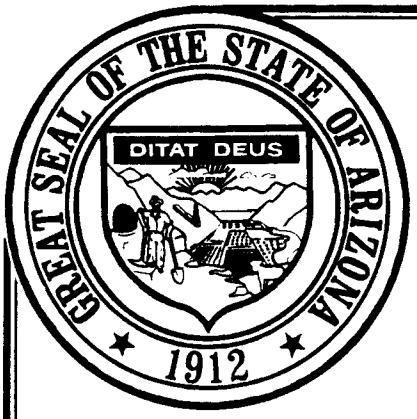


PERFORMANCE AUDIT

# BOARD OF DENTAL EXAMINERS

Report to the Arizona Legislature
By the Auditor General
January 1993
93-1

STATE OF ARIZONA
OFFICE OF THE
AUDITOR GENERAL

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January 22, 1993

Members of the Arizona Legislature

The Honorable Fife Symington, Governor

Dr. Ronald J. Peterson, D.D.S., President
Arizona State Board of Dental Examiners

Transmitted herewith is a report of the Auditor General, A Performance Audit of the Arizona State Board of Dental Examiners. This report is in response to the provisions of Laws 1990, Chapter 218, Section 22, which directs the Auditor General to evaluate the performance of the Board in handling consumer complaints.

In 1979 the State Board of Dental Examiners was one of the first health licensing boards audited under the State's Sunset Laws. This report now represents our fourth audit of the Dental Board. From our first audit we have reported on the need for the Board to better protect the public through its handling of complaints against licensees. Although the years have brought changes in Board members, Board staff and some Board statutes, today we still find the Board can significantly improve its complaint handling and disciplinary processes. Only now, the problems are compounded by a large backlog of complaints which has developed in the past two years.

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

This report will be released to the public on January 25, 1993.

Sincerely,

Douglas R. Norton
Auditor General

DRN:lmn

Enc.

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# SUMMARY

The Office of the Auditor General has conducted a limited scope performance audit of the Arizona State Board of Dental Examiners, under the provisions of Laws 1990, Chapter 218, Section 22, which authorizes the review and specifically directs the Auditor General to evaluate the performance of the Board in handling consumer complaints. This is the fourth performance audit of the Board conducted by the Auditor General.

The Arizona State Board of Dental Examiners is responsible for regulating the practice of dentistry in the State. The Board, comprised of 11 members, licenses approximately 2,600 dentists, 1,500 hygienists, and 14 certified denturists. The Board's operations are supported by 90 percent of the licensing fees it collects.

The purpose of the Board is to protect the public against unqualified practitioners. In each of the three previous audit reports, we found that the Board had not taken appropriate disciplinary actions or adequately handled consumer complaints in its regulation of licensees. In 1990, the Legislature mandated this special audit to determine the adequacy of the Board's handling of consumer complaints.

## The Board Has An Overwhelming Backlog of Complaints That Will Require Additional Measures to Address

**(see pages 5 through 14)**

Due to excessive delays in handling complaint cases, the Board has accumulated a backlog of over 300 cases, which seriously affects its ability to resolve complaints in a timely manner. For example, a complaint filed today will not likely be resolved for one and one-half years. This backlog has been increasing since 1990, when several events slowed the complaint handling process enough to create an accumulation of cases. To handle this backlog, the Board should take aggressive measures, including temporarily hiring additional staff and seeking additional funding.

## The Board Should Improve Its Complaint Investigation Process

(see pages 15 through 20)

The Board's use of committees to investigate complaint cases results in fragmented and incomplete investigations that are poorly perceived by both complainants and licensees. Although a 1989 statutory change eliminated the Board's specific ability to use investigative committees and authorized the use of investigators to investigate complaints, the Board continues to rely on investigative committees. The Board should eliminate the investigative interview committee and utilize a staff investigator, similar to several other healthcare regulatory boards in Arizona. Utilizing staff investigators could improve the quality of the investigations, improve the perceptions of both complainants and licensees, ensure efficient use of investigative resources, and increase the Board's access to further information about cases.

## The Board Needs To Take Steps To Address Problem Dentists and Improve Its Manner of Deliberating Complaint Cases

(see pages 21 through 25)

Although the Board has statutory authority to take disciplinary actions against licensees who repeatedly violate the statutes, it is reluctant to take action against repeat offenders. For example, while most licensees do not receive even a single complaint each year, we identified 14 dentists who had received as many as 20 complaints and seven disciplinary actions in the last seven years; however, the Board has initiated an effort to remove the license of only one of these 14 dentists. The Board's failure to adequately track violations and take disciplinary actions may contribute to its reluctance to act against repeat offenders.

There are also problems with the manner in which the Board reaches decisions on cases. Two recent court rulings raised serious questions about the process the Board follows when deliberating complaint cases. In both cases, the courts concluded that the Board lacked substantial evidence to amend its investigative committees' findings and conclusions and, therefore, the courts reversed the disciplinary action ordered by the Board.

**Current Requirements Discourage Complaint Filing**
**(see pages 27 through 28)**

The Board requires that persons file a "verified" complaint on the Board's complaint form, which must be notarized and accompanied by an authorization for release of records. These requirements are burdensome and may discourage the filing of complaints. The Legislature should consider removing the statutory requirement for complaint verification, and the Board should discontinue the requirement for the authorization for release of records.

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# INTRODUCTION AND BACKGROUND

The Office of the Auditor General has conducted a performance audit of the Arizona State Board of Dental Examiners, under the provisions of Laws 1990, Chapter 218, Section 22, which authorizes the review and specifically directs the Auditor General to evaluate the performance of the Board in handling consumer complaints. This is the fourth performance audit of the Board conducted by the Auditor General.

The Board is responsible for regulating the practice of dentistry in the State. The Board consists of eleven members: six licensed dentists, two licensed dental hygienists, and three laypersons. The Board licenses approximately 2,600 dentists and 1,500 hygienists, and certifies 14 denturists. The Board also conducts investigations, hearings, and proceedings concerning violations, and disciplines violators. During fiscal year 1991-92, the Board received 239 complaints.

## The Role of the Board

Traditionally, the role of the Dental Board is to protect the public. Over 50 years ago, the Arizona Supreme Court stated:

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

However, over the past 13 years, our audits have repeatedly found the Board needs to be more effective in fulfilling its role.

The Board is statutorily empowered to protect the public in two ways: through licensing those qualified to practice dentistry and regulating the conduct of licensees. However, in each of the three previous performance audits, we found that the Board was not taking appropriate disciplinary actions or adequately handling consumer complaints in order to regulate licensees.

In the 1979 Sunset audit and a 1981 follow-up audit, we found that the Board had not fulfilled its mandate to protect the public against incompetent dental practitioners. Again in 1987, we found that the Board continued to have problems in responding to consumer complaints and regulating licensees. In 1990, the Legislature mandated that we perform this special audit to determine the adequacy of the Board's handling of consumer complaints. As with the previous audits, we found the Board still needs to improve how it addresses consumer complaints.

## Staffing and Budget

For fiscal year 1991-92, the Board was authorized eight full-time equivalent (FTE) positions (see Table 1). The Board staff includes an Executive Director, an enforcement manager, an administrative officer, an investigator (dentist), an administrative secretary, and clerk typists. The Board recently added an administrative assistant position. Also, a half-time legal assistant position has been approved and will be filled in January 1993.

The operations of the Board are supported by 90 percent of the licensing fees it collects, which are deposited into the Dental Board Fund. The remaining 10 percent of these fees are remitted to the State General Fund. Board expenditures increased from $346,108 in 1990-91 to $386,756 in 1991-92. The Board has been appropriated $467,300 for fiscal year 1992-93.

## TABLE 1

## BOARD OF DENTAL EXAMINERS
## STATEMENT OF FTEs AND ACTUAL AND BUDGETED EXPENDITURES
## FISCAL YEARS 1990-91, 1991-92, AND 1992-93
(unaudited)

| | 1990-91 (actual) | 1991-92 (actual) | 1992-93 (approved) |
|---|---|---|---|
| FTE Positions | 8 | 8 | 8 |
| Personal Services | $196,537 | $221,940 | $242,100 |
| Employee Related | 35,243 | 30,741 | 54,400 |
| Professional and Outside Services | 33,966 | 27,028 | 64,000(a) |
| Travel, In-State | 4,839 | 6,662 | 6,500 |
| Travel, Out-of-State | 3,247 | 5,226 | 5,400 |
| Equipment | 95 | 7,145 | 8,800 |
| Other Operating | 72,181 | 88,014 | 86,100 |
| TOTAL | $346,108 | $386,756 | $467,300 |

(a) Amount includes $40,000 for the Impaired Dentist Program.

Source: Arizona Financial Information System reports for Fiscal Years Ended June 30, 1991 and 1992, and the State of Arizona Appropriations Report for Fiscal Year 1992-93.

### Audit Scope and Methodology

The scope of our audit is defined by Session Laws 1990, Chapter 218, Section 22:

> No sooner than eighteen months after the effective date of this act, the auditor general shall conduct a performance audit of the state board of dental examiners to determine the adequacy of the board's handling of consumer complaints.

In response to this directive, we present findings in each of the following four areas:

- The Board's timeliness in handling consumer complaints
- The adequacy of the complaint investigations process

- The adequacy of disciplinary actions
- Whether changes are needed to the requirements for filing complaints

To further assist us in our review of the complaint handling process, we utilized a panel of three retired dentists. Each of these dentists, who volunteered their assistance, has over 20 years' dental experience in private practice. The panel's work is presented in Finding II.

This audit was conducted in accordance with government auditing standards.

The Auditor General and staff express appreciation to the Board of Dental Examiners and its staff for their cooperation and assistance throughout the audit.

## FINDING I

## THE BOARD HAS AN OVERWHELMING BACKLOG OF COMPLAINTS THAT WILL REQUIRE ADDITIONAL MEASURES TO ADDRESS

On September 4, 1990, a woman filed a complaint against a dentist alleging that he had pulled several of her teeth without her permission. The Board staff notified her in a September 17, 1990, letter that she needed to provide additional information. She returned the requested information 8 days later. The Board staff did not request her records from the dentist until April 15, 1992, over 18 months later. On October 9, 1992, over two years after the complaint had been received, the Board voted to dismiss the woman's complaint.

The Board's excessive delay in handling this case is not an isolated incident. Complaint handling is currently so backlogged that unless changes are made, a complaint filed today will not likely be resolved for one and one-half years. This backlog of complaints has been increasing since 1990, when several events slowed the complaint handling process enough to cause a large accumulation of cases. Although the Board is making attempts to improve complaint handling, more aggressive measures are needed to address the backlog.

### Backlog of Complaint Cases Is Seriously Impacting Complaint Handling

The backlog of complaints is seriously impacting the Board's complaint handling process. Since 1990, the Board has failed to resolve most complaints in a timely manner. The cases have become so backlogged that, at the current rate, the backlog will take years to eliminate.

**Complaint handling untimely** - The Board has not resolved most complaints in a timely manner. We reviewed a sample of 150 complaints received by the Board between July 1988 and June 1992.[1] Of the 150 complaints we

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(1) We randomly selected 30 cases received by the Board in each of the last five years for review. All 1988 cases reviewed were received after July 1, 1988, and all 1992 cases were received prior to July 1, 1992. All case examples, including the one above, were derived from this sample.

reviewed, 93 had been closed and 57 were still open. As shown in Table 2, the closed cases took up to 18 months to resolve. In addition, 12 of the 57 open cases had been open more than one year. Further, as of July 1992, none of the 1992 cases we reviewed had been heard by the Board.

**TABLE 2**

**COMPLAINT RESOLUTION TIMELINESS OF SAMPLE COMPLAINTS RECEIVED BY THE BOARD JULY 1988 THROUGH June 1992(a) CLOSED CASES**

| Total Time Required To Resolve Complaint(b) | Number of Closed Complaint Cases(c) 1988 | 1989 | 1990 | 1991 |
|---|---|---|---|---|
| Less than 150 days | 7 | 16 | 4 | 0 |
| 150 days to 6 months | 8 | 7 | 6 | 0 |
| 6 to 9 months | 14 | 6 | 6 | 0 |
| 9 to 12 months | 0 | 0 | 6 | 0 |
| 12 to 18 months | 1 | 0 | 6 | 6 |
| Total Number of Closed Cases | 30 | 29 | 28 | 6 |

(a) None of the 1992 cases in our file review were closed on the date the case was reviewed.

(b) This time is measured from the date the complaint was received by the Board to the date of the Board meeting in which the Board issued its findings in the case.

(c) A case was considered closed when the Board issued its findings on the case.

Source: Auditor General staff review of complaint files conducted during July 1992.

Because of the delays in resolving complaints, the Board has failed to meet statutory requirements for complaint handling. Arizona Revised Statute §32-1263.02 requires that the Board issue its findings on a complaint within 150 days of the initiation of an investigation.[1]

(1) The investigator or informal interview officer must investigate the charges and make written recommendations to the Board within 90 days. The Board then has 60 days to issue its preliminary findings on the complaint.

Although the Board generally complied with the 150-day time limit in 1989, it exceeded the statutory time limit for most cases received in 1990 and 1991. Of the 28 cases received in 1990 in which the Board took action, only 4 cases (14 percent), were resolved within 150 days. None of the 1991 cases we sampled were resolved within the 150-day period.

The untimeliness of the Board's complaint handling process is also shown by the following case examples:

- Case 1 - On February 25, 1991, a patient filed a complaint against a dentist concerning the quality of care received. The patient was evaluated by two dentists who reported their results to the Board on March 28, 1991. At the time of our file review, Board staff had not completed their report on this evaluation, over 15 months after receiving the results.

- Case 2 - On January 4, 1991, a man filed a complaint with the Board involving the quality of his bridgework. The Board began to investigate his complaint on December 5, 1991, 11 months later. On January 21, 1992, the man was examined by two dentists as part of the Board's investigation. However, his case was not heard by the Board until June 5, 1992, almost one and one-half years, after he filed the complaint.

- Case 3 - On November 6, 1990, a woman filed a complaint against a dentist concerning a root canal that the dentist had allegedly done four times. On December 17, 1990, she participated in a clinical evaluation in which two dentists examined her. Board staff prepared a report on the evaluation 10 months later on October 15, 1991. The Board voted to dismiss the woman's complaint on December 13, 1991, over one year after she filed the complaint.

**Large backlog cannot be resolved in the near future** - Under current conditions, the large backlog of complaint cases could take years to resolve. As of December 31, 1992, the Board had 333 open cases.(1) The backlog of over 300 cases is the equivalent of over one year's worth of complaints (the Board received 258 cases in 1992).

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(1) Open cases were defined as cases where no initial Board action had been taken. If an action had been taken, but the case was pending further Board action, the case was not included in the backlog figures.

If the Board hears 60 new cases per meeting (20 percent more than it is currently handling)[1] and receives a consistent number of new cases (20 per month), it will not be able to eliminate the backlog until June 1995. Further, hearing 60 cases per meeting on a regular basis will be challenging, since the Board's best performance in recent years was in 1989 when it heard an average of 52 cases per Board meeting, ranging up to 65 complaints at one meeting.

## Several Factors Have Contributed to the Growing Backlog

After previous performance audits revealed problems in the Board's complaint handling process, the Board appeared to be making improvements in the process in 1989. However, in 1990, case handling became untimely and the current backlog began to develop. Several events in 1990 may have contributed to the Board's untimely complaint handling, including settlement of a lawsuit, turnover in staff, lack of a complaint tracking system, and the Board's slow response to a decreasing number of cases on meeting agendas.

**Improvements made following previous report** - A 1987 audit conducted by our Office noted the following deficiencies in the timeliness of the Board's complaint handling process:

- Many complaints received by the Board required excessive time to resolve and exceeded the statutory time limits.
- The Board often did not obtain needed records or complete investigative reports in a timely manner.
- The Board did not have a complaint tracking system and could not adequately monitor the status of its complaints.

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(1) The Board took initial action on 48 complaints in August 1992, 63 complaints in October 1992, and 34 complaints in December 1992, for an average of 49 cases per Board meeting.

In response to our 1987 report, the Board made some improvements in its complaint handling process. One of these improvements was a complaint tracking system, which began tracking complaints received in July 1988. In addition, the Board was able to handle cases in a more expedient manner. In our sample, 16 of the 30 cases from 1989 were resolved in less than 150 days, which is more than double the 7 cases in 1988.

Untimely case handling began in 1990 - Although the Board's timeliness in handling complaint cases improved in 1989, it slowed significantly in 1990. As shown in Table 2, page 6, the number of 1990 cases resolved in less than 150 days declined to four. Also, the amount of time for handling 1990 cases increased over the amount of time for handling 1989 cases. For example, our review indicated that 14 of the 1990 cases were unresolved for more than 9 months compared with only one case in 1989. As resolution of these cases extended into 1991, the cases received in 1991 became backlogged to the point where none of the closed 1991 cases we reviewed were resolved in less than 12 months.[1]

Several factors may have contributed to untimeliness - Several events beginning in 1990 contributed to the excessive untimeliness of complaint cases previously described. One significant event in 1990 was the settlement of a lawsuit brought against the Board by the Arizona State Dental Association (ASDA). Evidence presented by ASDA indicates one of the primary objectives of the lawsuit was to have the Board remove its Chief Investigator, who had been with the Board 10 years, citing bias against its members. Although the official settlement of the lawsuit did not stipulate his removal, according to the former Chief Investigator, he resigned from his position based, in part, on the pressure generated by the ASDA lawsuit.[2]

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(1) At the time of our review, 15 of the 1991 cases remained open; these cases had been pending from 6 to 12 months.

(2) The former Chief Investigator also attributed his resignation to an investigation by the Department of Administration, initiated immediately after the lawsuit settlement, which encompassed several allegations similar to those made by ASDA in its lawsuit. The investigation failed to substantiate these allegations.

The resignation of the Chief Investigator was only the beginning of turnover in management and investigative staff, which contributed to the delays in complaint processing. Disruptions caused by the following changes also impacted timeliness:

- The Board has had three different Executive Directors since 1990.
- The Chief Investigator position was vacant for eight months. During this time, the Executive Director filled in and the complaint handling process slowed further. Later, the Chief Investigator position was converted to an administrative position filled by a layperson, rather than a dentist.
- The Board has had three different investigators in the last two years.

In 1990, the Board abandoned its computerized complaint tracking system and has had no method for tracking complaints since that time.(1) Without a tracking system, the Board does not readily know the status of complaints and cannot determine the next step in the complaint handling process.

Another factor contributing to the delays in complaint handling was the Board's slow response to obvious signs that cases were becoming seriously backlogged. The Board and its management staff should have been aware of the backlog in complaint handling because the number of cases prepared for the Board meetings declined significantly. The Board's agendas averaged 52 cases per Board meeting in 1989 compared to 31 and 23 cases per Board meeting in 1990 and 1991, respectively. At the June 1991 Board meeting, the Board staff presented only 5 new cases to the Board.(2) Again, in February 1992 the Board had only 11 cases on the agenda for an initial action. At both meetings, the Board minutes do not indicate the Board was aware of the low number of cases on the agenda.

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(1) Current administrators are unsure of the reasons the complaint tracking system was abandoned.

(2) The Board also handled 8 cases involving petitions for review or rehearing, 3 cases involving action needed on a Hearing Officer's recommendations, and 1 case involving consideration of action on a previous Board order. Since these cases had previous Board action, we did not count these as cases which would reduce the Board's backlog.

## Changes Are Needed to Handle Backlog

Although recent efforts to improve timeliness have been made, they are not sufficient to handle the backlog of cases created by previous delays in processing complaints. The Board must take additional aggresive measures to handle its backlog of cases.

**Efforts made to improve complaint processing** - The Board has recently taken steps to change the complaint process to make it more timely.

- The Board changed the scheduling of the clinical evaluation procedure to expedite the evaluation process and facilitate the Board obtaining evaluation results in a more timely manner. Under the new scheduling approach, the evaluation is performed at a clinic and results are given to Board staff immediately after the evaluation.

- The Board has utilized temporary clerical assistance to handle some complaint processing tasks, such as scheduling clinical evaluations and investigative interviews, and preparing notices.

- The Board engaged a part-time paid consultant to assist the investigator with investigative reports. The consultant, who is a dentist, worked 184 hours for the Board in June, July, and August 1992. The Board has also requested another full-time investigator in the 1993-94 budget request.

- The Board has contracted to have a computerized complaint tracking system developed.

Temporary emergency measures should be taken - To eliminate the backlog of cases, the Board should take aggressive actions. As previously shown, the Board cannot clear the backlog at its current rate.

As a first step, the Board should hire additional temporary investigators (dentists) and clerical personnel. The Board recently added one temporary clerk and one temporary part-time investigator. However, to eliminate the backlog, the Board will need to increase the amount of temporary help. Based on comparisons with the Arizona State Board of Nursing and the Arizona State Board of Osteopathic Examiners, we estimate that the Board needs three to four additional full-time investigators for one year to address the backlog.(1) Based on its current workloads, we estimate that the Board would need two additional clerical staff for one year to support the additional investigative positions. The estimated cost of the investigators would be $120,000 to $160,000 and the additional clerical help would cost $32,000.(2)

The Board's present budget allocation does not provide sufficient monies to fund the needed positions. To cover the expense of additional help, the Board should consider proposing legislation to collect an emergency surcharge on dental licenses in order to raise the additional revenue, as the Arizona State Board of Nursing did in 1988. We estimate a $75 surcharge per licensed dentist would be necessary and recommend the surcharge be billed separately to all licensed dentists with appropriate sanctions for failure to pay by a certain date.(3)

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(1) These estimates are based on the Board modifying its current investigative process, eliminating its use of committees to investigate complaints, and instead relying upon trained staff investigators to pursue complaints (see Finding II).

(2) The Board currently pays approximately $20 per hour for the dentist investigator position, for a total of $40,000 per investigator annually. The Board currently pays approximately $8 per hour for temporary clerical help, for a total of $16,000 per clerk annually.

(3) A surcharge of $75 per licensed dentist would raise approximately $195,000.

Using temporary personnel to prepare cases should dramatically increase the volume of cases for the Board to review. With such an increase, the caseload may become too burdensome for the Board to handle at its bi-monthly meetings. Two alternative approaches should be considered for easing the Board's ability to handle the increase.

- The Board could hold monthly meetings temporarily until the backlog is resolved, or
- The Board could consider requesting legislation to allow it to form two separate panels, each containing at least one hygienist and one layperson.[1]

While the Board works to resolve the backlog, it should issue a quarterly report to the Legislature on the status of complaint cases, including the number of cases received, pending, and adjudicated. This would provide the Legislature with a means for monitoring the Board's progress until the backlog of cases is resolved.

## RECOMMENDATIONS

1. To eliminate the backlog of cases, the Board should
    - Seek additional funding for temporary personnel by requesting a supplemental appropriation funded through a surcharge on all licensees.
    - Use the additional funding to hire four temporary investigators and two temporary clerical staff.
    - Consider alternative approaches to hearing cases, including a panel approach or more frequent Board meetings.

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(1) The State Liquor Board has statutory authority (A.R.S. §4-111[D]) to allow the Chairman to designate panels to hold hearings and take disciplinary actions against its licensees. The State Board of Pardons and Paroles also has statutory authority (A.R.S. §31-401[I]) to work in panels of three to hear cases.

2. The Board should implement a complaint tracking system to ensure timely processing of cases.

3. The Legislature should consider the following:

   - Requiring quarterly reports from the Board on the status of the backlog
   - Providing the Board with authority to use two panels to hold hearings on complaints
   - Providing the Board with the authority to assess an emergency surcharge on its licensees

## FINDING II

## THE BOARD SHOULD IMPROVE ITS COMPLAINT INVESTIGATION PROCESS

The Board should improve its complaint investigation process. The current process results in fragmented and incomplete investigations and is poorly perceived by some participants. Revising the process could ensure complete investigations and improve public perceptions.

### Limitations of Current Process

The Board's current investigation process is hampered by its reliance on committees to investigate complaints. Through the use of committees, the process lacks the comprehensive nature of a regulatory investigation and results in incomplete investigations that are poorly perceived by some complainants and licensees.

Committee approach to investigations - The Board's investigation process relies on the use of committees to collect and analyze information and evidence in complaint cases. In most complaint investigations, the Board uses two separate committees, a Clinical Evaluation Committee and an Investigative Interview Committee.(1) A brief description of each committee and how it functions follows.

- Clinical Evaluation Committee consists of two volunteer dentists who examine the complainant in order to evaluate the adequacy of the dental work. Board practices do not allow evaluators to review the patients' dental records, and the evaluators are instructed not to discuss their findings with the complainant. The committee's findings are then summarized in a report prepared by the Board's staff investigator.

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(1) Clinical evaluations are routinely performed in cases involving quality of dental care complaints. Further, although statutes allow the Board to conduct an informal interview (similar to the investigative interview except that a Board member is required to preside over the panel), the majority of cases are assigned to investigative interviews.

- **Investigative Interview Committee** consists of two volunteer dentists and a layperson who sit as a panel and hear testimony from the complainant and licensee. (During the investigative process, this is the only opportunity for each party to present his or her side of the case.) Other evidence, including the findings of the Clinical Evaluation Committee and the complainant's dental records, may also be reviewed. The proceeding is held much like a hearing; a tape recording is made, and each party is sworn in and given a limited amount of time to present their case. The committee deliberates the case before the parties, formally indicating their findings of facts and conclusions regarding any statutory violations and recommendations for disciplinary actions. A summary report of the proceeding is compiled by the Board's staff investigator (who does not participate in the investigative interview) and forwarded to the Board for its consideration.

**Investigations process results in incomplete and substandard investigations** - The use of committees to gather evidence results in a fragmented and inefficient process. Unlike most boards that use investigators to conduct investigations, the Dental Board relies primarily on the investigative interview to collect and review evidence, and reach conclusions on whether a dentist has violated dental regulations. Thus, the process does not ensure that sufficient information, facts, and evidence have been obtained prior to a meeting to recommend case action. For example, although the investigative interview is generally the first opportunity the complainant has to explain his or her complaint, and the dentist has to respond to the complaint, the committee generally reaches a conclusion by the end of the interview, without further work to address the points raised during the interview. In addition, the Board's vehicle for gathering further evidence, its investigator, is assigned the clerical responsibilities of transcribing the interview tapes, and preparing written reports for the Board.

The Investigative Interview Committees' investigations are often incomplete or problematic. With the assistance of our consultants, we identified several deficiencies in complaint investigations as a result of the inadequate work of the Investigative Interview committee assigned to the case. These deficiencies include:

- Ignoring findings of the clinical evaluation when deliberating the facts of the case
- Omitting evidence presented by the complainant or the records in the case

- Neglecting to obtain pertinent evidence, including testimony from complainants and pretreatment X-rays
- Failing to address the primary allegations of the complaint
- Procedural errors, including recommendations inconsistent with the statutes, and incomplete and inaccurate reporting of findings

The following case examples demonstrate the problems with the investigative interview process.

Case One - In June 1990, a man filed a complaint alleging that a dentist had failed to properly diagnose his periodontal condition. More than a year later, an Investigative Interview Committee heard the case, but did not take testimony from the complainant because the Board had failed to notify him of the hearing. Acting on the committee's recommendation, the Board dismissed the complaint. However, when appealing the Board's decision, the complainant explained that he was also concerned about the orthodontic treatment he had received from the dentist. A clinical evaluation conducted after the appeal found the dentist's orthodontic work to be deficient.

Comment - Under the Board's current investigative process, obtaining evidence and input from the parties involved is limited to a single opportunity at the interview. In this case, although the complainant had significant additional information to present to the Board, he was never interviewed by the Board before it reached a decision. Consequently, the man was forced to appeal the Board's decision and require the Board to initiate a new investigation, which took place more than one and one-half years after the man filed the complaint.

Case Two - A woman filed a complaint alleging that a dentist had diagnosed unnecessary root canal treatment and then pressured her in an effort to have the work performed. A clinical evaluation confirmed the complainant's allegations, finding that a root canal was indeed not necessary. Despite these findings, as well as statements indicating their own doubts about the licensee's explanation of his diagnosis, the Investigative Interview Committee recommended dismissing the complaint. Additionally, records of the hearing indicate that committee members never questioned the dentist about pressuring the complainant to accept treatment.

Comment - This case illustrates not only the Investigative Interview Committee's failure to consider pertinent evidence, but also its failure to address a primary allegation in the complaint.

Case Three - In August 1990, the Board received a complaint from a woman that included several allegations, among them inadequate crown and bridgework, and obtaining a fee by misrepresentation. In hearing the case, the Board noted several deficiencies in the investigation performed by the Investigative Interview Committee, disregarded the

committee's recommendation to dismiss the complaint, and instead ordered sanctions against the licensee. The licensee appealed the Board's decision, and the Board ordered a new investigation, with specific instructions to evaluate the allegations regarding fees. However, the Board found that a second Investigative Interview Committee failed to evaluate the fee-related allegations, and ordered a third Investigative Interview Committee to review the complaint. At its April 1992 meeting, the Board accepted the recommendations of the third committee and took disciplinary actions against the dentist.

Comment - The Board, by its statements, recognized the incomplete and inadequate investigations conducted by the Investigative Interview Committees in this case, particularly after instructing the Committees to investigate specific allegations. Further, this case illustrates the inefficient and inconvenient nature of the current investigations process, which took more than a year and one-half to resolve this complaint.

Poor perceptions - In addition to its impact on the quality of investigations, the Board's investigation process is poorly perceived by some complainants and licensees. To identify participant concerns with the Board's complaint handling process, we spoke with 19 complainants and 12 licensees who had either contacted our Office or were referred to us. Their concerns, summarized below, primarily involve the activities of the Clinical Evaluation and Investigative Interview Committees.

Committee bias - Many complainants we spoke with believe the Investigative Interview Committees are biased. These beliefs stem from different experiences ranging from evidence not being accepted and testimonies being interrupted, to the licensee and the panel conversing prior to the interview. Some complainants felt the panel had reached a conclusion on their case before the interview.

Rude and insulting behavior - Some complainants indicated they were treated rudely or insulted by committee members. Complainants also stated they were made to feel inferior, and committee members appeared to be bored and uninterested during the interview.

Member qualifications questioned - Some licensees felt the Investigative Interview Committee members were not qualified to hear their cases. It was indicated that the committee members were untrained in the subject specialty area of dentistry. The appropriateness of a lay committee member participating in discussions involving technical issues was also questioned.

Time limitations on testimonies - Some complainants we spoke with cited instances during investigative interviews in which time limitations were placed on their testimonies, preventing them from presenting information pertinent to their case. Although the Board's Executive Director indicated time limitations are not imposed, an introductory statement read at the beginning of each interview indicates that participants have only five minutes to present their testimony.

**Disclosure of information** - Many complainants expressed concern about their inability to obtain information generated during the investigation process, particularly the results of the clinical evaluation. By statute, Board investigative materials are confidential to the public, including complainants, but are available to licensees involved in complaints, enabling them to establish a defense against the allegations. Complainants, who consider themselves a party in the complaint process, often feel this limited disclosure of information is unfair. The Board's actions may also contribute to this perception of unfairness since it does not routinely inform complainants of the reasoning behind the distribution of this information.

Through our work, we identified activities by Investigative Interview Committees that might tend to support the concerns expressed by the complainants and licensees we spoke with. Summaries of these instances follow.

**Case One** - While attending an investigative interview, we observed two committee members repeatedly telling a complainant that her testimony regarding fee information from her dentist's office was "wrong" and that she misunderstood what she was told. This transpired despite the fact that neither the licensee nor his office staff had been present at the interview, and therefore could not have been the source of information to contradict the complainant's testimony.

**Case Two** - At the conclusion of an investigative interview, we overheard the committee chairman comment that the complainant in the case, who had not attended the interview, was "not playing with a full deck," adding that he had previously treated the complainant as a patient. These comments, along with the committee member's prior relationship with the complainant, create serious questions about the objectivity of the committee member.

**Case Three** - In its written report transmitted to the Board for use in its deliberation of the case, an Investigative Interview Committee included as a finding of fact that "the patient will never be happy." The Board, apparently recognizing the inappropriateness of this statement, deleted it from the final findings in the case.

## Revising the Process Could Ensure Complete Investigations and Improve Public Perceptions

The Board should revise its complaint investigations process to ensure the completeness of investigations and improve public perceptions. It could do so by eliminating the use of committees to investigate complaints and replacing committees with staff investigators.

**Modify investigative process** - To improve its investigative process, the Board should eliminate the use of investigative interviews and rely on trained staff investigators to pursue complaint cases. Several Arizona healthcare regulatory boards utilize staff investigators. For example, the Boards of Medical Examiners, Osteopathic Examiners, and Nursing all use staff investigators to pursue complaint allegations. Each board has investigators licensed in their respective medical field, who are assigned overall responsibility for the investigation of the case, including the gathering and analysis of necessary evidence, interviewing the parties relevant to the complaint, and formulating recommendations for Board action.

In fact, a 1989 statutory change empowered the Board to revise its investigative process and begin using investigators. During the 1989 legislative session, A.R.S. §32-1263.02 was amended to eliminate the Board's specific ability to use "investigative committees" and authorized the use of "investigators" to handle complaints. Despite this statutory change, the Board has continued to rely on investigative committees.

Beyond potentially improving the quality of investigations, the use of investigators could benefit the Board in several ways. First, by eliminating the investigative interview from the complaint process, the Board would remove a major source of complainant and licensee perceptions of unfairness. Second, investigators familiar with cases could ensure the more efficient use of clinical evaluations, rather than the Board's current approach of sending most quality of care complaints for evaluation. Finally, the use of investigators creates a convenient and efficient mechanism for the Board to request additional investigatory work, rather than its current time-consuming practice of referring complaints back through the committee approach of investigating cases.

## RECOMMENDATION

To improve its complaint investigative process, the Board should eliminate its use of committees to investigate complaints, and instead rely upon trained staff investigators to pursue complaints.

## FINDING III

## THE BOARD NEEDS TO TAKE STEPS TO ADDRESS PROBLEM DENTISTS AND IMPROVE ITS MANNER OF DELIBERATING COMPLAINT CASES

The Board should take actions to address problem dentists and improve its deliberation procedures. Specifically, the Board should increase its efforts to take disciplinary actions against licensees who have repeatedly violated the dental statutes. In addition, the Board needs to improve its procedures for deliberating cases to ensure that disciplinary actions are upheld.

### Board Needs To Increase Efforts Against Repeat Violators

The Board should increase its efforts to take disciplinary actions against licensees who repeatedly violate the dental statutes. Although the Board has sufficient statutory power to act against repeat offenders, it has been reluctant to enforce stiffer penalties. The Board's failure to adequately monitor repeat offenders may contribute to this problem.

Statutory authority - The Board has adequate statutory authority to take action against licensees who repeatedly violate the standards. Arizona Revised Statutes (A.R.S.) §32-1263 empowers the Board to take disciplinary action against any licensee for unprofessional conduct. In turn, A.R.S. §32-1201.18 defines unprofessional conduct as including, "gross malpractice or repeated acts constituting malpractice." Finally, the Board is granted a wide range of disciplinary actions, from censure and restitution to license suspension and revocation.

Repeat offenders - To evaluate the Board's response to problem licensees, we identified 14 dentists who had accumulated numerous complaints and disciplinary actions over a long period of time, or several complaints in a short period of time (see Table 3, page 22). The significance of the number of complaints becomes more prominent when considering that in 1991, more than 90 percent of the dentists licensed in Arizona had no complaints filed against them.

## TABLE 3

## ACTION TAKEN AGAINST REPEAT OFFENDERS FOR COMPLAINTS RECEIVED JANUARY 1986 THROUGH AUGUST 1992

| Dentist | Complaints Received | Complaints Open | Complaints Dismissed | Complaints With Disciplinary Actions |
|---|---|---|---|---|
| A | 20 | 2 | 11 | 7 |
| B | 15 | 10(a) | 1 | 4 |
| C | 14 | 6 | 4 | 4 |
| D | 12 | 4 | 4 | 4 |
| E | 11 | 3 | 5 | 3 |
| F | 10 | 2 | 2 | 6 |
| G | 9 | 0 | 4 | 5 |
| H | 7 | 0 | 3 | 4 |
| I | 7 | 1 | 3 | 3 |
| J | 7 | 0 | 4 | 3 |
| K | 6 | 0 | 2 | 4 |
| L | 4 | 0 | 1 | 3 |
| M | 4 | 0 | 2 | 2 |
| N | 3 | 0 | 0 | 3 |
| TOTALS | 129 | 28 | 46 | 55 |

(a) This includes eight cases ordered to formal hearing that have not yet been heard.

Source: Auditor General staff analysis of complaints received by the Board from January 1986 through August 1992. Complaint information obtained from Board records for individual licensees.

Board reluctant to act - While the Board has the authority, it has been reluctant to act against repeat offenders. For example, in a review of licenses revoked by the Board since 1988, we were unable to identify any dentists whose licenses were revoked for repeated acts of malpractice or for the number of complaints and/or disciplinary actions taken by the Board against their license. In addition, of the 14 licensees identified in Table 3, at the time of our review, the Board had initiated an effort to remove the license of only one of these dentists.(1) The following examples of dentists listed in Table 3 illustrate the Board's reluctance to pursue action against repeat offenders.

(1) However, even this action is not expressly related to the number and frequency of violations committed by the licensee (see Dentist B example, page 23).

**Dentist D** received 12 complaints over the last seven years. The Board found the licensee had committed a violation in four of these complaints, including three complaints involving inadequate dentures. Despite previous disciplinary actions that included a total of 21 hours of continuing education in denture work, all four of the most recent complaints filed against the dentist (received in the last three years and still open at the time of our review) concern inadequate dentures.

**Dentist F** received 10 complaints in the last seven years, six of which were found to involve a violation. Although four of the six complaints with a violation concern inadequate oral surgery, and three were acted upon by the Board at the same meeting, beyond imposing censure and administrative penalties, the Board has done nothing to restrict this licensee's practice of dentistry in Arizona.

**Dentist B** received 15 complaints in the seven-year period. Although only four complaints resulted in disciplinary actions, the Board has ordered eight complaints to a formal hearing, including two ordered by the Board more than three years ago for allegations of "...conduct or practice constituting a danger to the health, welfare or safety of the patient or the public." Regardless of this record, the Board took no action to limit this licensee's privilege to practice dentistry until August 1992, when it summarily suspended his license for working for a company not under the supervision of a licensed dentist and for failure to maintain and provide dental records for his patients.

**Inadequate tracking may contribute to reluctance to act** - One possible reason for the Board's reluctance to act against repeat offenders could be the result of its failure to adequately track violations and disciplinary actions. Since 1989, the Board has failed to track violations and disciplinary actions taken against licensees. Therefore, the Board does not have a comprehensive record of the nature of the violations committed by these licensees or a record of recent disciplinary actions ordered against them. Without this information, the Board is unable to establish a pattern of violations that would lead them to take stronger actions.

## Board Needs to Improve Deliberation Procedures

In instances where the Board takes disciplinary actions, it needs to improve the procedures it follows when deliberating cases to ensure that its disciplinary actions have an adequate basis. Recent court rulings have questioned the Board's deliberation process and resulted in the

reversal of disciplinary actions taken by the Board. Despite these events, the Board continues to use questionable procedures when deliberating cases.

Recent court rulings - Two recent court rulings have seriously questioned the process the Board follows when deliberating complaint cases. In both cases, the courts concluded that the Board failed to support its decisions to amend the findings and conclusions of the Investigative Interview Committee with "substantial evidence." Therefore, the courts reversed the disciplinary action ordered by the Board.(1) Summaries of the two cases and the courts' decisions follow.

Case One - A patient filed a complaint with the Board alleging that a dentist had charged excessive fees. An Investigative Interview Committee found no basis for the allegation and recommended that the complaint be dismissed. The Board ignored the committee's recommendations and rendered its own findings and conclusions, censuring the dentist for "inadequate practice management."

On review, the superior court found that the record in the case contained no substantial evidence to support the Board's conclusions. Because the court also found that the Board lacked the statutory authority to censure the dentist for inadequate practice management, it reversed the Board's order against the dentist. On appeal by the Board, the State Court of Appeals upheld the superior court's ruling.

Case Two - A patient filed a complaint with the Board, alleging unsafe practices by a dentist. An Investigative Interview Committee found no evidence to support the allegations and recommended that the complaint be dismissed. When hearing the case, the Board decided to adopt new findings of fact that substantially changed those submitted by the Investigative Interview Committee. Based on these new findings, the Board concluded that the dentist's conduct was unprofessional and ordered restitution of fees paid by the patient.

After reviewing the record, the superior court found that the Board, without further investigation, improperly changed the findings of fact, and that these changes were unsupported by "substantive

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(1) In addition to the reversal of its disciplinary actions, the Board's failure to properly deliberate these cases resulted in direct financial loss to the State. For example, in the first case, the State must pay the dentist more than $7,600 in attorney's fees and expenses. Furthermore, these costs do not include the expenses incurred by the Attorney General's Office to defend the Board.

reliable evidence." The court further concluded that the Board's actions were "arbitrary and capricious" because the Board relied on a weak record of evidence to support its new findings of fact and expressed a desire not to investigate the case further. The court ordered the Board to either adopt the findings of fact and recommendations made by the Investigative Interview Committee or reinvestigate the case "...in order to appropriately resolve the case and to make an informed decision."

Board continues to use questionable procedures - The Board continues its practice of amending investigative findings and conclusions without using appropriate evidence. At the same meeting that the Board was informed of these court rulings against it, the Board ordered disciplinary actions in three cases involving the same dentist in the second court case described above. A review of the deliberation process followed by the Board in these cases indicates its continued failure to use substantial evidence when deciding cases. For example, in two of the three cases, the Board did not accept the recommendations of the Investigative Interview Committee and imposed a disciplinary action without stating on the record what evidence was used to reach its conclusion. In a third case, despite significant evidence from the Investigative Interview committee, the Board again reversed the committee's dismissal recommendation and imposed a disciplinary action based upon a single photograph of the patient. Further, the meeting records indicate the Board mentioned the evidence used to support its determination only after its Assistant Attorney General and Executive Director reminded it to do so.

## RECOMMENDATIONS

The Board should

1. Pursue appropriate levels of disciplinary action against licensees who repeatedly violate the standards of professional practice.

2. Develop a system to track violations and disciplinary actions against licensees and use this information to determine when stronger enforcement actions are needed.

3. Establish clear policies to guide it when hearing complaint cases to ensure that appropriate evidence is obtained to support its disciplinary actions.

## FINDING IV

## CURRENT REQUIREMENTS DISCOURAGE COMPLAINT FILING

The Board's requirements for filing a complaint create an unnecessary burden on the public. By eliminating certain filing provisions, the Board could streamline its complaint filing process.

### Filing Requirements Are Burdensome

The Board's procedures for filing complaints act as a deterrent. When a complainant contacts the Board to file a complaint (either by telephone or letter), the Board normally sends the complainant a complaint form and requests that the complainant complete the form and return it to the Board. Before returning the form to the Board, the complainant must have the form "verified," as required by A.R.S. §32-1263.02 and defined in §32-1201, as signing the form before a notary or an authorized Board employee. In addition, the Board requires that the complainant complete the "Authorization For Release of Information and Records" portion of the form, which it later uses in requesting dental records.

This process is an unnecessary burden for complainants. Although many complainants have already taken the time to write a letter to the Board detailing their concerns, their complaint letter is returned to them with a Board complaint form, which they then must complete, have "verified," and return to the Board. Further, if the complaint involves more than one dentist or patient, a separate form must be completed for each dentist or patient. The process of initiating an investigation is delayed until the form is received. Because of the inconvenience of filing a complaint, some complainants may not bother to return the complaint form. Through our review, we identified the following instance in which the process created a problem for a complainant:

- A woman sent a notarized complaint form to the Board with concerns about the treatment provided to her, her spouse, and her child by two dentists operating from one dental practice. The Board sent the woman six forms to complete (because two dentists were involved, two forms were required for each person treated). The woman did not return the forms.

## Other Medical Boards Do Not Have Similar Requirements

Other medical regulatory boards with similar enforcement responsibilities do not require complaints to be "verified," nor do they require complainants to provide authorization for the release of their records. For example, the Board of Nursing, the Board of Medical Examiners, and the Osteopathic Board will initiate a complaint investigation based on a letter received from a complainant. These boards are not required to perform the extra step of obtaining a "verified" complaint. Further, the boards do not require complainants to provide authorization for the release of their records. Instead, they request records based upon their statutory investigative powers, and if records are not provided they use their subpoena powers to obtain the needed information or records. Because the Dental Board already has the authority to request and subpoena the records necessary to conduct its investigations, it could discontinue the practice of requiring complainants to provide authorization for release of their records.

## RECOMMENDATIONS

1. The Legislature should consider amending A.R.S. §§32-1263.02 and 32-1201 to eliminate the requirement that complaints be "verified."

2. The Board should discontinue requiring complainants to complete an authorization for release of records and instead rely on its investigative and subpoena powers as granted in A.R.S. §32-1263.02.

## Comments On
## The State Board Of Dental Examiners' Response

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The following response was received from the State Board of Dental Examiners. Normally we meet with an agency prior to receiving their response to clarify wording and update data as needed. Because the Board did not accept our offer to meet and discuss the report draft, we did not have the opportunity to identify and make all needed clarifications until after receiving their reponse. We have placed an * within the margins of the Board's response to identify where we have revised our report to update data or address their concerns.

**ARIZONA STATE BOARD OF DENTAL EXAMINERS**

5060 North 19 Avenue, Suite 406 • Phoenix, Arizona 85015

Telephone (602) 255-3696

January 13, 1993

Douglas R. Norton
Auditor General
State of Arizona
2700 North Central, Suite 700
Phoenix, Arizona 85004

Dear Mr. Norton:

This is in response to your letter of December 3, 1992 forwarding a preliminary draft report of the performance audit conducted by your office of the Arizona State Board of Dental Examiners.

Enclosed is the Board's response to the draft audit. Unfortunately, the Board was unable to review the draft, develop a response, and then schedule a meeting with the audit staff. The timing of the submittal of the draft report, directly before the start of the December holidays, did not provide sufficient time for the review and the development of the response by the Board prior to any meeting. Consequently, the response is forwarded in the absence of any discussion of the draft with the audit staff.

It must also be pointed out that, in the opinion of the Board, the report does not accurately reflect the operations of the Board's complaint processing program. While the Board will agree that a backlog of cases has developed, the reasons stated in the audit are inaccurate. Further, we believe that the audit is prejudiced against the Board. Examples that support this belief are contained in the response.

Please feel free to call me at 867-9844 or Mark Steinberg, Executive Director of the Board, if you have any questions or require additional information.

Sincerely,

Ronald J. Peterson

Ronald J. Peterson, D.D.S.
President of the Board

Enclosure

**RESPONSE TO THE PERFORMANCE AUDIT OF THE ARIZONA STATE BOARD OF DENTAL EXAMINERS**

The Arizona State Board of Dental Examiners has eleven members and consists of six dentists, two hygienists, and three consumer representatives. The Board is a citizen run agency. Although members receive modest compensation for each meeting, they spend many hours assisting the Board in a variety of activities as well as preparing for each meeting without any compensation. The Board process is an excellent example of citizen participation in the public's business.

No one would argue with the audit findings that the Board is faced with significant delays in processing and resolving complaints against licensees. However, the major disagreement with the audit concerns the reasons for the delays and the recommendations on the case processing procedures.

The audit report faults the complaint processing system for the delay. This is where the Board strongly disagrees with the conclusions contained in the audit report. It appears that the auditors found the Board's procedures to be unique and, therefore, suspect. The audit recommendations are based, not on facts demonstrated in the report, but on subjective statements unsupported by facts. As such, they have no place in an audit report. The Board's procedures are not at fault and should not be abandoned to be replaced by a staff-based investigative system. The Board previously used a staff-based system that proved to be costly, cumbersome, and ineffective.

The Board also believes the audit report does not reflect accurately its current procedures, staffing, or operations. The report covered a period of major problems, but does not include a period of rapid progress in the management of the complaint processing system. In brief, the audit report was outdated as it was being prepared.

The Board's complaint processing procedures includes the participation of over 120 volunteer dentists from around the state who serve as investigators. This process will be described further in this response. The audit faults the Board, in part, for using this volunteer-based process because other boards do not use such a process. This does not appear to be a sufficient reason to change the Dental Board's complaint investigation system.

In fact, the volunteer-based investigation system is the very core of the Board's operations and could be emulated by other state boards with similar responsibilities. Its strength is its broad based involvement of many practicing dentists who volunteer their time and expertise. The Board does not depend on just one or two state employees. The broad-based professional representation results in the development of an unbiased community standard of practice for dentistry.

In addition, the cost savings of a volunteer-based system are very significant. The state could not afford the costs associated with paying for the services of the volunteers, including the many specialists, that provide their expertise on a regular basis.

The audit was conducted over a four and half month period with the assistance of at least seven audit and dental professional participants. The Board has had less than 30 working days to respond to the draft audit report.

The audit report states that three dentists volunteered their assistance with the audit. It is unclear what the qualifications of these dentists were to evaluate the Board's performance. It did not appear that these dentists were licensed by Arizona or if they had any previous board or peer-review experience. It is also unknown if they had been disciplined by the state in which they were licensed. The Auditor General should provide this information to the Board as part of the audit.

The techniques for conducting evaluations of dental treatment performed by other dentists is not included in the standard training for dentists. There is a certain degree of training required and it is questionable whether or not these non-Arizona licensed dentists had the qualifications necessary to evaluate the performance of the Board or any other dentist. The Board provides training programs to its consultants on dental evaluation techniques, the laws governing dentistry in Arizona, and operations of the Board. The training is given before the dentist evaluates the treatment of others.

The report also relies on subjective statements, not facts to support a recommendation. The audit includes the following statements on Page 18: "some" or "many complainants believe" or "some indicated" or "some licensees felt...." These are subjective statements, not facts. Consequently, they should not be included in the audit as they cannot be compared to the total number of people involved in the process. Further, in the absence of any identification, it is impossible to determine what bias may be included. Beliefs or feelings, in addition, are not facts and cannot be used to determine recommendations. This situation is a clear indication of the bias and inadequacy of the audit.

The audit states that it was conducted in accordance with government auditing standards. The Board requests a description of the specific standards for this report. The report has been reviewed by the members and staff of the Board as well as two independent auditors. It is the conclusion of all reviewers that the report is biased and does not provide an accurate and helpful description of the Board. Further, the report does not describe in a factual manner any pattern of problems. It just states what is obvious: There is a backlog of complaint cases.

**FINDING I - THE BOARD HAS AN OVERWHELMING BACKLOG OF COMPLAINTS THAT WILL REQUIRE ADDITIONAL MEASURES TO ADDRESS**

The first section of the draft report begins with a description of * a case filed with the Board in September of 1990. In the absence of more detailed information, it is difficult to accurately identify the case. However, the case appears to be one where suspension or revocation of the dentist's license was possible. Therefore, as required, the Board forwarded the matter to the Office of the Attorney General for a formal hearing under the provisions of the Arizona Administrative Procedures Act. This hearing has not been held. The scheduling of the formal hearing remains outside the control of Board, but the case is symptomatic of a more general problem.

The Board has experienced ongoing difficulty in obtaining adequate legal assistance from the Office of the Attorney General in a timely, consistent, and accurate manner. There are over 15 cases awaiting the scheduling of a formal hearing by the Attorney General's staff. The Board has repeatedly requested action on these cases, but to no avail. To suggest that the Board is remiss in its handling of the case is not correct.

As previously stated, there is no question that the Board has a backlog of complaint cases awaiting final disposition. However, the reasons for the backlog are not those stated in the audit report. In addition, the Board recognized the problem and is taking "aggressive" measures to expedite the process.

Several factors contributed to the backlog of complaint cases. The contributing factors were related to staffing and administrative problems, not of the process used by the Board to investigate complaints.

During 1990, the members of the Board discovered that the Executive Director and the chief staff dentist were carrying out their responsibilities in an totally inappropriate manner. There were allegations of misuse of funds, nepotism, sexual harassment, and other improper activities. When the involved staff were confronted with the allegations, with the advice of counsel, they resigned.

The draft audit report states that the Board's staff dentist claimed he resigned under pressure from the State Dental Association. This statement does not reflect the reasons for the resignation and is not confirmed by other individuals involved with this matter. Clearly, it is irresponsible for the audit to have included these statements without any collaboration other than a footnote that implies the dentist in question was truthful.

In fact, the Department of Administration investigation referenced in the footnote does not support this inference. The report supports some of the allegations. The self-promoting and unverified statements of a former employee have no place in the audit report.

Following the termination of the dentist involved in the above referenced matter, the Board proceeded to employ a new dentist. Unfortunately, the new dentist experienced critical health problems which resulted in his untimely death. This situation resulted in further delays in the processing of cases and was beyond the Board's ability to quickly rectify. A new Executive Director was hired, however, this individual resigned to return to her home state. Again, this left the Board in a position of not being able to respond in a timely manner until new staff was hired. This is not to suggest that the Board was unaware of the growing problem.

The problems related to staffing are not an excuse, but rather represent the facts the Board has had to deal with. Such problems, unfortunately, are not uncommon, but the impact is more significant when faced by a very small agency such as the Board.

A new and highly qualified staff dentist was hired but was immediately summoned for jury duty and assigned to a month-long trial. Subsequently, a new Executive Director was hired and a number of steps were then implemented to deal with the complaint process and the backlog of cases. This was accomplished with the assistance of the dentist, when he returned from fulfilling his obligations as a juror, and a part-time dental consultant. Additional steps have also been taken to improve the effectiveness of the process. These steps are discussed throughout this response.

The audit alleges that the Board handles "about 40 cases" per Board * meeting. This is not an accurate reflection of the Board's current procedures. At the August two-day meeting, 64 cases were heard. An additional 77 were heard at the October two-day meeting and another 64 at the December meeting. Eighty cases are scheduled for the February two-day meeting. At this rate, the Board can be expected to eliminate the backlog and become current by the fall of 1993.

The draft report alleges on Page 10 that the Board abandoned its computerized tracking system in 1990. Current staff were unaware of the tracking system until the former staff dentist who developed the system came to the Board's offices and tried to obtain additional compensation for making it work. A complaint tracking system was not fully developed. The staff dentist who resigned (and was inappropriately paid over regular compensation to develop such a system) is the only person who claims the system was adequate. It was not adequate and of no use to the Board.

The arrangement for this work was done without the knowledge or authorization of the Board and contributed to the resignation of the then Executive Director and staff dentist. The arrangement was possibly illegal and the work certainly inadequate. It was stopped.

The Board recognized the need for a new automated information system to handle all the Board's needs and one that included a complaint case tracking component. In the absence of such a system, it is impossible to manage its licensure information and complaint cases with any acceptable level of effectiveness.

Consequently, the Board authorized and now has an automated system that allows for tracking of all necessary information including complaints. The basic licensure information component is operational and the necessary historical complaint data is currently being entered into the system. The complete system will be fully operational by March of 1993.

The report states that at the June 1991 meeting the Board dealt with only five cases. This suggests that the Board is lax in meeting its responsibilities. The minutes of this meeting reflect a different story. The Board disposed of four times that number of cases in addition to dealing with a number of other important matters. These other matters included a detailed discussion and approval of policies and procedures on a number of subjects related to the practice of dentistry. *

These administrative matters included regulations for continuing education, the criteria for issuance of a sedation permit, and new complaint procedure requirements. There is more to the Board's duties than solely the disposition of complaints, important as that responsibility is.

The report recommends that three to four additional dentists be obtained by the Board on a temporary basis. The Board agrees that additional professional staff is required. A part-time dental consultant was hired in the spring of 1992. The services of another temporary dental consultant was recently added and another is under consideration for a total of three part-time consultants.

In addition, the Board is considering a reorganization plan to add a second full-time dental position. With an anticipated reallocation of its budget, the Board believes it can cover the costs associated with these staff increases out of its current resources. There is no need for any special assessment as recommended in the audit report.

The Board has also moved to a two-day meeting schedule, in place of its one day meeting, every other month. This enhanced schedule permits the Board to deal with a greater number of cases in a timely manner. There is no need for splitting the Board into separate panels. No valid purpose can be served by this recommendation other than to fracture the process.

The audit recommends quarterly reporting on the complaint process. The Board already reports on an annual basis. The Board will report on a more frequent basis to the Governor and the Legislature on its progress in the absence of any further requirement to do so.

**FINDING II - THE BOARD SHOULD IMPROVE ITS COMPLAINT INVESTIGATION PROCESS**

This finding is the very heart of the Board's complete disagreement with the focus of the audit. The audit report states that the investigation process is hampered by its reliance on volunteers to investigate complaints. Nothing in the history of the Board's operations can support this finding. The audit's statement is an opinion and not a statement of fact.

The following is a description of the Board's complaint handling procedures and the response to the audit findings.

Filing of the Complaint: A complaint filed with the Board must be signed by the patient or a representative and verified. In the absence of this signature and permission to obtain records, the Board would not be able to breach the wall of confidentiality of patient/doctor records and start the investigation. Further, by requiring the verified signature, the Board can be assured that the complaint is being filed by a patient, and not by any unknown person for a purpose unrelated to dental treatment. For example, some individuals have attempted to file against their former employer using the names of patients. By being certain of the identity of the person making the complaint, the Board can protect the privacy rights of the patients and the due process rights of the licensee.

This requirement does not mean that the Board will not investigate a matter based on a phone call or letter without the identity of the person making the contact. The Board has initiated its own investigation and complaints involving drug abuse, mistreatment of patients, and other such matters.

The Board requests the assistance of local or Federal law enforcement officials when the subject of the investigation requires non-dental expertise and involves matters in addition to direct dental treatment.

Clinical Evaluation: The clinical evaluation is conducted when the complaint involves a question of treatment. The evaluation is performed by two volunteer dentists unrelated to the case. If a specialty treatment area is under review, a fully qualified specialist in that area is included in the evaluation team. The audit report is wrong when it states that specialists are not used when appropriate. *

The procedures used during the clinical evaluation are those in use by most dental peer-review programs, other state dental boards, and teaching institutions. They are standard procedures for dental evaluation. It is clear that the auditors do not have any familiarity with the accepted procedures for evaluation of dental treatment. Consequently, they are in error to recommend a different procedure for clinical evaluations.

The purpose of the clinical evaluation is to obtain an accurate and current status report of the patient's dental condition. It is conducted in a manner to avoid any hint of bias. Names are not used to maintain anonymity. Records and x-rays are included when necessary. The audit report is in error when it states that they are not included.

At least two clinical evaluation sessions are scheduled each month in Phoenix at a local dental clinic that is made available to the Board at no charge. Evaluations are conducted in Tucson when required at a local dental office which is also made available to the Board at no charge.

Investigative Interviews: Investigative Interviews are conducted by two dentists, different from those that conducted the clinical evaluation, and a lay person representing consumers. The dentist and the patient have the opportunity to present their case in full. (It is claimed in the report that this is the only opportunity the parties have to present their case. Again, the report is in error. Each party may make a presentation to the Board when it considers the case on the appropriate Board meeting date.)

All relevant records are also reviewed by the three-member panel and questions asked of all parties. Witnesses may also testify on behalf of either side. The audit report states that there is a limit to the time allowed for each party to present their case. This statement, again is untrue. No time limit is imposed for the discussion of any relevant matter relating to the complaint. Each case is schedule for at least one hour. However, some sessions may last 30 minutes while others have lasted for several hours.

The process and time allotted permits a full discussion of the issues, a determination of the facts, and the development of recommendations for consideration by the Board.

The participation of volunteer dentists insures that the process is fair and based on a standard of practice that is accepted by the entire dental profession. The alternative to this community-based approach is to have the Board hire a sufficient number of staff dentists. This system was tried and failed to provide an acceptable procedure in terms of fairness. No one wants state employees making decisions that are best made by independent professionals with the assistance of consumer representatives.

The audit claims that the panels gathering evidence results in a fragmented and inefficient process. No evidence to support this statement can be found in the report. The statement is simply untrue and is a sign of the auditor's dislike of a system they failed to understand.

There is no evidence that a staff investigator would be able to gather any more information or reach a different conclusion than reached by an independent panel. To state otherwise, is an opinion not substantiated by facts. All relevant and available information is included in the investigatory process.

There are some patients who object that they cannot bring up issues and present information that is not under the jurisdiction of the Board or related to the treatment under question. To allow a non-focused process would unnecessarily delay the resolution of cases and add nothing to the proceedings. This is not a requirement solely of this Board, but rather one in use by every agency responsible for conducting investigations. Again, the auditors failed to understand the need to limit discussion to the matters before the Board.

The auditors also concluded, with the assistance of their consultants, there were several deficiencies in the investigations. The Board questions the understanding of the process on the part of the auditors, and their dental consultants.

The members of the investigation panel, and eventually the Board, do not ignore the findings of the clinical evaluation teams. The evaluations are used by the panels and the Board during the review of the cases as one of many factors that must be considered. The process should not be limited to just one factor for the resolution of the case. It seems strange that the report in one part criticizes the Board for not having sufficient information and in another criticizes the Board for considering additional information.

It is also untrue to state that evidence is omitted. Not all information that is submitted by a patient is relevant to the case. If information or material is not relevant, it should not be included regardless of the claims of a patient or dentist.

The Board does not neglect to obtain pertinent evidence, including testimony from complainants and pretreatment x-rays as claimed in the report. The Board does not fail to address the primary allegation of a complaint. The cases presented to support these general findings demonstrate that the process works by allowing the complainant ample opportunity to correct the record by submitting new and relevant information.

The listing of cases should not be included in the report as they are not identified in a manner to permit verification of the description and findings. Further, their selection is questioned. The report states that the cases reviewed were selected on a random basis.

It is of interest that the selected cases appear to be the most high-profile and problem cases under consideration by the Board during the audit period. They clearly do not represent a cross section of the Board's complaint files. It appears their selection was predetermined.

The auditors admit they met with a dozen individuals to discuss the process. The names of the individuals are not provided and the Board cannot determine the outcome of their cases to determine the relevancy of their comments. Clearly, this meeting did not include a cross section of all individuals who filed a complaint. Rather, it consisted of those individuals with a particular bias against the Board. This meeting should have never been held under these non-representative conditions. Audit reports should not base its findings on "some" or "perceptions." To do so is not part of any standard audit procedure.

Suffice it to say that not everybody is going to be pleased with the Board's determinations. Many licensees are upset even when the complaint against them is dismissed. They object to any questioning of their professional abilities and to the time lost from their practice while attending hearings. The Board will proceed with investigations regardless of any individual's feelings to the contrary of the need.

Many patients are upset even when the complaint is upheld. They are unhappy for a variety of reasons which include that the Board cannot award damages like a civil court or punish the dentist with a term in jail. The Board's goal is not to make people "happy." It is to protect the public's health and safety by investigating complaints and taking appropriate steps to sanction a licensee when they fail to meet accepted standards of care.

In an effort to deal with the actual and documented mistakes and problems experienced by patients and licensees with the process, the Board has increased its training programs and case review procedures. This will insure that the case files are complete and handled in a proper and timely manner.

The auditors recommend that the Board revise the complaint processing procedures by eliminating the volunteer panels and rely on trained staff. This recommendations assumes that the volunteers cannot perform as adequately as staff dentists. However, no documentation or facts are presented in the audit to support this statement, and the cost would be substantial. It is a conclusion based on a preconceived opinion. The current procedures of other Boards are used to support the opinion.

A careful review of the complaint processing procedures and outcomes of the other Boards demonstrates that they are experiencing delays as well. The reasons for the delays vary from Board to Board and are unrelated to the procedures utilized. What works for one health board may be totally unrealistic for use by another board. The review of dental care is different from that used to review nursing care or medical care.

For the great number of cases received by this Board, the treatment under question is a physical reality subject to review by trained dentists. The very nature of dental evaluation cannot be turned over to non-dentists and there is no need to create some new mid-level of state employees to do what is unnecessary. The volunteer dentists are effectively performing the evaluation function.

The auditors also claim that the removal of the investigative interview panels would remove dissatisfaction and poor perceptions on the part of patients and licensees. No fact or documentation is presented to support this conclusion. It is an opinion based on the statements of a few consumers who have not had their cases upheld or dentists who have been sanctioned. Unsupported opinions have no place in an audit.

The investigative interview allows a full discussion of the complaint by all participants. The resulting recommendations are submitted to the Board for consideration in its deliberations. The outcome of any particular case may not be to the liking of the dentist, the patient or both, but it is most often the correct outcome based on the facts available to the Board. A careful review of the Board's decisions by qualified and unbiased professionals will support this position.

**FINDING III - THE BOARD NEEDS TO STATE STEPS TO ADDRESS PROBLEM DENTISTS AND IMPROVE ITS MANNER OF DELIBERATING COMPLAINT CASES**

The Board has consistently recognized the need to take action against dentists who violate the dental statutes. Its record on this matter is clear. During the audit period of 1990-91, the Arizona State Board of Dental Examiners had the highest percentage of cases resulting in some form of disciplinary action in the nation. No State had a higher rate of actions against licensees who fail to meet accepted standards of dental care. The Board now stands third in the nation among all state dental boards.

This record is clear and demonstrates the seriousness with which the Board carries out its responsibilities. To state otherwise is again, an opinion that cannot be supported by facts.

The Board has and continues to deal with repeat offenders with every resource at its disposal. As stated earlier in this response, the Board has forwarded to the Office of the Attorney General over 15 cases for the purpose of conducting formal hearings. These cases were forwarded for Formal Hearing because revocation of the licenses was requested by the Board.

The Attorney General's office has not scheduled these hearings after repeated requests to do so by the Board. This failure is not acceptable to the Board. Consequently, the Board is entering into an interagency agreement with the Attorney General's office to provide the Board a full-time Assistant Attorney General to be assigned to the Board. The Assistant Attorney General will carry out various duties on behalf of the Board. These duties will include the holding of the Formal Hearings on an expedited basis. The Board will pay for these services out of its existing budget.

The chart contained in the audit report on Page 22 presents information on the complaint process. This chart is a gross oversimplification of the status of unidentified cases. Therefore, there is no way the Board can respond in detail. The information in the chart is not significant. The cases that are presented on Page 23 also do not present an accurate description of the status of cases handled by the Board.

The audit states that recent court rulings have questioned the Board's deliberation process; however, the report does not identify the cases they referenced. The Board's actions are based on the legal advice provided by the Assistant Attorney General assigned to the Board.

During the last 2 years, the Board has been subject to frequent changes in the assigned staff. This constant rotation has resulted in inconsistent and poor legal assistance which sometimes has left the Board in a precarious position. The agreement to obtain full-time legal counsel will correct this situation in an effective manner.

The actions taken in the cases listed on Page 24 were based on the advice of the legal counsel then assigned to the Board. This lack of adequate legal counsel has been addressed above. The cases should have been listed in a manner that would have permitted the Board and its counsel to verify the audit's description of the case.

**FINDING IV - CURRENT REQUIREMENTS DISCOURAGE COMPLAINT FILING**

The audit claims that the complaint filing procedures are unnecessary and burdensome to the public. This statement is not supported by any facts and is the uninformed opinion of the auditors.

The Board requires that all complaints be signed in the presence of a notary public or a Board employee. This is not a burden, but it does insure the accuracy of the identity of the person filing the complaint.

The Board also requires the patient's permission to obtain records. With the identity certain, the Board can obtain records without violating a patient's right to privacy. The Board has reason to believe that this procedure goes a long way to eliminate the possibility that the privacy rights of patients are violated based on the filing of an improper complaint.

The assurance that the complaint is valid also protects the due-process rights of dentists. The filing of a complaint and the resulting investigation would violate the right to due-process if the complainant is not the actual patient but some other individual attempting to harass the dentist. The Board understands its obligation to investigate complaints and that to treat the dentists in a fair manner that recognizes their rights.

The problem identified on Page 28 of the audit is not sufficient grounds to eliminate the protection that the current procedure affords the dentist and the public. Further, the case cited has nothing to do with the alleged problem. The family submitting this case was requested to file a complaint for each case.

This procedure is standard practice in all such investigations and permits a full investigation, including the collection of all records for each patient and a resolution of each problem on its own merits. The audit finding is mere speculation unsupported by any facts.

The audit reports that other health boards do not have similar requirements. This statement is true. They do not for the reasons previously stated. The audit offers nothing to support that any change in the Board's procedures will result in a different outcome for any one or group of cases.

Again, the recommendations are based on the feelings or opinions of the auditor. They are not based on any facts and must be considered irrelevant to the audit.

**CONCLUSION**

The Arizona State Board of Dental Examiners, its staff, and consultants have carefully reviewed the draft audit report. It agrees with the conclusion that there is a backlog of complaint cases awaiting review by the Board for final disposition. However, it strongly disagrees with the findings and recommendations contained in the audit.

The Board has concluded that the audit is based on speculation and opinion, not on supportable facts. Further, the Board believes that the auditors have a strong bias against the Board's procedures and attempted to discredit them in the absence of any factual basis.

The Board has implemented a number of procedural changes to expedite the processing of complaints. The Board has increased the number of clinical evaluation clinic nights to at least 3 per month. Investigative interview panels now meet on an average of 2 times per week to dispose of as many as 14 cases per week. The Board now meets for 2-day meetings every other month, in place of its one day meeting. The Board will deal with as many cases as necessary to reduce the backlog and keep current with the new cases that are filed. In addition, the Board will have the assistance of adequate legal counsel to avoid legal problems and deal with each case in the proper manner.

All of these steps, plus many others, are permitting the Board to deal with cases in a timely manner. This will go a long way to reducing the frustration that many feel when they face delays they should not have deal with.