[JACD18b: Forum – Disciplined licenses]

Disciplined Dental Licenses: An Empirical Study

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Abstract
The records of 255 dentists with recent disciplined licenses for four states were read and various characteristics were coded. These were compared with 196 randomly selected records of dentists without disciplinary actions. Disciplinary actions were about evenly divided across those stemming from technical irregularities (principally diagnostic bad practice), mismanagement of patients such as overtreatment, and drug use, DUIs, felonies and other personal issues. Disciplinary issues were significantly underrepresented among younger dentists but overrepresented among those with multiple offices and fictitious business names. Dentists practice in communities with higher median household income, but those with disciplined licenses are more prevalent in low-income communities. Rate of discipline, sanctions, and access to records varied widely across states. Although there was a slight tendency for dentists with disciplined licenses to not be members of the ADA, this may be a result of those with disciplined licenses to distance themselves from the organized profession. Complaints come from patients and law enforcement and not from dentists or benefits carriers. Dental licensure is a state issue, under the management of departments such as consumer affairs, and because a small number of bad actors damage the reputation of the entire profession, organized dentistry should engage as partners with those responsible for regulating licensure. [End of abstract]

This project is intended to describe the mechanisms used by state departments of consumer affairs, or agencies with different names but similar responsibilities, to ensure the safety of the public with respect to licensed dentists. Although dentists are expected by their colleagues and by the public to adhere to a higher standard of care, called professionalism, they are licensed and regulated by states to conduct a business that meets minimal commercial standards for public safety. Investigation and enforcement of behavior that does not meet these standards may result in revocation or conditions placed on dentists' privilege to conduct business in the state. Licenses can be maintained only under conditions set forth in state regulations, and curbing of these privileges in proper fashion is referred to as disciplining a license. State dental boards operate as agents of executive branches of government and must, according to the most recent interpretation of the United States Supreme Court, function within that structure. [1]

Procedure

This project is empirical, in the sense of describing representative behavior that has led to disciplined licenses and their consequences. It is not meant to comment on whether these mechanisms are just or whether they function well.

Disciplined licenses were investigated in four states: California, North Carolina, Ohio, and Oklahoma. These states have participated in the ACD Gies Ethics Project in other respects, such as having had focus group of dentists, dental leaders, and patients provide opinions about professional ethics generally.

An attempt was made to access all records of disciplinary actions arising during the 24-month period September 2015 through July 2017. In most states a list is maintained by profession of practitioners whose licenses are under investigation for possible inappropriate commercial behavior. These lists are online under the various state agencies, such as the dental board of the state. Cross-links are provided to sites where various demographic information about the licensee is given, along with further links to documents containing the accusations and actions taken against the licensee, as well as amendments and appeals. The records of disciplinary action contain the name of the practitioner, but the identities of patients are protected, usually by using initials. Such records are public, and may be required by law in all states to be made available to the public as a means of facilitating the public's participation in their own safe seeking of care. This information was available online in California and North Carolina. It was not available directly to the public in Ohio or Oklahoma, but personal appeals to those in responsible positions in those states did produce what is believed to be a full record of the disciplinary actions taken there during the time period studied.

The disciplinary documents are multiple and lengthy. They contain a good deal of boilerplate, such as establishing the authority of the board to take action in specific cases and affirmations that the practitioner is a fully informed and competent participant in the process. The narrative description of the case is detailed, often containing dates and dosages of medications and technical description of clinical findings and procedures. When multiple patients are involved, these descriptions can run well over 20 pages. In situations where a court case is involved, as in public assault or DUI, the summary court ruling is incorporated. The action taken by the board is contained in a separate document from the accusation, and usually follows after several months of investigation. Appeals for shortening of probationary periods may also be included in the documentation. Much of the content of the action is also standard. In the case of revoked but stayed licenses, the conditions can number more than a dozen and often occupy as many pages. Demographic information, such as year of initial licensure in the state, special permits, zip code, fictitious names, etc., are contained in the records or can be found on the Web paths leading to the records.

The process for capturing data was as follows. Six months of records were retrieved and reviewed. Based on this reading a 26-item scoring sheet was created. Eight new months of records, just over 50 cases, were coded, and some adjustments were made in the scoring form. Finally, 255 records were reviewed in their entirety, some multiple times, and were read and scored. The results were entered into a database on an Excel spreadsheet for analysis.

A question arose regarding the economic level of patients treated by dentists with various types of disciplined licenses, as well as those treated by dentists who had no disciplinary actions against them. The analysis described in this paragraph was conducted only for California dentists because, compete data of the type required were only available for that state. Software was used to determine the median household income of individuals living in the zip codes where the dentist had his or her office. [2] (When multiple offices were listed, one address was chosen at random using a shuffled deck of cards.) Because a comparison was to be made between dentists with disciplined licenses and those without, a mechanism was needed to sample the incomes of patients in zip codes of dentists generally. Dentists are given license numbers sequentially by date of initial licensure. For each dentist with a disciplined license, a match was found for an undisciplined dentist by advancing the identification number by one until a match was found of an undisciplined dentist actively practicing in the state. This procedure had the added advantage of matching the two samples by age since numbers are assigned sequentially by date of licensure.

The entire sample contained 255 dentists with disciplined licenses and 139 with no disciplined license.

Type of Commercially Inappropriate Behavior

Disciplinary actions were classified as being (a) technical in nature (faulty diagnosis or treatment), (b) involving practice management (overtreatment, poor records, patient abuse, unlicensed practice), or (c) personal (impairment due to alcohol, drugs, or cognitive function and criminal activity such a tax evasion).

Table 1. Characteristics of disciplined licenses by type of inappropriate behavior

Behavior	Technical	Practice Management	Personal
N	86	98	71
Diagnosis	64%	27%	4%
Treatment	65	25	4
Overtreatment	9	38	3
Case management	24	20	0
Incomplete records	42	26	3
Informed consent	27	16	1
Overbilling	7	39	6
Abandonment	0	6	1
Unlicensed practice	1	20	1
Overprescribing	0	13	7
DUI	0	1	18
Drugs	0	4	32
Cognitive impairment	0	0	17
Sexual misconduct	0	1	13
CE/Paper work	1	4	20
Other crimes	0	3	14
Deaths	7	1	0
Multiple patients	17	33	11
Court records	0	18	38
Out-of-state	1	0	10
Repeat offenders	7	10	25
ADA membership	40	37	35

Technique Problems [second-level heading]

One-third of the disciplinary cases were classified as technical, being principally matters of poorly performed dental procedures. The most prominent faulty behaviors was incomplete diagnosis, including performing periodontal procedures without recording pocket depths, extractions with incomplete records, failing to take diagnostic radiographs, overlooking patients' medical conditions, incorrect design of implants, and performing restorative work with no

characterization of the disease condition. Some technical faulty behavior involved inadequate performance of the procedure. Here, issues included removing the wrong tooth, poorly aligned implants, ill-fitting dentures, and poor technique during surgical procedures. One or both (diagnosis and treatment) were involved in all cases of misconduct classified in the technical category.

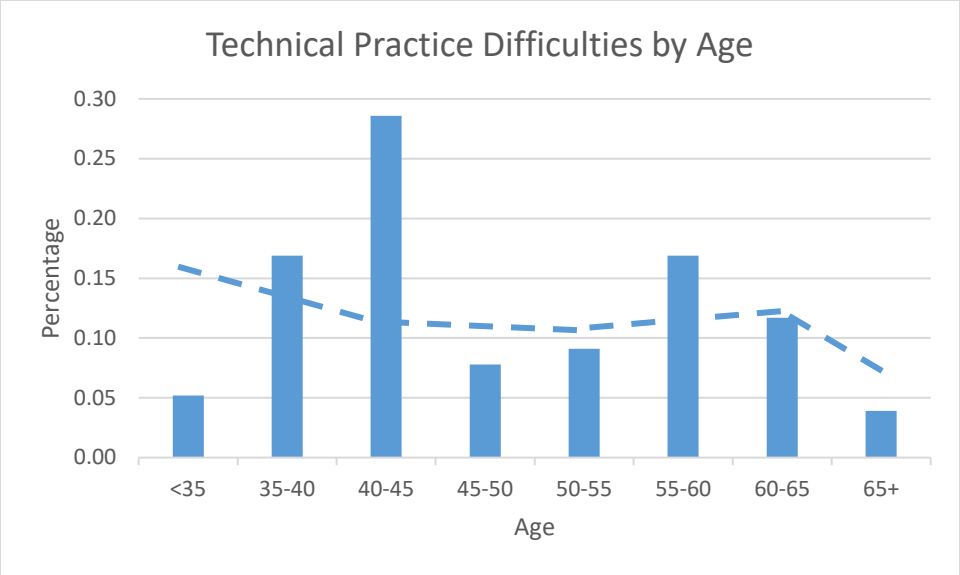
There was a single case reported of an open margin and another of incomplete root planning. The impression was of "piecemeal" care, or procedures performed out of sequence rather than of technical incompetence. In some cases it was clear that dentists just did several procedures because they seemed convenient. Much of the "incompetence" might better have been described as deviation from comprehensive patient treatment.

There were three secondary faults that often accompanied technical difficulties. These included poor case management, incomplete records, and lack of informed consent. Case management refers to sequencing and monitoring of patient progress between treatments or following surgical cases. None of the seven deaths recorded in this sample occurred in the dental office or immediately after treatment. They followed dismissal and were associated with improper case monitoring. Incomplete records were consistent with the advantageous nature of treatment planning in this category. Failure of informed consent followed the same pattern of appearing that the dentists modified procures and treatments "on the fly."

The records are insufficient to know who registered the complaint, but the narratives in cases in the technical quality category support an impression of being patient-initiated. These appeared to be patients who were dissatisfied with both the care received and the way in which the dentist managed the complaints. Typically, they involved repeated office visits and responses that were deemed below the standard for commercial transactions. In about one in six cases, a pattern was discovered either among the complaints or by investigators involving multiple patients.

There was no association between ADA membership and disciplined licenses due to technical issues compared with other types of misconduct, chi-square = 1.449. Penalties for problems of a technical nature were much lighter than for cases involving practice issues or personal issues. Sixty-six percent of technical cases resulted in license revocation or stayed revocation. When the matter was for other reasons, 82% of cases resulted in revocation or stayed revocation (chi-square = 14.376, $p < 0.001$). In other words, technical shortcoming were not considered to be as blameworthy as other faults committed by dentists.

The figure below shows disciplined licenses for technical matters by age. There are two peaks in this curve: one for practitioners in their early forties and another in the late fifties. The dashed lines represent the distribution of active dentists in the United States by age. Where the columns are above the dashed line, this represents a concentration of technical license difficulties in these age categories. Dentists under 40 years of age are marginally less likely to practice at a technical level that causes concern. Chi-square = 2.381, $p = 0.080$.



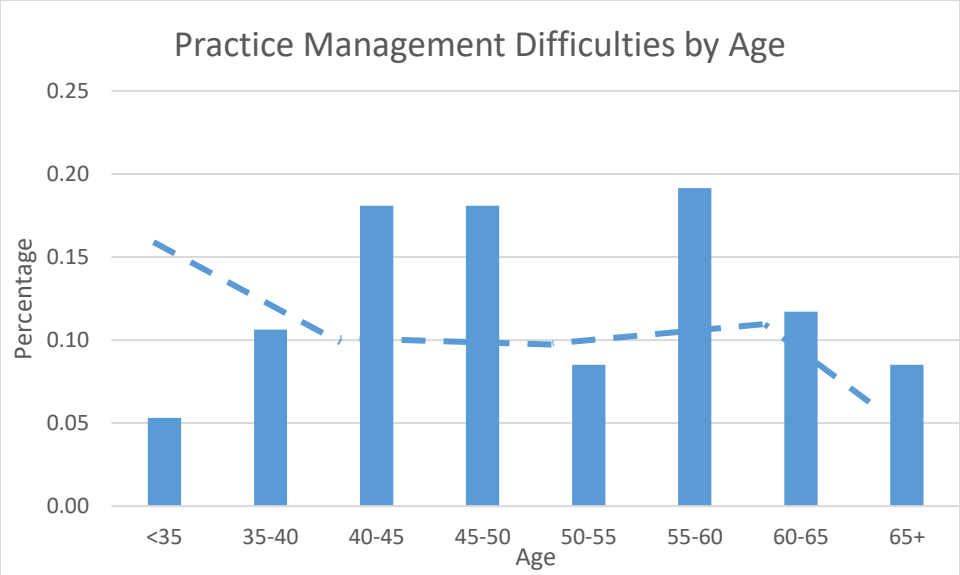
Practice Management [second-level heading]

Thirty-seven percent of the cases were classified as principally involving practice management, the most common type of disciplinary problem. Issues here included overtreatment and overbilling. Common parts of this pattern were poor case management, incomplete records, and care provided by unlicensed individuals. Less frequent, but still part of the picture were failure to inform the patient of treatments performed, prescribing unnecessary controlled substances to patients, and patient abandonment.

The difference between the treatment and practice management categories is a judgment call, dependent on the overall patterns of complaints in the disciplinary records. Practice management cases involved multiple appointments and featuring overtreatment, overbilling, and performing work the patient had not been informed of. Although there were cases of diagnostic and treatment issues, these were not major concerns, and it appeared to be the case that three-quarters of practice management issues did not entail technically deficient dentistry. The impression was that dentists in this group were pursuing their own economic interests rather than patient oral health goals.

There was little overlap between patient management problems and general problems such as impaired dentists. This category did, however, have a tendency for a habit or pattern, with one-third of the cases involving multiple patients and 10% of the disciplinary actions being repeat offenders.

There was no association between ADA membership and engagement in practice management types of poor practice. Chi-square = 0.354, NS. However, dentists judged guilty of such poor practices were penalized by having revoked or revoked and stayed licenses almost three time as often was were those involved in technical matters. Chi-squared = 12.213, p = 0.007.

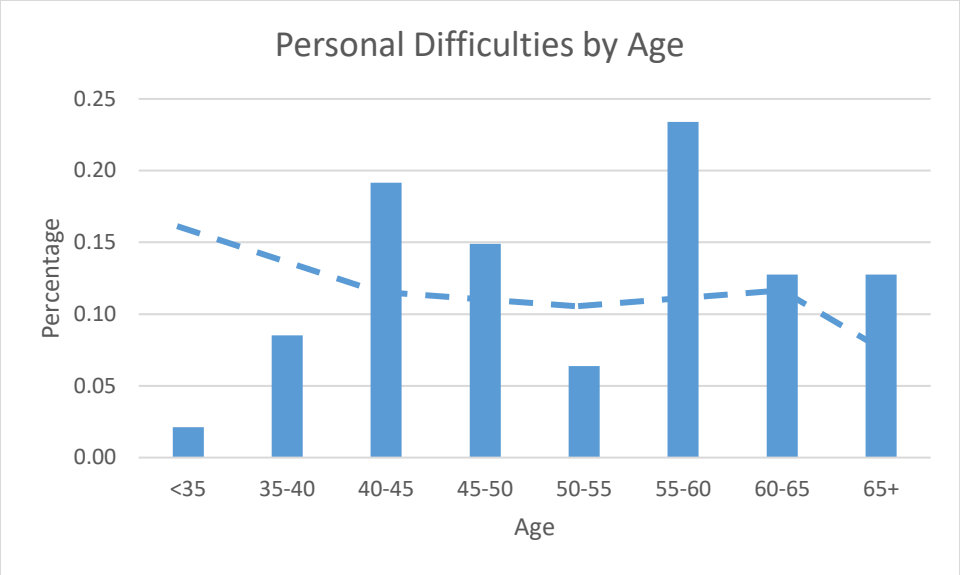


The figure above shows the distribution of problems with practice management categorized by age of practitioner. The most conspicuous trend is that young practitioners (under age 40) are underrepresented. Chi-square = 8.180, p = 0.004.

Personal [second-level heading]

Just over a quarter of the cases involving disciplined licenses were classified as personal issues. These generally involved problems outside the dental office. The most common problem was use of drugs by the dentist. Other common impairments included alcohol use, generally identified in DUI convictions, and cognitive challenges. Sexual misconduct was reported nine times. Other crimes included spousal abuse, tax evasion, and impersonating a state dental board officer for the purpose of harassing fellow dentists. There were two cases of Medicaid fraud. Also included in this category were "paper work" violations, such as being short on CE hours or filing transfer papers from other states after the deadline. Cases in the personal category were often supported by court records. There were usually multiple infractions, and one-quarter of the individuals in this category were repeat offenders for the same offence. Difficulties in this category tended to be independent of technique or practice management issues.

Dentists with life issues were marginally less likely to be ADA members, chi-square = 3.574, p = 0.06. They were also more likely to receive light penalties chi-square = 20.478, p < 0.001. A public reprimand was more common than having the license revoked. The strongest penalty (revoked license) was, in most cases a voluntary surrender of license taken by very senior practitioners.



The accompanying figure shows that personal difficulties leading to disciplined licenses are clearly associated with age. Older practitioners are much more likely to be impaired by using drugs and alcohol and to have committed crimes. Chi-square = 15.735, $p < .001$.

Practice Environment of Dentists with Disciplined Licenses [first-level heading]

While it is impossible to assemble a detailed picture of the circumstances surrounding the disciplining of dental licenses from public records, there are two types of information that provide some insight. The zip codes where practices are located and whether dentists have multiple offices and fictitious business names are part of the public record.

The table below shows the average income of all individuals living in the zip code where California practices were located in 2015. The median household income in California in was $61,818. The chart below shows that dentists provide more services to patients in locations with higher average incomes. The concentration of dentists in more affluent communities is statistically significant at $p < .001$ for all categories except dentists who have licenses disciplined for practice management reasons. This includes overtreatment, overbilling, and lack of comprehensive care. Poor quality technical work – improper diagnosis or faulty treatment – was slightly more likely to be experienced by poor patients, but not as common as taking advantage of patients by misleading treatment. The differences just summarized are statistically significant by a one-way ANOVA at $p < .001$. Both Schaffé and Duncan multiple range tests identified the same clusters of dentist types: Practice management problems formed one group, clean practitioners and those with personal problem formed another. Dentists with disciplined licenses as a result of technical problems shared some of the characteristics of each group.

Table 2. Median household income in zip codes of dentists with various characteristics of disciplined licenses and percentage having multiple offices and fictitious business names.

	N	Mean	SD	Mult Off	Fict Name
No discipline	139	$79,094	$29,939	0.146	0.254

Technical Faults	83	67,361	25,471	0.276	0.395
Practice Management	88	61,924	24,575	0.392	0.667
Personal	51	80,478	20,717	0.421	0.421

This pattern was repeated with respect to having multiple offices and a fictitious business name. The historical family dentists was known by his or her personal name, had an established and long-term location, and waited for patients to come for care. Those with disciplined licenses of all types were more than twice as likely to have multiple offices and much more likely to use a fictitious business name. This was especially noticeable in the case of dentists whose licenses were disciplined for such behavior as overtreatment and overbilling. The chi-square test found that these differences were statistically significant beyond $p < .001$.

It was not possible to determine from the case narratives or other records which dentists were employees, associates, or independent contractors, itinerate or otherwise.

Membership in Organized Dentistry

Dentists with disciplined licenses are somewhat less likely to be members in the tripartite structure of organized dentistry. The online ADA directory of members was searched by name (with cross-checks for state and first name) and membership was recorded. Overall, 39% of dentists with disciplined licenses were members of the ADA when the data were checked. This is significantly less than the 65% current ADA membership for active dentists. Percent membership by type of disciplinary action, considering only California and North Carolina, was technical = 44%, practice management = 42%, and personal = 29%. Membership in both California and North Carolina is 67%.

There is some uncertainty in these numbers. For example, only one of the 45 dentists with North Carolina disciple licenses were found in the ADA online membership registry. Staff at the North Carolina Dental Association performed a hand check of their records for the past five years. This search revealed that 15 of the 45 disciplined licenses were for dentists who had been members of organized dentistry during the past three years, and that four dentists listed as members of organized dentistry in North Carolina currently were not in the ADA database. It is possible that the data reported here understate the proportion of dentists with disciplined licenses who are members of organized dentistry.

Another possibility is that dentists withdraw from organized dentistry when they are under investigation or that states de-list dentists who have disciplined licenses. This would be in line with the fact that dentists who have experienced personal issues are less likely to be ADA members. Those with revoked or surrendered licenses often retire or move to other states seeking to begin a new career. As a follow-up exercise, 100 dentists from the pool of disciplined licenses were sent a customized letter containing a very short survey of attitudes toward ethics. Twelve of the 100 were returned because of a “bad address”; none of the dentists with disciplined licenses responded to the ethics survey. It is easier to defend the notion that dentists who have problems in practice pull away from organized dentistry than the alternative that organized dentistry prevents dentists from engaging in unprofessional behavior.

Sanctions

In the table below are listed the sanctions given for each of the types of professional misconduct. Reprimand or public reprimand is a finding of misconduct with no further sanctions against the practitioner other than the fact that the public can locate and read the matter, either online or by requesting documentation of the state dental board. Nineteen percent of the cases reviewed resulted in reprimands. Suspension is seldom used (5%) and involves prohibition from practice for a stated period of time, often with no other requirement, except perhaps for court costs. In Ohio, there were a number of cases of 14-day suspensions, including a case involving a death.

Stayed revocation, the most common penalty (46%), is the board's attempt to rehabilitate dentists. Dentists are prohibited from practicing during this period that may last from one to five years. Multiple requirements are imposed, such as closing one's office and having minimal contact with patients (as in charity work or teaching). Dentists must also notify others, such as representative of other boards if the dentist moves to another state, and obey all laws (generally), inform the board of changes of address, and arrange for transfer of patients. Ethics courses, remedial course work, psychological evaluations and biological testing and monitoring are typically required to address specific issues. Court costs and costs of monitoring are normally included, and sometimes community service is expected. Failure to adhere to any of these requirements, especially not complying with monitoring in the case of substance abuse, can result in removing the stay and having the license permanently revoked. A revoked license means the dentist can no longer practice, absent a successful appeal for reinstatement.

Table 3. Likelihood of various sanctions by type of professional misconduct.

	Reprimand	Suspension	Revoke-Stayed	Revocation
Technical issues	44%	0%	38%	18%
Practice management	12	11	56	25
Personal	5	3	44	47

The table above shows the association between type of misconduct and actions. Faulty diagnosis or treatment of the technical type most typically result in public reprimands. Practice management issues such as over treatment, overbilling, prescribing drugs for patients, or otherwise failing to render continuous comprehensive care in the patients' best interests is most likely to result in a stayed revocation of the license. Personal issues such as crimes or substance abuse and impairment lead to revocation, with stays in about half of the cases. This category also includes voluntary surrender of one's license. Often, older dentists or those with severe impairments retire or move to other states.

Identifying Issues

The records do not contain sufficient information to classify or even characterize factors that initiate disciplinary inquires. Although state dental boards say that they are "complaint driven," it is unclear where these complaints come from. The information below is anecdotal.

It is usually said that complaints come from patients. Because of limited resources, the investigative branch of the departments of consumer affairs usually focus their investigatory

efforts in response to multiple complaints about a dentist. The case reports of unprofessional care of a technical or practice management nature involved descriptions of mistreatment of more than one patient in 40% of the cases. Complaints from fellow dentists and from office staff are rare to unheard of.

There are no national reports of the system for monitoring dentists against state practice acts. In 2006 the U. S. Department of Health and Human Services published a study for the medical field. [3] There is wide variety among the states examined. Of complaints received, 14% were not followed up because there was no jurisdiction and 65% were not followed up because of insufficient evidence. Nineteen percent were settled or dropped and 2% went to hearing. The investigator and prosecution coast of disciplining a license was generally between $50,000 and $100,000.

There are several sources of information about unprofessional conduct that come automatically to state dental boards. One involves the board's own procedures. Failure to meet CE hours or irregularities in applications are known immediately. There were several such cases in this dataset. Other routine sources of information about misconduct involve other governmental agencies. It is federal law that deaths must be reported to professional boards if a professional is associated with the case. There were seven such examples in this dataset. Another case of mandatory reporting is state statues regarding felonies. This typically involve DUI convictions for repeated offenses, dispensing of drugs, and criminal matters such as aggravated assault. There were 44 such cases in this dataset. Together, about a quarter of incidents in this study would have been unavoidable knowledge to the boards.

The relationship between insurance companies and boards is unclear. Carriers have vast amounts of detailed knowledge regarding treatment and billing patterns, activities that bear on the practice management category of professional misconduct. Careful reading of the narratives left the impression that problems of this nature were initiated only by patients, disgruntled over what they regarded as unfair billing. There have been reports that insurance companies prefer to manage practice management issues themselves as commercial rather than professional matters. When patterns of inappropriate behavior are detected, carriers contact the provider and threaten to terminate the contract unless the behavior stops. There were only two cases reported here involving prosecuted Medicaid fraud, and those involve the government.

It is also unclear what the relationship is between malpractice actions and disciplined licenses. Malpractice is a civil action (a harm to a specific person) whereas licenses are disciplined involving damage against the public. It is unknown whether carriers or courts alert dental boards of actions or whether boards feel inclined to follow up on such matters.

There is also a somewhat parallel disciplinary track involving organized dentistry. Virtually all states have a mediation mechanism for disputes between dentists and patients called peer review. This mechanism is available only to members of the tripartite structure, and the issues typically involve disputes over fees. Generally, it is a condition for participation in this process is that information disclosed or discovered in peer review is not available to malpractice attorneys or to state dental boards. A few states have a judiciary function through a committee of the state dental association for independently investigating and sanctioning members who have been discipline by the state dental board. The grounds for such action are the code of professional conduct (enforceable) language in the state's ethical code. Independent fact finding and hearings are possible, and continued membership in organized dentistry may be revoked or conditioned.

Differences across States

There are significant differences across states in their enforcement of professional conduct. The table below shows the number of disciplinary actions taken per 1,000 licensed dentists.

Table 4. Disciplined licenses per 1,000 active dentists.

	Dentists	Action/year (per 1000 dentists)
California	20,150	5.25
North Carolina	3,241	6.94
Ohio	4,131	1.09
Oklahoma	1,306	1.15

The two states with low percentage rates of disciplined licenses are likely the result of different investigatory and enforcement standards rather than the level of dental care provided. For example, of the 12 total cases in a two-year period in Ohio and Oklahoma combined, ten of them were unavoidable by the board, including court actions, patient deaths, or board paperwork. Only two cases resulted in licenses being revoked. Neither state supports a computer verification for patients to check on the status of their provider. The records used in this study were obtained by direct contact with officers in the states. One of the officers in the board of dentistry explained that the state budget has been severely cut and that only those cases involving drugs or deaths were given priority.

Seventy percent of problems with cognitive impairment of practitioners were identified in North Carolina, a state that had only 17% of the dentists in this sample. This is most likely the result of the state's contracting with the North Carolina Caring Dental Professionals Program.

Reflections

This report will not contain recommendations. This is a field of study where very little is known regarding trends that policy would be premature. However, it is possible to offer a few reflections.

First, this is an understudied area. Although certain types of information are available as public record, even that is sometimes difficult to access. Cost of investigation and enforcement and litigation are chilling factors. It may also be the case that the profession is slightly reluctant to shine a light on the less exemplary aspects of dentistry.

State dental boards deserve respect and appreciation form both the public and the profession. They volunteer to engage in difficult work. The responsibility for commercially inappropriate behavior by dentists should extend to more than this small number.

Secondly, bad behavior is a process. The age and zip code income data combine to paint a picture of dentists who grow into inappropriate habits. It is indefensible to characterize dentists who engage in commercially inappropriate behavior as "born bad," or "bad by nature or nationality," or even as becoming bad by taking a one-time conscious decision. As one colleague who has reviewed the data remarked, "It seems to take a number of years for them to learn how to become dishonest dentists."

There seems to be support for the view that dentists "learn" either good or bad habits and perfect them over time and that practice circumstances interact with care patterns. To the extent that this is true, there is an imperative in the entire profession to interact with all its members, not just those who share similar values. Physical isolation and psychological distancing – "they are just the uncorrectable bad ones, end of story" – are not the answer. If they can learn bad habits, they can learn good ones as well.

As a third point, it may be unsound for the leadership of organized dentistry to shun the small number of unprofessional practitioners. If there were two classes of dentists – the good and the bad – the age curve for disciplined licenses would have a spike as soon as practitioners were allowed to function independently. Instead, young practitioners are underrepresented among the bad actors. The two peaks correspond with the Baby Boomer and the Gen-X generations, although may be a confounding with stages in dental practice. The younger of these groups is concerned with practice debt (not educational debt) and the older group contains many superannuated practitioners who have extended their careers to a point that involves increasing life challenges and more limited capabilities. The fact that dentists without disciplinary actions treat populations that are almost 30% wealthier than the population at large gives them some cushion for freedom of behavior that those engaged in overtreatment, overbilling, and other shady practices do not enjoy.

In the fourth place, the reputation of dentistry, which is tarnished by some, cannot be controlled by the profession at the national level. The ADA Code of Professional Conduct applies to the voluntary members of that organization and penalties for violating the code extend only as far as discontinuing membership. Dental professionals, per the ADA code are urged to belong to a professional association, but there are alternatives. Licensure is not controlled by the profession, but by branches of state government charged with ensuring a level playing field between providers of all services and those they serve. This process exists at the state level, and there are notable differences across states, even in the case of dentistry. The profession must partner with a number of autonomous organizations to elevate the level of care provided to the public.

Finally, dentists are human. In any population there will be a range from the outstanding to those who are having difficulty leading the kinds of lives we all take aspire to. Most of those who read this report will find it difficult to relate to the world of dentists with disciplined licenses. For that we should all be grateful. This report focuses on a very small segment of the profession, but its size and strangeness should not be an excuse to ignore it. Both patients and the dentists themselves are hurt by the behavior described in this report. Large segments of the public see this behavior, and not knowing otherwise, mark this as the way dentists behave. About one-third of the American public, according to the Gallup poll do not trust dentists to have their (the public's) best interests at heart (http://news.gallup.com/poll/1654/honesty-ethics-professions.aspx). This is the lowest level of public trust of any of the health professions regularly surveyed.

The profession has more conspicuously engaged indirectly with this issue at the policy level than through direct action by individual dentists being proactively involved with their colleagues or by reporting unprofessional behavior. This is an issue for the entire profession, working with others.

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[1] https://www.acd.org/_jacd/JACD-84-2.pdf

[2] https://www.incomebyzipcode.com/

[3] aspe.hhs.gov/basic-report/state-discipline-physicians-assessing-state-medical-boards-through-case-studies