work done on more than ten teeth in the preceding six months. This bill would require the DHS Director to implement the pilot project to reduce fraud in the provision of dental services in the Medi-Cal program and would specify that, as part of the program, the Director may request any patient receiving Medi-Cal dental services to visit another dentist for a review of dental services previously provided. [A. Health]

SB 1259 (Brulte), as introduced February 26, provides that health plans that cover dental benefits are deemed, commencing January 1, 2000, to cover dental services legally rendered by an RDHAP, and 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]

AB 498 (Longville), as introduced February 18, would provide that it is 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. The Coalition states that this bill will ensure that dental patients are no longer placed at risk due to potentially harmful microorganisms that are frequently present in dental water. According to the Coalition, the American Dental Association recognized this problem as early as 1978, and in 1993 the ADA established a Waterline Task Force to evaluate the issue. The Coalition states that recent independent studies have concluded that water emerging from 90% of dental unit waterlines is not fit to drink according to U.S. Environmental Protection Agency standards, and—despite extensive documentation on the subject—the ADA has yet to formally require its members to take even basic steps to rectify the problem. In response to arguments that there have been no documented serious health effects from contaminated dental water, the Coalition states that diseases that patients are exposed to, such as Legionnaire’s disease, have long gestation periods with potentially fatal consequences; and argues that it is irresponsible to suggest that someone must get sick or die from contaminated dental unit water before policymakers address the problem. [A. Health]

LITIGATION

Several cases pending in state and federal courts raise important issues for dentists who place mercury amalgam fillings in patients’ teeth.

Committee of Dental Amalgam Manufacturers and Distributors, et al. v. Stratton, 92 F.3d 807 (Ninth 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.

Proposition 65, the “Safe Drinking Water and Toxic Enforcement Act,” was passed by California voters in 1986, and is now codified at Health and Safety Code section 25249.5. 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. In 1994, the district court held that, because the FDA has classified the two component parts of amalgam (dental mercury and amalgam alloy) under the MDA, dental amalgam is a medical device under the MDA and Proposition 65 is thus preempted by the federal law.

In 1996, the Ninth Circuit reversed. Although the court found that the MDA defines the term “medical device” very broadly and that dental amalgam “does fall within the reach of the MDA,” it also noted that there is a strong presumption against finding that state law is preempted by federal law. Additionally, the U.S. Supreme Court has already held that the preemption provision in the MDA is to be construed restrictively, because to construe it broadly “would...have the perverse effect of granting complete immunity from...liability to an entire industry....” The Ninth Circuit held that state requirements are preempted by the MDA only if specific counterpart requirements or regulations that are applicable to a particular device exist.” Proposition 65 is a state law of general applicability which applies to all products and services that pose a health risk to the public; it is not directed toward any product or industry. Thus, “the consumer warning requirement under California’s Proposition 65 is not ‘specific’ enough to trigger preemption because it is ‘not the kind of requirement that Congress and the FDA feared would impede the ability of federal regulators to implement and enforce specific federal requirements.’”

The Ninth Circuit reiterated: “The State of California has listed mercury as a product which causes reproductive harm. As a result, consumer warnings for dental amalgam are now required,” and remanded the case to the district court for further proceedings.

As noted above, the Ninth Circuit stated only that the Proposition 65 warning must be provided; it did not specify who must provide the warning or in what fashion. The initiative’s warning requirement may be satisfied in a number of ways. Under Health and Safety Code section 25249.11(f), the requirement may be satisfied through “general methods such as labels on consumer products, inclusion of notices in mailings to water customers, posting of notices, placing notices in public news media, and the like, provided that the warning accomplished is clear and reasonable.” At this writing, the parties are in settlement negotiations over the nature of the warning to be provided to consumers that dental amalgam contains mercury—a substance known to the state to cause birth defects.

The state courts are also reviewing cases related to the use of mercury amalgam by dentists. In an unpublished decision issued on January 19, the Third District Court of Appeal restored a professional negligence action against a dentist who placed mercury amalgam in the teeth of a patient who is allergic to mercury, and a product defect action against a manufacturer of mercury amalgam. In Mikel v. Kerr Manufacturing Company, No. 3 Civil C028134, plaintiff Lieselotte Mikel appealed from a summary judgment issued against her and in favor of defendants Michael A. Severen, DDS, and Kerr Manufacturing Company. Plaintiff received mercury amalgam fillings from Severen in 1984, and began experiencing significant health problems within one month; while these symptoms continued, plaintiff received additional mercury fillings from Severen in 1990. That year, Plaintiff saw a segment of “60 Minutes” which described the potential side effects of mercury amalgam. She asked Severen if her mercury amalgam fillings could be causing her ailments. According to the court, “[h]e told her ‘no,’” told her that they were totally safe, and gave her two flyers [sic] from the American Dental Association (ADA) that supported his statements.” Plaintiff alleged that she relied on Severen’s assurances and did not further investigate mercury poisoning as the cause of her ailments.

After losing consciousness several times in 1991, plaintiff again asked Severen if her mercury fillings could be the cause; “again, Severen assured her there was no relationship.” In 1994, plaintiff was treated by an internist in Germany who told her to “have her teeth checked out when she got home,” stating that “people occasionally do not react well to fillings.” Upon hearing this, Severen instructed plaintiff to be tested for allergies by her dermatologist. One month later, the dermatologist determined that plaintiff was allergic to mercury; however, he declined to opine whether mercury played a role in her health problems. Plaintiff stopped treatment with Severen in January 1995, and sued him for professional negligence in October 1995; she also sued Kerr, the manufacturer of the mercury amalgam, for product liability and failure to warn. The court consolidated the two complaints. Severen moved for summary judgment based on the statute of limitations applicable to health care providers; Kerr moved for summary judgment based upon lack of causation and the statute of limitations. The trial court granted both motions.

On her appeal as to Kerr, plaintiff argued that her mercury amalgam fillings were a “substantial factor” in causing her ailments, and that her expert witness had testified that her symptoms are “evidence of a toxic response” and the...
amalgam “played a role.” Kerr disputed that this testimony rises to the level of a “substantial factor” in terms of causation. Comparing the testimony of the two experts, the appellate court reversed the trial court’s ruling, finding that “a triable issue of material fact exists regarding causation....[plaintiff’s expert’s] description of a ‘clear causal relationship’ between the toxic effects of mercury amalgam fillings and plaintiff’s health problems amounts to more than a slight, trivial, negligible, or theoretical factor.” As to Kerr’s statute of limitations claim, the appellate court held that plaintiff did not “discover” that her ailments may be caused by her mercury fillings until her dermatologist told her she was allergic to mercury in November 1994; because she sued Kerr in October 1995, her action was timely.

In the trial court, Severen’s motion for summary judgment was based upon Civil Code section 340.5, which provides that a plaintiff must file an action for injury or death based upon the professional negligence of a health care provider within three years of the date of injury or one year after the plaintiff discovers, or reasonably should discover, the injury—which ever occurs first. The limitations period may be tolled by fraud or intentional concealment. The trial court granted Severen’s motion based upon the three-year period. The appellate court sustained this ruling as to the 1984 fillings, finding that plaintiff made no inquiry about her mercury fillings until after she saw the “60 Minutes” segment in 1990. As to the 1990 fillings, however, the court reversed the summary judgment in favor of Severen, holding that plaintiff is entitled to amend her complaint to plead facts in support of her claim of concealment on the part of Severen. The Third District remanded the case to the trial court for further proceedings.

The Dental Board is involved in another pending state case concerning the use of mercury amalgam. On March 18, the Board heard a petition for reinstatement by Ralph Andrew Landerman, whose license had been revoked by BDE in 1992 following Landerman’s failure to comply with the terms of a 1987 stipulated disciplinary action. Although the Board ultimately denied Landerman’s petition for reinstatement on April 12 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....”, three Board members quizzed Landerman during the March 18 oral argument on whether he would pursue a “mercury-free” practice. According to the transcript of the hearing, Board member Richard Benveniste, DDS, called the use of mercury amalgam “completely safe” and questioned Landerman why he would want to engage in a mercury-free practice. Board President Robert Christoffersen, DDS, pursued this line of questioning at length, stating at one point: “An amalgam-free practice does not fit the current practice of dentistry.” Board Secretary Kit Neacy, DDS, demanded to know whether Landerman would agree to work in a dental office in which amalgam was used.

Because of the Board’s emphasis on Landerman’s “mercury-free” status, Landerman’s counsel, Charles G. Brown of Washington, D.C., has filed Landerman v. California Board of Dental Examiners, et al., No. SCV 221662 (Sonoma County Superior Court). In this petition for writ of mandate, Brown alleges that BDE’s articulated reason for denying Landerman’s petition (“he has been out of dentistry too long”) 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.” Brown alleges that no statute, rule, or BDE policy requires that a dentist “abstain from being mercury-free”—in fact, state law and Board policy are the opposite. For example, Business and Professions Code section 1648.10 requires the Board to “develop and distribute a fact sheet describing and comparing the risks and efficacy of the various types of dental restorative materials that may be used to repair a dental patient’s oral condition or defect.” The fact sheet must include “a reference to encourage discussion between patient and dentist regarding materials to and inform the patient of his or her options.” [14:1 CRLR 43; 13:4 CRLR 46] Thus, Brown alleges that the Board’s “demands made to Dr. Landerman to abstain from being mercury-free and to foresew working in a mercury-free dental office...are arbitrary, capricious, prejudicial, and an abuse of discretion.” At this writing, Landerman’s petition is pending.

On January 13, the U.S. Supreme Court heard oral argument in California Dental Association v. Federal Trade Commission, 128 F.3d 720 (9th Cir. 1997), in which the Ninth Circuit held that the Federal Trade Commission has jurisdiction over CDA, and that CDA’s advertising restrictions unreasonably restrain trade in violation of section 1 of the Sherman Act and section 5 of the FTC Act, justifying the FTC’s issuance of a cease and desist order. [16:1 CRLR 42]

Part of the American Dental Association, CDA is a nonprofit trade association for licensed dentists in California; about 70% 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. CDA asserted, and the court accepted, that "the state Board of Dental Examiners generally does not pursue violations of state laws on advertising by dentists, and CDA has attempted to fill in the gap with its own enforcement efforts."

The 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 CDA's restrictions on price advertising were unlawful per se, and that its 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 Ninth Circuit held that—despite CDA's nonprofit status—the FTC has jurisdiction over CDA because CDA "is engaged in substantial business activities that provide tangible, pecuniary benefits to its members....The FTC is not purporting to regulate the CDA's charitable or education activities;...the Commission is concerned with CDA behavior that directly affects the profitability of its members' practices. Under these circumstances, the FTC properly exercised jurisdiction over the CDA." On the merits, the court upheld the FTC's cease and desist order. Although it disagreed that CDA's advertising restrictions are per se unlawful, it sustained the Commission's use of the abbreviated "quick look" rule of reason analysis and its conclusion that CDA's price advertising restrictions are unreasonable. "The restrictions CDA placed on price advertising amounted in practice to a fairly 'naked' restraint on price competition itself....[P]rice advertising is fundamental to price competition—one of the principal concerns of the antitrust laws." The court also sustained the FTC's finding that CDA's nonprice advertising restrictions are unlawful. "These restrictions are in effect a form of output limitation, as they restrict the supply of information about individual dentists....Limiting advertisements about quality, safety and other non-price aspects of service prevents dentists from fully describing the package of services they offer, and thus limits their ability to compete."

At this writing, the U.S. Supreme Court has not yet issued its decision.

**FUTURE MEETINGS**

- May 13-14, 1999 in San Diego.
- August 19-20, 1999 in San Francisco.
- November 4-5, 1999 in Sacramento.

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**Medical Board of California**

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**Medical Board of California** (MBC) is a consumer protection agency within the state Department of Consumer Affairs (DCA). The 19-member Board consists of twelve physicians and seven public members. MBC members are appointed by the Governor (who appoints all twelve physicians and five public members), the Speaker of the Assembly (one public member), and the Senate Rules Committee (one public member). Members serve a four-year term and may be reappointed to a second term. The Board is divided into two autonomous divisions: the Division of Licensing and the Division of Medical Quality. The Board and its divisions are assisted by several standing committees, ad hoc task forces, and a staff of 250 who work from 12 district offices located throughout California.

The purposes of MBC and its divisions are to protect consumers from incompetent, grossly negligent, unlicensed, impaired, or unethical practitioners; enforce the provisions of the Medical Practice Act, Business and Professions Code section 2000 et seq.; and educate healing arts licensees and the public on health quality issues. The Board's regulations are codified in Division 13, Title 16 of the California Code of Regulations (CCR).

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