District of Columbia
DENTAL SOCIETY
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Testimony before the Council of the District of Columbia

Committee on Health

Hearing on the Dental Specialties Licensure and Scope of Practice Amendment Act of 2023

July 10, 2024

Kurt Gallagher, CAE
Executive Director

Good morning Chairperson Henderson and members of the committee. My name is Kurt Gallagher and I serve as executive director of the DC Dental Society. Today I am testifying on behalf of our more than 400 member dentists who care for the oral health and well-being of the members of the District community. I expect to be joined by several dentists this morning. I would like to note that because dentists book their calendars months in advance, it may not be possible for all to testify who intend to do so.

Thank you for holding this hearing today, because it provides an opportunity to explain why DCDS is opposed to a provision of the Dental Specialties Licensure and Scope of Practice Amendment Act of 2023 that would establish a license for specialist dentists that is contingent upon achieving and maintaining board certification. In addition to this opposition, near the end of my testimony I will address several provisions of the legislation that DCDS does support.

I understand the DC Health will offer amendment language to establish an alternate pathway for licensure for dentists who have "successfully completed a[n accredited] dental specialty residency program." We support the insertion of this language to expand eligibility to all specialist dentists who have completed an accredited dental specialty residency program, not only those who have attained and maintain board certification. Such language should be inserted into the bill in two locations:

- In Sect. 508c(c)(2)(A) (after line 78)
- In Sect. 508c(e)(2)(B) (after line 100)

We are optimistic that the legislation will be amended to recognize as a specialist all dentists who have successfully completed an accredited dental specialty residency program, which includes many who have served District residents for years and decades. I would like to take a few minutes to reiterate why DCDS is strongly opposed to limiting specialist licensure to only those dentists who have achieved and maintain board certification. I will provide a brief overview, as I have attached to this testimony our letter of June 11 that was sent to this committee that provides in-depth comments. The list of dentists who signed the letter has grown to more than 130 dentists who serve the DC community.

As the committee considers this legislation, I would like to pose a fundamental question: why are we considering this proposal to require specialist dentists to obtain a license specific to their area of specialization? I pose this question because, as I learned while preparing this testimony, this approach is very different from how the District and other states handle licensure for physicians. I have attached

documentation from the website of the Federation of State Medical Boards that includes the following statement:

> Physicians in the United States are not licensed based upon their specialty or practice focus. Certification in a medical specialty, such as by a member board of the American Board of Medical Specialties (ABMS) or the AOA's Bureau of Osteopathic Specialists (AOA BOS), is not required to obtain a medical license.[1]

If a specialist license is not required for physicians, then why for dentists? I have heard no cogent or compelling justification from proponents of the legislation regarding why a new license must be established for specialist dentists. Current DC regulations already prohibit general dentists from identifying as a specialist if they have not successfully completed an accredited dental specialty residency program. The proposed new license is redundant and unnecessary.

On the matter of requiring board certification, if implemented now or in the future, the impact on the health and well-being of DC residents could be severe. Upon implementation, suddenly half of all dentists who have successfully completed an accredited dental specialty residency program would be prohibited from practicing openly as a specialist dentist in DC. That is because approximately half of all specialist dentists have not achieved board certification.[2]

Because this provision of DC law would be tied to licensure, a tangle of legal and regulatory questions would emerge. Certainly specialist-today-not-tomorrow-dentists would not be listed as a specialist in DC government databases and websites that list licensed health professionals, including on the DC Medicaid website. Would the legislation have a similar effect on dental insurance lists of providers? What impact would a lack of specialist licensure have on insurance coverage? In addition, specialist-today-not-tomorrow-dentists would be prohibited from exercising their First Amendment right to engage in truthful speech about the specialized expertise they gained through successful completion of an accredited dental specialty residency program, a program that lasts between two and six years.

It is the two to six years of study and successful completion of an accredited dental specialty residency program that transforms a general dentist into a specialist, not board certification. Dentists who successfully complete an accredited dental specialty residency program are recognized as a specialist by the institution where they completed their training, by the ADA and by their relevant specialty society.

I do not want my comments to be construed as detracting in any way from the laudable achievement of board certification. It represents potentially years of additional study post-residency. The public may consider board certification status, among other factors, when deciding which specialist to see. In order to maintain an adequate population of specialist dentists in the District who can care for the public—particularly for the most complex oral health conditions—recognition as a specialist must not be tied to

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[1] "About Physician Licensure," Federation of State Medical Board, https://www.fsmb.org/u.s.-medical-regulatory-trends-and-actions/guide-to-medical-regulation-in-the-united-states/about-physician-licensure/

[2] The proportion of specialists who have achieved board certification varies widely by specialty. For example, the American Board of Oral and Maxillofacial Surgeons estimates that 75% of all OMS are board certified whereas according to the American Association of Endodontics, 26% of endodontists are board certified. A compilation of estimates from organizations representing specialist dentists and a survey among member dentists determined that approximately half of all specialist dentists in the District have achieved and maintain board certification.

board certification status. If enacted, DC would be an outlier in our region and across the country by imposing the board certification requirement.

If you have not yet read our letter of June 11 outlining in detail our opposition to tying licensure to board certification, I ask you to review it after this hearing. The impacts of requiring board certification include:

- Increased challenge in finding a specialist and securing a timely appointment in the District. Many residents likely would be forced to seek specialized dental care in Maryland and Virginia.
- A likely increase in demands on emergency rooms because fewer residents can secure an appointment with a specialist quickly.
- A disproportionate impact on residents who rely on specialists for primary oral care, particularly patients living with a chronic or systemic disease such as diabetes, HIV, or lupus.
- Great difficulty attracting and retaining early career specialists as late career specialists enter retirement. Most specialists would not be board certified upon completion of an accredited dental specialty residency program and therefore would be ineligible to obtain a specialist license.
- The prohibition would violate fundamental principles in the United States regulating advertising that require advertising to be truthful and not misleading.
- The prohibition would insult half of the specialist dentists currently practicing, many of whom has served the District community for years or decades, by refusing to recognize the clinical expertise they gained by successful completing two to six years of study in an accredited dental specialty residency program and putting that expertise to use caring for the District community.
- For the reasons described above, perhaps as many as half of all specialist dentists would leave the district.

We appreciate that legislative language will be offered by DC Health to provide an alternate pathway to licensure as a specialist dentist that does not require board certification. We strongly urge this committee to ensure that any legislation it might advance base recognition as a specialist dentist upon the successful completion of an accredited dental specialty residency program.

Regarding potential amendments to the bill, I would like to address the concept of “board eligible” in case it emerges in discussions as alternative language. The board eligible threshold is vague and varies by specialty. Therefore the board eligible threshold is unclear and open to subjective interpretation. For some specialties, passing a qualifying examination is required to pursue board certification. Is a dentist who successfully completed an accredited dental specialty residency program board eligible if they have not taken and passed such a qualifying exam? As the executive director of the DC Dental Society I admit that I cannot definitively state the answer to that question. Such problematic language should be avoided in the bill.

Requiring completion of an accredited dental specialty residency program is a clear standard that does not vary by specialty. There is unanimous recognition by the institution where the specialty training occurred, the American Dental Association and the dental specialty societies that such a dentist qualifies as a specialist. This point about language has an important practical implication as well, because depending on how “board eligible” is defined, this approach has the potential to disqualify nearly as many specialists as the board certification requirement.

Should this this committee vote to advance legislation to establish a specialist dentist license or registration requirement, we urge the implementation deadline be synchronized with the 2025 licensure

renewal process for dentists that will end on December 31, 2025. Establishing a second licensure or registration deadline in 2025 so close to the biannual renewal is bound to create confusion and problems for specialist dentists as well as for DC Health. Additionally, the proponents of the legislation provide no compelling rationale for why a second license should be required for specialist dentists instead a single license like in Virginia or Maryland that involves some type of registration of specialty.[3]

Provisions We Support

There are three provisions that we support in the Act that would amend section 102 paragraph 5 (D.C. Official Code§ 3-1201.02) to expand the definition of the practice of dentistry:

- Subparagraph A authorizes dentists to place and remove dental implants. This change explicitly acknowledges procedures that dentists have been performing for decades and preempts any potential confusion related to the addition of the definition of oral and maxillofacial surgery to the DC Code in subparagraph 10A.

- Subparagraph K authorizes dentists to administer immunizations and vaccinations when certified by the Board of Dentistry to do so. This expansion is an acknowledgement of the critical role that dentists serve in advancing the health and well-being of the District community.

- Subparagraph L authorizes dentists to use "botulinum toxin [e.g., BOTOX® Cosmetic] or another neurotoxin approved by the Food and Drug Administration." Dentists are well suited to administer botulinum toxin injections and other neurotoxins because of their extensive education on facial anatomy, muscles, and nerves as part of their formal curriculum in dental school. Dentists also routinely administer intraoral injections, and the administration of botulinum toxin or other neurotoxins requires similar knowledge and skills as those procedures.

  We ask this committee to further expand the scope of practice to include the use of FDA approved neurotoxins for cosmetic as well as dental purposes. Last year the Commonwealth of Virginia adopted legislation to authorize dentists to administer botulinum toxin for cosmetic purposes. We propose the following substitute language for subparagraph L that adapts the legislative language adopted in Virginia last year and also includes an authorization for dentists to administer dermal fillers:

  > In addition to the possession and administration of injections of botulinum toxin or another neurotoxin approved by the Food and Drug Administration for dental purposes, a dentist may possess and administer for cosmetic purposes injections of botulinum toxin, other neurotoxins approved by the Food and Drug Administration, or dermal fillers, provided that the dentist has completed training and continuing education in the administration of injections of dermal fillers or neurotoxins approved by the Food and

[3] Note that Virginia does have a separate registration requirement for an oral and maxillofacial surgeon to register their practice. See "Application Instructions for Oral & Maxillofacial Surgeon Registration of Practice" at https://www.dhp.virginia.gov/media/dhpweb/docs/dentistry/forms/RegistrationAppOMS.pdf. For other specialists in Virginia, registration of specialty is part of the license application process. In Maryland, when a dentist initially applies to be identified as a specialist, a separate "Application for Board Identification as a Specialist" must be submitted. Neither Virginia nor Maryland require board certification for recognition as a specialist dentist.

Drug Administration for cosmetic purposes, as deemed appropriate by the Board of Dentistry.

Thank you for your attention and consideration of our concerns regarding the proposal to establish a secondary license for specialist dentists that requires the achievement and maintenance of board certification. If enacted in its current form, approximately half of the specialist dentists who currently practice in the District would be prohibited from practicing openly as a specialist. Thank you also for considering our recommendations regarding the expansion of the scope of practice for dentist to include an authorization to administer FDA approved neurotoxins and dermal fillers for cosmetic purposes. I welcome any questions you may have.

Attachments:

- Application for Board Identification as a Specialist (Maryland)
- Application Instructions for Oral & Maxillofacial Surgeon Registration of Practice (Virginia)
- About Physician Licensure, Federation of State Medical Boards
- DC Dental Society Letter of June 11, 2024

PLEASE SUBMIT $150.00 APPLICATION FEE

MARYLAND STATE BOARD OF DENTAL EXAMINERS
Spring Grove Hospital Center • The Benjamin Rush Building
55 Wade Avenue • Tulip Drive
Catonsville, Maryland 21228
(410) 402-8511

APPLICATION FOR BOARD IDENTIFICATION AS A SPECIALIST

Pursuant to the Code of Maryland Regulations, 10.44.14 I hereby make the following application:

1. Name: _____
   Last First Middle

2. Date of Birth: _____

3. Mailing Address: _____
   No & Street City State Zip Code

4. Telephone Number: (____) _____

5. Dental Degree from: _____ Year of Graduation: _____

6. I am licensed to practice dentistry in the following states:

   _____ License # _____

   _____ License # _____

   _____ License # _____

7. Check the area of specialty that is applicable to you. The Board recognizes the following areas of dentistry as specialties:

   - ☐ Dental Anesthesiology
   - ☐ Dental Public Health
   - ☐ Endodontics
   - ☐ Oral and Maxillofacial Pathology
   - ☐ Oral and Maxillofacial Radiology
   - ☐ Oral Medicine
   - ☐ Oral and Maxillofacial Surgery
   - ☐ Orthodontics and Dentofacial Orthopedics
   - ☐ Pediatric Dentistry
   - ☐ Periodontics
   - ☐ Prosthodontics
   - ☐ Orofacial Pain

8. Specialty Training Received: _____ _____
   Dental School Name Dates of Attendance

   Year certificate received: _____.

I hereby enclose **certified** proof of completion of a Board approved specialty training program (such as a copy of certificate or a letter from the school). I understand that **an original school certification must be affixed to transcript or diploma documents. Letters from educational institutions on original letterhead, bearing an original signature do not require a raised, embossed school seal.**

9. **Answer only** if you have not completed a specialty training program:

   a. Have you reasonably represented to the public that you were a specialist prior to July 1, 1979? ____If so, how many years?

   b. I hereby certify that I have been specializing in the field of _____ prior to July 1, 1979, and reasonable represented to the public that I was a specialist and limited my practice to the above identified specialty field. The dates during which I have limited my practice to that specialty are _____.

   c. On a separate sheet of paper identify the education and experience on which your claim to be a specialist is based.

TO BE COMPLETED BY ALL APPLICANTS

Signed: _____
Signature of Applicant

A F F I D A V I T

State of _____

County of_____

I hereby certify that on this _____ day of _____, 20___, before me the subscriber, a notary public, in and for the county aforesaid, personally appeared _____ and made oath in due form of law that the above facts are true to the best of the applicant's knowledge. As witness, my hand and notarial seal.

_____
Notary Public

S E A L

My Commission expires on: _____

Revised 12-03-20

INSTRUCTIONS FOR APPLICATION
FOR BOARD IDENTIFICATION AS A SPECIALIST

1. In accordance with the Code of Maryland-Regulations, 10.44.14, these instructions have been developed to facilitate the completion of the Application for Board Identification as a Specialist.

2. An applicant may apply for the following areas of dentistry as specialties:

Dental Anesthesiology	Oral and Maxillofacial Surgery
Dental Public Health	Orthodontics and Dentofacial Orthopedics
Endodontics	Pediatric Dentistry
Oral and Maxillofacial Pathology	Periodontics
Oral and Maxillofacial Radiology	Prosthodontics
Oral Medicine	Orofacial Pain

Any area of specialty approved by the Commission on Dental Accreditation or its successor organization.

3. Only a licensed dentist, who has successfully completed a Board-approved specialty training program.

4. Applicants must provide certified proof of such program or a written statement, under oath, that sets forth the basis for the dentist's claim that, before July 1, 1979 (see Code of Maryland-Regulations 10.44.14.05 (C) 1 and 2).

5. The applicable non-refundable fee is $150. Make all remittances payable to the State Board of Dental Examiners. **DO NOT SEND CASH.**

Incomplete applications will be returned and will be subject to a $50.00 application reprocessing fee.

6. The completed application is to be forwarded to:

Maryland State Board of Dental Examiners
Spring Grove Hospital Center
The Benjamin Rush Building
55 Wade Avenue/Tulip Drive
Catonsville, Maryland 21228

7. Any questions concerning the completion of the application or the process may be directed to Ms. Deborah A. Welch, Licensing Coordinator at (410) 402-8511.

Revised 12-03-20

Virginia Department of Health Professions
Board of Dentistry

9960 Mayland Drive, Suite 300
Henrico, Virginia 23233
(804) 367-4538 (Tel)
(804) 698-4266 (eFax)
bodlicensing@dhp.virginia.gov
https://www.dhp.virginia.gov/Boards/Dentistry/

APPLICATION INSTRUCTIONS FOR ORAL & MAXILLOFACIAL SURGEON REGISTRATION OF PRACTICE

Pursuant to **18VAC60-21-310** every licensed dentist who practices as an oral and maxillofacial surgeon, as defined in § 54.1-2700 of the Code, shall register his practice with the board. An oral and maxillofacial surgeon who fails to register and continues to practice oral and maxillofacial surgery may be subject to disciplinary action by the board.

A completed application shall include the following unless otherwise stated below. An incomplete application and/or fee will delay the processing of your application. Incomplete applications remain active for one year from the date of receipt. After one year from date of receipt, you would need to reapply for Virginia registration. Documents submitted with an application are the property of the Board of Dentistry and cannot be returned.

____ 1. **Application:** Please be sure that all information and questions are completed on the application.

____ 2. **Application Fee:** The fee for an **oral & maxillofacial surgeon registration of practice is $175** and must be paid with a check or money order, made payable to **The Treasurer of Virginia**. The fee can be used for one year from date of receipt. Pursuant to 18VAC60-21-40(G), all fees are non-refundable. Your application will not be reviewed until you have submitted payment. Please mail the completed application and fee to the address noted above.

____ 3. **Official Transcript of completed OMS program:** Final **original** transcript bearing SEAL, date degree received (conferred date) and registrar's signature. Copies of transcripts, certificates and diplomas are not acceptable. If you completed a post-doctoral program at a hospital which does not maintain transcripts, a dated detailed letter (on official letterhead) that addresses the coursework and clinical training that you completed, signed by the Program Director, is required.

(Options: Mail to the Board (address listed above) or the school, e-scrip, or parchment services provider may directly email the transcript information to bodlicensing@dhp.virginia.gov.)

Note: An official transcript –must be on original official school paper (sealed) or an online version that Board staff must download from the school, e-scrip, or parchment services website. **Documentation from foreign countries non-accredited CODA/CDAC schools' programs is not required and will not be considered.**

OMS Requirements listed in **60-27** Guidance on Sedation Permits, *effective February 3, 2022*

- The requirement for a sedation permit does not apply to an oral and maxillofacial surgeon (OMS) who maintains membership in the American Association of Oral and Maxillofacial Surgeons (AAOMS) and who provides the Board with reports that result from the periodic office examinations required by AAOMS (18VAC60-21-300 (A)).

- An OMS must hold a sedation permit if not a member of AAOMS. If the OMS holds a sedation permit and then becomes a member of AAOMS, the OMS must notify the Board within 30 days of becoming a member of AAOMS.

- An OMS, who is a member of AAOMS, must submit AAOMS office examination reports to the Board within 30 days of receipt.

Pursuant to **18VAC60-21-320. Profile of information for oral and maxillofacial surgeons.**

A. In compliance with requirements of § 54.1-2709.2 of the Code, an oral and maxillofacial surgeon registered with the board shall provide, upon initial request, the following information within 30 days:
   1. The address of the primary practice setting and all secondary practice settings with the percentage of time spent at each location;
   2. Names of dental or medical schools with dates of graduation;
   3. Names of graduate medical or dental education programs attended at an institution approved by the Accreditation Council for Graduate Medical Education, the Commission on Dental Accreditation, and the American Dental Association with dates of completion of training;
   4. Names and dates of specialty board certification or board eligibility, if any, as recognized by the Council on Dental Education and Licensure of the American Dental Association;

5. Number of years in active, clinical practice in the United States or Canada, following completion of medical or dental training and the number of years, if any, in active, clinical practice outside the United States or Canada;
6. Names of insurance plans accepted or managed care plans in which the oral and maxillofacial surgeon participates and whether he is accepting new patients under such plans;
7. Names of hospitals with which the oral and maxillofacial surgeon is affiliated;
8. Appointments within the past 10 years to dental school faculties with the years of service and academic rank;
9. Publications, not to exceed 10 in number, in peer-reviewed literature within the most recent five-year period;
10. Whether there is access to translating services for non-English speaking patients at the primary practice setting and which, if any, foreign languages are spoken in the practice; and
11. Whether the oral and maxillofacial surgeon participates in the Virginia Medicaid Program and whether he is accepting new Medicaid patients.

B. The oral and maxillofacial surgeon may provide additional information on hours of continuing education earned, sub-specialties obtained, and honors or awards received.
C. Whenever there is a change in the information on record with the profile system, the oral and maxillofacial surgeon shall provide current information in any of the categories in subsection A of this section within 30 days.

Pursuant to **18VAC60-21-340. Noncompliance or falsification of profile.**

A. The failure to provide the information required in 18VAC60-21-320 A may constitute unprofessional conduct and may subject the licensee to disciplinary action by the board.
B. Intentionally providing false information to the board for the profile system shall constitute unprofessional conduct and shall subject the licensee to disciplinary action by the board.

Virginia Department of Health Professions
Board of Dentistry

9960 Mayland Drive, Suite 300
Henrico, Virginia 23233
(804) 367-4538 (Tel)
(804) 698-4266 (eFax)
bodlicensing@dhp.virginia.gov
https://www.dhp.virginia.gov/Boards/Dentistry/

APPLICATION FOR ORAL AND MAXILLOFACIAL SURGEON REGISTRATION OF PRACTICE Page 1

INSTRUCTIONS: Type or print clearly. Complete all sections. If the space provided for any answer is insufficient, complete your answer on a separate page, specify the number of the question to which it relates, sign the page and enclose it with the application. Please mail the completed application and fee to the address noted above.

I. GENERAL INFORMATION: PLEASE COMPLETE ALL SECTIONS (PRINT OR TYPE)

Name: Last*	First	Middle/Maiden	Suffix

Address of record (Mailing Address)	City	State	Zip Code	Telephone Number
Publically Disclosable Address	City	State	Zip Code	Telephone Number

Email address	Fax #

Date of Birth	**Social Security Number or Virginia DMV control Number****
_____/_____/_____ Month Day Year	____ ____ ____---____ ____--____ ____ ____ ____

***Name change:** **Documentation must be provided to show name change(s) if name has ever been changed from the time you attended school or while you were licensed in other jurisdictions.**

****In accordance with § 54.1-116 of the *Code of Virginia*, you are required to submit your Social Security Number or your control number issued by the Virginia Department of Motor Vehicles. If you fail to do so, the processing of your application will be suspended and fees will not be refunded. This number will be used by the Department of Health Professions for identification and will not be disclosed for other purposes except as provided by law. Federal and state law requires that this number be shared with other agencies for child support enforcement activities.**

Date of Completion of Residency	Name of Completed OMS Residency Program. **Please attach a copy of the certificate of completion**:
_____ _____ _____ Month Day Year	

Virginia Dental License Number:

II. APPLICANT HISTORY: ALL QUESTIONS MUST BE ANSWERED.

If any of the following questions are answered "YES", explain, and substantiate with documentation. Letters must be submitted by your attorney regarding malpractice suits. Letters must be submitted by any treating professionals regarding health treatment and shall include diagnosis, treatment, and prognosis.

1. Are you relocating to Virginia or an adjoining state or the District of Columbia with a spouse who is 1) on federal active-duty orders, or 2) a veteran who has left active-duty service within one year of submission of this application? If "YES", include a copy of the official military orders with the application. [ ] Yes [ ] No

2. Are you active-duty military? If "YES", include a copy of your official military orders with the application. [ ] Yes [ ] No

3. Have you ever been dropped, suspended, expelled, or disciplined by any school or college for any cause whatever? If "YES", give details, schools(s), address(es) and date(s). Please note: the Board may ask for additional documentation. [ ] Yes [ ] No

_____

_____

4. Have you ever been denied a license, or the privilege of taking a dental licensure/competency examination by a licensing authority? If "YES", give details, jurisdiction(s), and date(s) on a separate page, and include a copy of the disposition/record certified by the Clerk of the Court. Please note: the Board may ask for additional documentation. [ ] Yes [ ] No

_____

_____

5. Have you ever been convicted of a violation or plead Nolo Contendere, to any federal, state, or local statute, regulations, or ordinance, or entered into any plea bargaining relating to a felony or misdemeanor? (Excluding traffic violations, except convictions for driving under the influence.) "Additionally, any information concerning an arrest, charge, or conviction that has been sealed, including arrests, charges, or convictions for possession of marijuana, do not have to be disclosed." [ ] Yes [ ] No

If "YES", give details, jurisdiction(s), and date(s) on a separate page, and include a copy of the disposition/record certified by the Clerk of the Court. Please note: the Board may ask for additional documentation.

_____

_____

6. Have you ever voluntarily surrendered your clinical privileges while under investigation, been censured or warned or been requested to withdraw from the staff of any hospital, nursing home other health care facility, or any health care provider? If "YES", give details, jurisdiction(s), and date(s) on a separate page. Please note: the Board may ask for additional documentation. [ ] Yes [ ] No

_____

_____

7. Have you ever had any of the following disciplinary actions taken against your license to practice dentistry, your DEA permit, Medicare, Medicaid, or are any such actions pending: suspension/revocations, or probations, or reprimand/cease and desist, or monitoring of practice, or limitation placed on scheduled drugs? If "YES", give details, jurisdiction(s), and date(s) on a separate page. Please note: the Board may ask for additional documentation. [ ] Yes [ ] No

_____

_____

8. Have you ever had any membership in a professional society revoked, suspended, or sanctioned in any manner? If "YES", give details, jurisdiction(s), and date(s) on a separate page. Please note: the Board may ask for additional documentation. [ ] Yes [ ] No

_____

_____

9. Have you ever been a defendant in a military court martial or received medical or other than honorable discharge? If "YES", give details, jurisdiction(s), and date(s) on a separate page. Please note: the Board may ask for additional documentation. [ ] Yes [ ] No

_____

_____

11 Have you had any malpractice suits brought against you in the past ten (10) years? [ ] Yes [ ] No

If "YES", please provide details for each pending or closed case, list additional claim(s) on a separate page and provide a letter from your attorney explaining each case. Please note: the Board may ask for additional documentation.

Claimant:_____ Date of Incident_____

Name of Defense Attorney:_____

Settlement or Verdict Amount:_____

Name of Involved Insurance Company:_____

Brief description of the claim:_____

_____

_____

ADDITIONAL LICENSURE QUESTIONS:

1. Do you have any reason to believe that you would pose a risk to the safety or well-being of your patients or clients? If "YES", please provide a full explanation and supporting documentation to the Board. Please note: the Board may ask for additional documentation. [ ] Yes [ ] No

   _____

   _____

2. Are you able to perform the essential functions of a practitioner in your area of practice with or without reasonable accommodation? If "NO", please provide a full explanation and supporting documentation to the Board. Please note: the Board may ask for additional documentation. [ ] Yes [ ] No

   _____

   _____

3. Have you ever been disciplined by any entity? If "YES", please provide a full explanation and supporting documentation to the Board. Please note: the Board may ask for additional documentation. [ ] Yes [ ] No

   _____

   _____

4. Have you ever had any conditions or restrictions been imposed upon you or your practice to avoid disciplinary action by any entity? If "YES", please provide a full explanation and supporting documentation to the Board. Please note: the Board may ask for additional documentation. [ ] Yes [ ] No

   _____

   _____

VIRGINIA BOARD OF DENTISTRY
APPLICATION AFFIDAVIT

I hereby certify that I am the person referred to in the forgoing application and the attached supporting documents and that the information on this application and in the attachments is true, complete, and correct to the best of my knowledge.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present) business and professional associates (past and present) and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Virginia Board of Dentistry any information, files or records requested by the Board which is material to me and my application.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me in the application and supporting documents are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension, or revocation of my license to practice in the Commonwealth of Virginia.

I have carefully read the laws and regulations related to the practice of oral and maxillofacial surgeons**. I hereby agree to abide by and remain current with the applicable laws and regulations which are available on** http://www.dhp.virginia.gov/Boards/Dentistry/PractitionerResources/LawsRegulations/, and

I have attached a check or money order in the amount of $_____ made payable to the **Treasurer of Virginia**. I fully understand that funds submitted, as part of the application shall not be refunded.

_____ _____

Applicant Signature **Date**

FEDERATION OF STATE MEDICAL BOARDS

U.S. MEDICAL REGULATORY TRENDS AND ACTIONS

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ABOUT PHYSICIAN LICENSURE

How Physicians Gain Licenses to Practice Medicine

In the United States, medicine is a licensed profession regulated by the individual states. One of the most important functions of the nation's state medical boards is issuing licenses to physicians. Through licensing, state medical boards ensure that all practicing physicians have appropriate education and training, and that they abide by recognized standards of professional conduct while serving their patients.

school graduation, postgraduate training, and passage of a comprehensive national medical licensing examination that tests their knowledge of health and disease management and effective patient care. Applicants must submit proof of their education and training and provide details about their work history. They also must reveal information that may affect their ability to practice, such as health status, malpractice judgments/settlements and criminal convictions. Only those who meet a state's qualifications are granted permission to practice medicine in that state.

After physicians are licensed, they must renew their license periodically, usually every one or two years, to continue their active status. During this license renewal process, physicians must demonstrate that they have maintained acceptable standards of ethics and medical practice and have not engaged in improper conduct. In nearly all states, physicians must also show that they have participated in a program of continuing medical education.

While the specific requirements for obtaining a medical license vary somewhat between jurisdictions, state medical boards review the credentials of applicants and look closely at a number of factors, including:

- Medical education
- Medical training (i.e., residency training)
- Performance on a national licensing examination
- Mental, moral, and physical fitness to safely practice medicine

Medical Education: All jurisdictions require that candidates for physician licensure have obtained an MD or DO degree. For most medical education programs in the United States, the MD or DO degree involves a post-baccalaureate four-year program of education. Graduates of international medical schools (IMGs) may present the equivalent of the MD degree (e.g., MBBS).

There are 155 allopathic and 37 osteopathic medical schools in the United States. All of these medical school programs are accredited by either the Liaison Committee on Medical Education (LCME) or the American Osteopathic Association Commission on Osteopathic College Accreditation (AOA COCA).

It should be noted that acquisition of an MD or DO degree does not automatically confer a license to practice medicine in the United States. The medical practice act in most jurisdictions restricts individuals holding a physician credential from publicly

Medical Training: After graduation from medical school, physicians routinely enter into postgraduate training – usually a residency training program. At one time it was common for physicians to spend their first year of postgraduate training (PGY-1) in an internship exposing them to a broad array of clinical scenarios. After this intern year, the physician then moved into the more specialized training of their chosen residency training program. Most physicians today do not experience a true rotating internship during PGY-1 but instead move directly into the specialized training of their residency program.

All state medical boards require licensure candidates to complete at least one year of postgraduate training in order to be eligible for a full and unrestricted medical license. In some jurisdictions, the requirement is higher — the physician must complete two or three years of residency training to obtain a license. In more than a dozen jurisdictions, progress through postgraduate training requires a physician to successfully complete the licensing examination sequence and obtain a full, unrestricted license prior to reaching a designated point in their postgraduate training. For example, some jurisdictions require physicians in training to complete the licensing examination sequence prior to entering PGY-2 or PGY-3.

The postgraduate training period often marks the first formal interaction of prospective physicians with a state medical board, as most boards issue a resident or training permit for physicians to practice within the limited, supervised context of their residency program.

For many years, state medical boards required that the training be completed in a residency program accredited by either the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA). In 2014, the AOA, ACGME, and the American Association of Colleges of Osteopathic Medicine (AACOM) agreed to a single accreditation system for graduate medical education programs in the United States, which was implemented in 2020 and now unifies the various programs.

These programs are approximately three to seven years in duration, depending upon the specialty.

Some state medical boards recognize training in the accredited programs conducted in other countries – for example, residency programs accredited by the Royal College of Physicians and Surgeons of Canada.

Osteopathic Medical Licensing Examination (COMLEX-USA). The USMLE is open to physicians holding an MD or DO degree. Physicians with a DO degree usually complete the COMLEX-USA sequence.

These are national multi-part examinations taken at various points in a prospective physician's career and designed to assess the physician's knowledge, clinical and communication skills. Students in U.S. medical schools routinely take the first two steps of the licensing examination prior to graduation from medical school. The final step of the examination sequence is usually taken during residency training.

Many boards limit the number of attempts a physician can make to pass the USMLE or COMLEX-USA. Additional attempts are often allowed, but only after physicians have been redirected for additional training prior to taking the exam again. Most boards also place restrictions on the time period for completing the examination sequence. These time- and attempt-limits are designed to ensure the currency and adequacy of knowledge of newly licensed physicians.

More detailed information on **State-Specific Requirements for Initial Medical Licensure** is available at the FSMB website.

Fitness to practice: All state medical boards are concerned with the physical, mental, and moral fitness of prospective licensure candidates. A number of boards explicitly define the practice of medicine in their licensure applications to ensure that physicians clearly understand the expectations for minimally acceptable performance. The licensure application in each state commonly asks questions about the personal history and background of the applicant, including work history, physical and/or mental conditions that might impact their ability to safely practice medicine. Criminal background checks at the time of license application are also conducted by many boards.

Compared with U.S. medical graduates, IMGs follow a slightly different pathway after completing their medical education at a school outside the United States. Before entering into a residency training program in the United States, they must be certified by the Educational Commission for Foreign Medical Graduates (ECFMG). This certification is required in order for IMGs to enter into an ACGME-accredited residency training program in the United States. ECFMG certification requires verification of the physician's medical degree and successful completion of USMLE Step 1 and 2. The

their medical school years, many more do not begin the sequence until after their graduation from medical school. Ultimately, IMGs take the same licensing examinations as U.S. MD graduates and obtain residency training in the same accredited programs.

When a physician applies for a medical license, staff at the state medical board receiving the application will verify the physician's credentials (e.g., medical degree, postgraduate training), confirm that the physician has successfully passed the USMLE or COMLEXUSA, query the FSMB's disciplinary data bank and closely review the physician's responses to questions on the licensure application for missing or inconsistent information. In some instances, the board may request that the physician appear for a formal interview before either the full board or a subcommittee of the board.

The license that the physician eventually receives from a state medical board is for the general, undifferentiated practice of medicine. Physicians in the United States are not licensed based upon their specialty or practice focus. Certification in a medical specialty, such as by a member board of the American Board of Medical Specialties (ABMS) or the AOA's Bureau of Osteopathic Specialists (AOA BOS), is not required to obtain a medical license. However, other practical considerations — such as obtaining hospital privileges — lead most physicians to obtain specialty certification. The majority of physicians in the United States hold specialty certification through the ABMS or AOA BOS.

The Interstate Medical Licensure Compact

In 2015, a group of U.S. state medical boards joined together to launch the Interstate Medical Licensure Compact, which offers a new, expedited pathway to licensure for qualified physicians who wish to practice in multiple states.

A compact is a legal agreement, authorized by the Compact Clause of the U.S. Constitution, that allows states to collectively work together to address shared needs or issues. There are more than 200 interstate compacts in effect today.

Among the issues driving the need for the Interstate Medical Licensure Compact are physician shortages, the recent influx of millions of new patients into the health care system, and the growing need to increase access to health care for individuals in underserved or rural communities through the use of telemedicine. Proponents of telemedicine have often cited the state-by-state licensure process required for multiple-

In addition to significantly streamlining the process of gaining medical licenses in multiple states for physicians, the Interstate Medical Licensure Compact is designed to increase access to health care for patients in underserved or rural areas, and to allow them to more easily connect with medical experts through the use of telemedicine technologies. Any state or territory may join the Compact, but in order for a state or territory to join the Interstate Medical Licensure Compact, its legislature must enact the Compact into law.

As of 2020, 29 states, Guam, and the District of Columbia are participating members of the Compact, with several other states actively considering legislation to join.

States participating in the Compact formally agree to adopt common rules and procedures that streamline medical licensure, thus substantially reducing the time it takes for physicians to obtain multiple state licenses. The Interstate Medical Licensure Compact Commission provides oversight and the administration of the Compact, creating and enforcing rules governing its processes, but each participating state maintains its individual authority and control over the practice of medicine within its borders. Participating states retain the authority to issue licenses, investigate complaints, and discipline physicians practicing in their state.

To be eligible for licensure by utilizing the Compact process, physicians must possess a full and unrestricted license in a Compact member state, be certified (or “grandfathered”) in a medical specialty, have no history of being disciplined, penalized or punished by a court, a medical licensing agency or the Drug Enforcement Administration, and meet several other robust requirements.

To participate, an eligible physician designates a member state as the State of Principal Licensure and selects the other member states in which a medical license is desired. Upon receipt of this verification in the additional Compact states, the physician is granted a separate, full and unrestricted license to practice in each of those states.

To date, more than 10,000 medical licenses have been issued using the Compact process.

The Compact is voluntary for both states and physicians. Physicians who cannot or do not want to participate in the Compact’s expedited licensure process are still able to

To learn more, please visit **www.imlcc.org**.

Pathway to Physician Licensure in the United States

The FSMB has created a **visual illustration** of the pathway physicians must take in order to become licensed in the United States.

THE DEFINITIONS BELOW EXPLAIN TERMINOLOGY USED IN THE PATHWAY TO MEDICAL LICENSURE ILLUSTRATION:

Open All / Close All

AACOMAS

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District of Columbia
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June 11, 2024

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Council of the District of Columbia
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Re: Opposition to Dental Specialties Licensure and Scope of Practice Amendment Act of 2023 (B25-0632)

Dear Chairperson Henderson,

We are writing behalf of the more than 400 member dentists and the nearly 200 specialist dentists practicing in the District to oppose the Dental Specialties Licensure and Scope of Practice Amendment Act of 2023 ("the Act"). Ultimately, we are writing on behalf of the public, whose health and well-being we support on a daily basis by providing dental care, alleviating pain, and performing a range of procedures that can save lives, including the prevention of medical complications resulting from untreated oral disease conditions[1], the diagnosis and surgical removal of oral cancer as well as surgical reconstruction, and the provision of alternative treatments for those who cannot tolerate CPAP for the treatment of sleep apnea.

The Act would have an immediate and enduring adverse impact on the health and well-being of DC residents by triggering a mass exodus of approximately half of the specialist dentists ("specialists") currently practicing in DC and by preventing early career specialists from practicing in DC upon completion of a specialist residency program.

Only Half of All Specialists Would Qualify for a DC License

The Act would require all specialists to hold a current certification from a recognized dental specialty certifying board (new Sec. 508c.2). The percentage of specialists who are board certified varies by specialty.[2] **Because of the board certification requirement, we estimate that half all specialist dentists**

[1] Specialist dentists treat the most serious and advanced oral health conditions. The tragic deaths of Deamonte Driver, Kyle Willis, and Vadim Anatoliyevich Kondratyuk highlight the serious consequences that can result from neglected oral health.

"Toothache Leads to Boy's Death," ABC News, March 5, 2007, https://abcnews.go.com/Health/Dental/story?id=2925584
"Man Dies From Toothache, Couldn't Afford Meds," ABC News, September 2, 2011, https://abcnews.go.com/Health/insurance-24-year-dies-toothache/story?id=14438171
"Tooth infection leads to young dad's death, family says," CBS News, February 1, 2017, https://www.cbsnews.com/news/tooth-infection-leads-to-young-dads-death-family-claims/

[2] The percentage of specialist dentists practicing in each specialty that are board certified varies widely. For example, the organization that administers the board certifying exam for oral and maxillofacial surgeons (OMS), the

overall who practice in the District <u>would not be eligible</u> to obtain a specialist license to continue practicing in DC, including a large number of specialists who have served the Washington community for decades. As a result, patients who require specialized care, often to treat the most severe oral health conditions, would be forced to wait longer to receive treatment and may need to travel outside the District to receive that care. In addition to worsening oral health conditions, longer wait times also can have an impact on patients with health conditions that are not specifically related to oral health. For example, those who are preparing to undergo certain surgical procedures may require treatment and ultimately clearance from a specialist. Longer wait times could delay surgery and affect the prognosis for the patient.

Specialists Reduce Emergency Room Visits

All dentists provide both preventive care as well as remedial treatments for oral health conditions that emergency rooms are ill-equipped or unable to treat, including even the most basic oral health problems such as caries/cavities. Specialist dentists treat more complex oral health conditions that can cause significant pain and serious health complications if not treated, often within a short timeframe. For those living with chronic and systemic health conditions such as diabetes, HIV, and lupus, the impact of not receiving swift treatment may be greater, creating a stronger motivation for the person to seek care from an emergency room if they are unable to secure an appointment with a specialist dentist. Because emergency rooms lack the specialized equipment and staff with expertise to treat many dental conditions, patients are likely to be referred to a specialist dentist.

Many Specialists Provide Primary or Regular Dental Care

For some DC residents, specialist dentists are the primary or sole provider or oral health care. For example, some general dentists do not treat minors, thereby increasing demand for pediatric dentists. In addition, for children as well as adolescents with special needs, a pediatric dentist may be the most appropriate provider of oral care. Patients with missing or deficient teeth may need the care of a prosthodontist to fabricate custom appliances such as bridges and dentures (full or partial) or otherwise support a full mouth rehabilitation. Patients living with a chronic or systemic disease such as diabetes, HIV, or lupus may need regular visits to a periodontist to monitor the health of tissue within the mouth, support healthy gums, and prevent bone loss.

<u>Specialists Complete Six Plus Years of Training Before Practicing</u>

It is important to understand the numerous years of training specialist dentists complete before they are able to practice in their specialty. Dentists train for four years in a post-graduate program to earn their doctor of dental surgery (DDS) or doctor of medicine in dentistry (DMD) degree.

Dentist who choose to specialize complete an additional 2-6 years of post-doctoral training in a residency program in their chosen specialty. Upon completion of that accredited residency program, they are qualified to practice in their specialty and are eligible to sit for a board certification exam.

American Board of Oral and Maxillofacial Surgeons, estimates that 75% of all OMS are board certified whereas according to the American Association of Endodontics, 24% of endodontists are board certified. A compilation of estimates from organizations representing specialist dentists determined that approximately half of all specialists have achieved or maintain board certification.

The decision whether to seek board certification after a residency program is a personal choice that each specialist must make for themselves based upon their financial circumstances, ability to complete additional training, and other factors. Some specialists, including those who have practiced in the District for decades, opted to bypass board certification so they could focus on providing care to the public. In addition, some specialists may have passed the board certifying exam in the past, but have chosen not to pay regular fees to the certifying body to maintain their certification. For these and other reasons, only about half of all specialist dentists have achieved and maintained board certification. As a result, **about half of all specialist dentists would not be eligible to obtain a specialist license under the Act and would be forced to relocate their practice to Maryland or Virginia.**

The Act Would Impede Early Career Specialists and the Generational Transition

Pursuing board certification typically requires an additional 1-2 years of study and research following a specialist residency program in order to pass a certifying exam. Under the Act, a recently graduated specialist dentist likely would not be eligible to secure a specialty license and therefore would not be eligible to practice in DC. This new licensing requirement would be implemented when an increasing number of late career specialists are retiring and when the District needs an influx of additional specialists to fill the gap to increase the healthcare workforce to treat a growing population.

The Act Would Force Specialists to Violate U.S. Principles Regulating Advertising

Laws and regulations in the United States at the federal and state level pertaining to advertising and marketing are founded upon two principles:

- Advertising must be truthful.
- Advertising must not be misleading.

The Act purports as a goal to "ensure that dentists are appropriately qualified to practice dental specialties and to hold themselves out to the public as specialists." As noted above, specialist dentists have completed 2-6 years of post-doctoral training in their chosen specialty and are qualified to practice. The requirement in the Act that a specialist must hold a current certification from a recognized dental specialty certifying board (new Sec. 508c.2) would prevent qualified specialists from practicing and from presenting themselves to the public as a specialist. Therefore, the Act would infringe upon the First Amendment right of specialists to communicate to the public truthful information about the advanced, post-doctoral training they have completed that qualifies them as a specialist.

Furthermore, the Act would force the Board of Dentistry and specialists who have achieved board certification to engage in misleading speech by indicating that only specialists who have achieved board certification are qualified to practice as a specialist. Board certification has no impact on clinical care and is not necessarily an indicator of the experience of the dentist.

The Act Would Require a Second License

The Act would require specialist dentists to obtain a second license from the Board of Dentistry in addition to their dental license (new Sec. 508c.1) instead of establishing a single dental license that notes the recognized specialty. In comparison, Virginia does not require board certification for any dental specialty. A separate registration is required only for oral and maxillofacial surgeons (OMS). For other specialists in Virginia, registration of specialty is part of the license application process. In Maryland,

when a dentist initially applies to be identified as a specialist, board certification is not required, only proof of completion of a specialty training program.

Under DC law, dentists and other dental professionals are required to renew their license every two years. The most recent license renewal period occurred at the end of 2023. The proponents of the legislation provide no compelling rationale for why specialist dentists should be required to obtain a second, specialty license within one year from passage instead of implementing any new registration or licensing requirement as part of the licensure renewal process at the end of 2025. Likewise, the proponents of the legislation provide no compelling rationale for why a second license is required for specialists instead a single license like in Virginia or Maryland.

Provisions We Support

There are three provisions that we support in the Act that would amend section 102 paragraph 5 (D.C. Official Code§ 3-1201.02) to expand the definition of the practice of dentistry:

- Subparagraph A authorizes dentists to place and remove dental implants. This change explicitly acknowledges procedures that dentists have been performing for decades and preempts any potential confusion related to the addition of the definition of oral and maxillofacial surgery to the DC Code in subparagraph 10A.

- Subparagraph K authorizes dentists to administer immunizations and vaccinations when certified by the Board of Dentistry to do so. This expansion is an acknowledgement of the critical role that dentists serve in advancing the health and well-being of the Washington community. We are concerned that implementation of this provision may be delayed by the timing of action by the Board of Dentistry to enact regulations to recognize acceptable training programs.

  Earlier this year, the Board of Dentistry finalized regulations to expand the scope of practice for dental assistants to create the position of Level III Dental Assistant. The regulations became effective on March 1, 2024, the date of publication in the District of Columbia Register, however the Board of Dentistry has yet to publish a list of the approved hands-on course specified in the regulation as a requirement for registration as a Level III Dental Assistant. The result is that no qualified or potentially qualified dental assistant can apply to register as Levell III Dental Assistant despite codifying the position in DC regulations.

- Subparagraph L authorizes dentists to use “botulinum toxin [e.g., BOTOX® Cosmetic] or another neurotoxin approved by the Food and Drug Administration.” Dentists are well suited to administer botulinum toxin injections and other neurotoxins because of their extensive knowledge of facial anatomy, muscles, and nerves. Dentists also routinely administer intraoral injections, and the administration of botulinum toxin or other neurotoxins requires similar skills as those procedures.

  Subparagraph L also contains two limiting provisions that are of concern:

  - “to treat a diagnosed dental condition approved by the Mayor through rulemaking” – we are concerned that implementation of subparagraph L will be delayed by the timing

- of implementing regulations and that the list of procedures approved by the Mayor will be unreasonably restricted. Furthermore and as noted above, dentists regularly perform procedures similar to administering botulinum toxin or other neurotoxins. Specialized training, addressed specifically in our next comment, could be designed to cover the use of botulinum toxin or other neurotoxins for cosmetic as well as dental purposes.
- "when certified by the Board of Dentistry to do so" – we support the requirement that dentists be properly trained in the use of botulinum toxin and other FDA-approved neurotoxins. Similar to our concern noted above regarding the speed by which the Board of Dentistry develops and implements regulations, we are concerned that implementation of subparagraph L may be delayed for years due to the slow pace of the regulatory approval process.

- We wish to reiterate an alternate approach that we offered to the Committee on Health in our letter of December 15, 2023, on the Health Occupations Revision General Amendment Act of 2023. In 2023 the Commonwealth of Virginia adopted legislation to authorize dentists to administer botulinum toxin for cosmetic purposes. We propose the following substitute language for subparagraph L that adapts the legislative language adopted in Virginia last year:

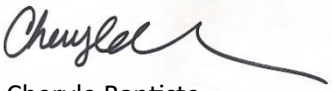
    - (L) In addition to the possession and administration of botulinum toxin injections for dental purposes, a dentist may possess and administer botulinum toxin injections for cosmetic purposes, provided that the dentist has completed training and continuing education in the administration of botulinum toxin injections for cosmetic purposes, as deemed appropriate by the Board of Dentistry.

Conclusion

Thank you for your attention and consideration of our concerns regarding the proposal to establish a secondary license for specialist dentists. If enacted in its current form, approximately half of the specialist dentists currently practicing in the District would be forced to relocate to Maryland or Virginia. The impact on the health and well-being of District residents would be profound due to delays in receiving specialized care and an increased likelihood that they would need to travel outside of the District to receive that care.

We welcome the opportunity to work collaboratively to advance legislation that empowers dentists to continue to support public health and the safety of DC residents through the provision of timely and appropriate dental care that addresses the health needs of the public.

Sincerely,



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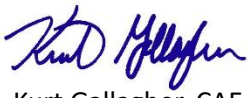

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DC Dental Society, Opposition to B25-0632, June 11, 2024

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DC Dental Society, Opposition to B25-0632, June 11, 2024

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