1976

1976 Transactions

American Dental Association

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AMERICAN DENTAL ASSOCIATION

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Report of President

Robert B. Shira

Mr. Speaker, Officers and Trustees, Members of the House of Delegates, Distinguished Guests, Ladies and Gentlemen:

It has been a rare privilege to serve you as President of the American Dental Association. While at times I have felt discouraged and frustrated, for the most part my tenure has been filled with rich and rewarding experiences. I thank you all for allowing me to serve as your President and for the loyal support you have given me. I also thank you for your efforts in achieving the goals of the American Dental Association.

I know most of you personally and I know you would not be serving in this House of Delegates if you did not share my pride in being a dentist and share my wish that we do all we can to preserve and advance the practice of dentistry. Serving in the House of Delegates is a time-consuming and, frequently, a wearying job, but this is the cost of the leadership you will exercise in the next few days in making important decisions for dentistry and the public it serves.

This is a time for leadership. We are living in a progressive era, a time of great change. These changes are having a profound effect upon us as individuals and upon us as a profession. They are here to stay—they are not going away. Current changes will be followed by more changes in the future. It is important that we, the members of the dental profession, band together and influence those changes that affect us and our profession to enable us to practice in the future in the manner we desire and to allow us to continue to deliver the high quality oral health care which has made American dentistry famous.

Today, American dentistry is recognized as the finest in all the world and the dentists of all nations look to us for leadership. In my opinion American dentistry reached this position of excellence because for over 200 years dentistry was controlled by dentists. Dentists were the sole arbiters of what went on in the profession and no one challenged this arrangement. During this period the private practice, fee-for-service delivery system, that has served the public and the profession so well, was developed. This system permitted dentists to assume the initiative and through their knowledge and skills newer techniques, new concepts and newer and better materials were developed and the profession, as we know it today, evolved.

Dentistry controlled by dentists was beneficial to all concerned. However, with the

passage of the medicare and medicaid legislation in the 1960's major changes occurred that have created shock waves and trauma. This legislation placed the government directly into the health care arena and brought Congressmen onto the scene in the role of critics of health care organizations and health care costs. Labor unions became interested and in 1968 Walter Reuther made his famous statement that health care was not a privilege but a right and that comprehensive health care should be available to all Americans. Since that time, dentistry has been challenged in a new and meaningful way by many segments of our society, by the government, by the public, by unions, by consumer groups, by health planners who would have us throw everything out the window and start over again, and by some misguided individuals who hold that we are not a profession but a trade or business and that health care can be produced in the same way General Motors produces cars or utility companies produce and distribute electricity and telephone services.

We should not be overawed or frightened by these challenges for if they were not here it would mean that dentistry was not important enough to consider in the context of a rapidly changing society. I think and I know you think dentistry is important and we want to make it important to every American.

As I have traveled around the country in the past three years, I can assure you that the dentists are concerned—the troops are restless. The dentists are worried about their future and the future of their profession. They want to become involved in combating the forces that are affecting their freedom to practice as they desire.

While the concerns of the dentist are easy to identify, it is much more difficult to find adequate solutions to their problems. The dentist is concerned about the rapid growth of prepaid dental programs and the effect and limitations they will have on his mode of practice and life style.

The dentist is concerned about the government subsidized Health Maintenance Organizations (HMOs) and the unfair competition they will develop. He is concerned about Professional Standard Review Organizations (PSROs) for while they are currently functioning only in institutions he sees this as only the first step and that controls on private practice will eventually follow.

He is very concerned about the threat of National Health Insurance and he wonders if it becomes the law of the land will it provide an environment in which private practice, our greatest asset, can flourish.

The dentist is deeply concerned about government intervention and controls such as:

1. The pressure of government to shear from the profession its traditional right to govern itself, to discipline its members and to make peer judgments on the quality of dental care.

2. The pressure of government to exercise ever increasing control over dental education by dictating the length of the educational period, the content of the curriculum and by exercising the right of the profession to accredit its educational institutions and to enforce high standards in professional education.

3. The pressure of government and other third parties to place rigid restrictions on the costs of dental care in spite of increasing inflation and the decline of the dollar's purchasing power.

4. The pressures of government to take over the present system of state licensure and to enforce the distribution of dental manpower by statute or regulation.

Another challenge is the so-called manpower shortage. In my opinion, it really is a scare and no shortage really exists. In the 1960's the health planners, mistaking the need for dental care with the demand for dental care, were able to convince the government that a shortage of dentists existed. This led to the establishment of thirteen new dental schools and the requirement for existing schools to increase their enrollments if they wished to receive federal capitation support. This mandatory enrollment increase occurred on three separate occasions. These actions resulted in a marked increase in the available dental manpower. As I have traveled around the country I have yet to go into an area where the dentists felt there was a shortage of dentists. Recent published reports confirm this fact. Yet the original version of the 1976 manpower legislation included another mandatory enrollment increase. It was only through the action of our Washington office and the efforts of the members of the dental profession who contacted their senators and protested this action that the Beall amendments were adopted. The law recently passed and signed by the President provides for alternate methods for schools to qualify for capitation without again increasing the size of the entering classes.

I believe we all recognize that the problem in dental manpower is one of distribution and not an inadequate number of dentists. In my opinion, increasing the number of dentists will not solve this problem and alternate programs such as financial incentives, tax relief, loan forgiveness, etc. must be developed to influence dentists to go to underserved areas. Furthermore, the current use of the dentist-patient ratio to determine manpower needs is not valid and a better measure, one that includes an evaluation of the demand for dental care, must be developed.

The manpower scare led to calls for expansion of the role of dental auxiliaries. This issue today is literally tearing our profession apart. Expanded functions were welcomed by the auxiliaries for they are as desirous as any humans to improve their stature and economic well-being. A special reference committee of this House of Delegates will be considering the report developed from the Workshop on Utilization of Auxiliaries held this spring. It is my sincere hope that this House will adopt guidelines that will be acceptable to all concerned—the dentist, the dental hygienist and dental assistant, so we can solve this problem and proceed with our work of providing quality care for our patients.

You will note that I did not mention expansion of duties for the dental laboratory technician. I strongly believe we are not ready for such an adventure and that we probably never will be. We must use all of our resources to prevent from happening here what happened in Canada which was the recognition and legalization of dental laboratory technicians for intraoral denture services. This was done over the strong but delayed opposition of the dental profession. This is one battle dentistry in the United States cannot lose, no matter what effort or what amount of money it will take to win it. The illegal dental practitioners are well organized and well financed and they are pushing hard to attain their objectives. They will not stand idly by while we leisurely mobilize our forces to combat their efforts. We must act now—not tomorrow—for tomorrow may be too late.

There are other challenges that come from within the profession—continuing education, the need to strengthen and support our own organizations so they can work effectively, the development of professional leadership to minimize the intervention of non-health professionals and the need of strengthening our ability to convince the public and the government of our unique competence in delivering high quality services to the people.

Serious as these problems are, I believe one of the greatest problems facing us today is the fragmentation that is occurring within our profession. The American Dental Association which was once the recognized spokesman for the dental profession is finding itself being challenged by other groups. In recent years because the profession has not only grown at a rapid rate but also because of the complex issues at stake, fragmentation has taken place. One of these groups, the dental assistants, at their meeting in 1975 were instructed by their national leaders to return to their respective states and vigorously attempt to obtain licensure or certification from their legislatures. Their national leaders are also investigating the possibility of collective bargaining as a means of obtaining their objectives. Also in a covering letter that accompanied a news release from their national organization the President of the American Dental Assistants Association stated, in part: "The release expresses the deep concern of our Association that the dental health of the public is being endangered by dentists who employ unregulated, unqualified persons as dental assistants to perform sophisticated procedures in the mouth." To me this represents fragmentation.

Some dental hygienists, undoubtedly motivated by their interest in expanded functions, are asking for the delegation of certain duties that most dentists feel should only be performed by dentists. Some of the dental laboratory technicians are stating publicly that they no longer want to be considered as dental auxiliaries, that they want to run their own "show" and do not want the dentists looking over their shoulders. Certain dental laboratory leaders are exploring the possibility of direct billing to third party carriers and even to patients for the work they do. To me all of this represents fragmentation.

Furthermore, there are at least four dental organizations in addition to the American Dental Association that have established Washington offices and have congressional liaison representatives. I am fearful that with dentistry speaking with multiple voices at the national level, our audiences will become confused and this may dilute our effectiveness and lead to further fragmentation of our profession.

I occasionally hear dentists say that the American Dental Association does not adequately represent the interests of the general practitioner. If this is so—and I hasten to state that I do not agree with this statement—I must ask why? I have repeatedly stated that the general practitioner is the backbone of our profession and that his interests must be protected at all costs. The American Dental Association should represent all dentists. If there are problems in this representation we should identify them and take corrective action. The mechanism to make changes is present and if changes are indicated, let us make them without delay.

In my tenure as an officer of this Association, I have repeatedly emphasized the need for unity in our profession. Dentistry is a complex profession made up of many segments. The dental team is made up of dentists who are general practitioners, specialists, researchers, teachers, and administrators, as well as dental hygienists, dental assistants and dental laboratory technicians. All members of the team are dependent on each other and all make contributions to the overall effort. I often hear dental hygienists and dental assistants refer to the "dental hygiene profession" and the "dental assisting profession." I hold that there is only one profession and that is "dentistry." All segments of the profession are essential to the efficient and effective fulfillment of our mission.

As we face the many challenges confronting us it is essential that we present a united front and speak with one voice to our many audiences. Diversity of opinion is invaluable and in no sense should it be ruled out. I would emphasize, however, that while

there is room *within* the profession for a broad range of opinions and programs, diversity in itself should end at the profession's door. The entire profession should present a unity of purpose and a unity of voice in its approach to the outside world which includes all of dentistry's publics--Congress, state and local governments, unions, industry, consumer groups, third party carriers, and above all else, the general public.

I believe the American Dental Association is the proper organization to speak for dentistry and I further believe all allied groups should operate under the covering umbrella of the Association. Since its founding the Association has attempted to promote the interests of all members of the profession. Over the years the Association has been successful in reflecting the attitudes of most segments of the profession to the public and to the federal and state governments and it has served to enhance dentistry's reputation and the quality of care delivered to the public. Further the Association has been in a large measure responsible for the increased quality of dental care, dental education, dental research and dental literature.

We must all recognize the fact that dentistry is only a small segment of the total health field and we cannot afford to squander our resources and our strength with diverse messages. We must come together to stay strong.

I have several suggestions that will do much to restore unity. First, we should recognize the contribution made by dental auxiliaries and give them the recognition they deserve. We should assist in solving their problems and above all, pay them adequately for the contributions they make.

Next we must recognize that prepaid dental programs are here to stay and they are going to expand in the future. We must learn to live with them and work with the carriers to see that the programs are designed to be in the best interests of our patients and of the profession. We must work diligently to prevent the carriers from interfering with the doctor-patient relationship that has worked so well, for so long, for all concerned.

We must realize that in the future there is going to be more than one way to practice dentistry. Certainly private practice will survive with solo practices, partnerships, associateships and group practices. There may well be ethical capitation programs and undoubtedly there will be an expansion of the subsidized clinics to provide care for the indigent. The important thing to remember is that changes are going to occur and if we wish to preserve our proven effective delivery systems, we must have input into what these changes will be.

This means that we must all get involved, not just a few, but everyone—every dentist, every dentist's wife, every dental hygienist, every dental assistant, every dental laboratory technician, and every member of the dental trade. Laws will be introduced in Congress and in the various state legislatures that will affect the way dental care is delivered and the way the dentist will practice. If dentistry wishes to influence this legislation then it must get involved in political action. We must seek our legislators who want the same thing that we want—and that is the finest possible oral health care for the people we serve. There are legislators who also want this so we must seek them out and support them—support them physically by working for them in their campaigns and supporting them with our money. We certainly cannot buy their votes, but we can buy the right to be heard. I am firmly convinced that if we tell dentistry's story, the story of the private practice, fee for service delivery system, to the right people in the right place at the right time, we will be able to preserve our profession

as we know it today for the benefit of the patients we serve and for those who follow us in this wonderful profession.

Now I would like to discuss some of the specific concerns that have been expressed during the past year. One is the desire to develop alternate plans for dealing with the rapid expansion of prepaid dental programs. While approximately thirty million people are now covered by some type of a prepaid dental program, it is estimated that this number will reach sixty to eighty million by 1980.

One of the alternate plans that has been proposed is the development of dental unions. I am aware of at least one component society that has formed a union and I know that individual dentists have joined a national organization that is in reality a union comprised of physicians and dentists.

I can see no present circumstances under which I could support self-employed dentists in private practice establishing or joining a trade union for the purpose of negotiating economic benefits with third parties involved in providing dental health care. As a citizen I accept trade unions for, in spite of abuses, they have the virtue of bringing employer and employee to the negotiating table to hammer out solutions that are acceptable to both parties. I believe, however, that members of a profession have a higher interest and obligation than the negotiating of economic benefits. I believe in the principles and ethics of the dental profession which state firmly that the first and overriding obligation of the dentist must be his service to his patient and to the public. I also believe just as firmly that every dentist has a right to a livelihood commensurate with his education and service to his patients. However, I do not believe that membership in a trade union is the way for a dentist to enforce that right. The profession has local, state and national dental societies to insure that the rights of both the public and the profession are safeguarded in the interest of providing the highest type of health service. I would rather put my faith in fair play in the hands of my elected dental society officials than I would in trade union managers who may not place the best interests of the public and the profession first in their negotiations.

The right to strike is the principal weapon of the trade union and, although I may be considered old fashioned, I am not yet prepared to strike against my patients.

Finally, I am concerned about the public reaction to an effort by dentists to seek union status to negotiate economic benefits. I see a fatal conflict in holding ourselves out as health professionals recognized by law and society and then turning around and compelling all of the advantages of the market place through union negotiations. The public would make its own decision in such a conflict.

Another concern that bothers us is the controversy that exists concerning the use of the root canal filling materials for which therapeutic claims are made. Of course I am referring to N_2, RC-2B or the Sargenti technique. I am particularly concerned that this controversy was aired before a public Congressional hearing and at an open meeting of the Dental Drug Products Advisory Committee of the Food and Drug Administration. These hearings resulted in extensive coverage in the news media, including papers and magazines with a national circulation.

In my opinion, such controversies should be discussed and settled within the profession and not aired in public. The inevitable result of public discussion of such problems is a decrease in the trust and confidence the public has in their dentist and in the dental profession. There is no question about the importance of resolving the issue and that the American Dental Association should play an important role in de-

termining the proper role for these materials in dental practice. However, the discussions and controversies should be confined to dental organizations and the public should be informed only after a solution has been found that is acceptable.

I strongly urge all organizations who may be confronted with controversial issues to keep them within the profession and not make them public issues.

A growing concern is developing about dental education. There is the feeling that our dental schools may not be placing the proper emphasis on developing clinical proficiency in their students. The 1974 House of Delegates expressed this concern and directed that a curriculum survey be accomplished. The Council on Dental Education contacted each dean expressing concern and pointing out that the curriculum should cover all aspects of clinical dentistry and that all graduates should be capable of practicing comprehensive dentistry in a capable manner. The Federation of Prosthetic Organizations also contacted the deans stating they felt the training in prosthodontics at the undergraduate level was inadequate. It is essential for schools to evaluate their objectives and make certain they are providing the proper educational opportunities for their students. I personally feel that it is the responsibility of dental schools to teach students to recognize dental disease, to diagnose the disease, then develop a treatment plan to correct the problem and complete the treatment at an acceptable level of quality. They must also be taught their own limitations and not undertake procedures that are beyond their comfortable range of operative ability.

The curriculum survey ordered by the 1974 House of Delegates is nearing completion and the preliminary report has been submitted to this House. If this survey reveals deficiencies, corrective measures should be implemented without delay to insure that only qualified students who are capable of practicing good comprehensive dentistry are allowed to graduate.

The Committee on Advance Planning of the Board of Trustees has worked diligently this year to develop plans to make the Association more responsive to current problems and challenges. The Board of Trustees considered the Committee's recommendations last week and has forwarded the report with their recommendations to the House of Delegates. If adopted it will result in certain changes in the organization, management and operation of the Association.

One item the Committee did not consider was the length of the term of the trustee. They decided not to consider this subject until they could also evaluate the advisability of changing the current structure of the fourteen Trustee Districts.

However, I believe these issues can be separated and I hope this House of Delegates will consider making a change in the tenure of the trustees. Currently a trustee can serve for two three-year terms, a total of six years. If he decides to run for President-Elect and is successful, his tenure is extended to eight years. If he does not seek this office and is elected to the Office of Treasurer for a three-year term, his tenure becomes nine years.

This arrangement limits the number of qualified members who are able to serve in these responsible positions. In multiple state districts that have the policy of rotating the office among the various states, the opportunity of a leader in any particular state to serve as a trustee is remote.

I am firmly convinced that there are many capable leaders in our profession who would make excellent trustees and who should have a better opportunity of serving on the Board of Trustees. Therefore, I am requesting the Reference Committee on President's Address and Miscellaneous Matters to give serious consideration to de-

veloping changes in the *Constitution and Bylaws* that would limit the term of trustees to one four-year term or two two-year terms. I suggest that the change become effective for trustees elected after the 1976 House of Delegates and that any trustee now serving or elected in 1976 not be affected by this change.

Any individual being considered as a possible trustee will have demonstrated his leadership qualities and will be familiar with the responsibilities and duties of the trustee. If selected he can become well oriented on Board procedures during his first year and then function efficiently and effectively for the remainder of his term. By limiting the term of trustees in this manner it will allow more dentists to serve and result in a more rapid turnover of Board members. This should result in new ideas, new thoughts and new leadership for our profession.

This year the Board considered the possibility of electing one of the active trustees as Treasurer. It was not implemented because our *Constitution and Bylaws* specify that the Treasurer be elected by the Board of Trustees from any active or life member of the Association. The current procedure has been to elect a retiring trustee to serve as Treasurer for three years. This policy is expensive and adds little to the efficient operation of the Board of Trustees. The Board of Trustees is recommending a logical change in the *Constitution and Bylaws* that would change this procedure. The Board is recommending the election of one of the trustees to the office of Treasurer and having this trustee also serve as chairman of the Finance Committee. This is a practical and economical solution and, in my opinion, worthy of adoption. I strongly urge your support of this proposal.

While on the subject of reorganization and realizing I am bringing up a very "touchy" subject, perhaps it is time for the House of Delegates to consider placing a limit on the length of time a member can serve as a delegate. Terms are limited for trustees and council members and perhaps this should be extended to delegates. We all realize the importance of the experience, knowledge and wisdom that comes to delegates from long tenure. We also realize the importance of getting more dentists involved in the affairs of the Association and of bringing younger members into our decision making body. Hence, it would be ideal if we could develop a happy medium which would incorporate the wisdom and experience of long tenure with the enthusiasm, vitality and new ideas of newer delegates. We are told there is approximately a thirty percent turnover in the House of Delegates each year. If this were studied carefully I believe it would probably reveal that the turnover is primarily in the newer delegates and that the older delegates go on and on and on.

I realize that determining the terms of delegates is the responsibility and prerogative of the constituent societies and that the national organization should not dictate to these societies. However, I do believe it proper for the House of Delegates of the American Dental Association to develop guidelines in this area and then encourage the constituent societies to consider adopting them.

I am pleased to report that there have been several favorable actions taken during the past year. The first was our response to the request of the Federal Trade Commission, They wanted to evaluate our *Principles of Ethics* to determine if we were violating the anti-trust laws. We evaluated the situation and, with the advice of outside counsel, we determined we were not violating the law. We therefore refused to comply with their request. To my knowledge this is the first time our organization has "stood up" to the federal government in their attempts to regulate the dental profession.

A second important stand was taken in July when we presented testimony before the

President's Council on Wage and Price Stability. In April the Council had published a report on the escalating health costs. Dental costs, which for a decade had risen more slowly than the average costs for other services throughout the economy, were excluded. We resented this, so, utilizing government figures and statistics, we pointed out that dentists had done an outstanding job in holding the line on fees and that dental care costs had not been inflationary, instead they had exerted a moderating influence on overall health costs. Furthermore, we pointed out that the increase in the costs of conducting a dental practice had far outstripped the increase in dental fees.

This testimony received wide coverage in the professional and lay press and did much to improve our image in the eyes of the public.

A third item worthy of mention was covered earlier in my report. This was the fine response from the members of the profession that was largely responsible for the changes in the current manpower legislation which made it much more compatible with Association policy. It demonstrated the importance of concerted action and the real political "clout" we have when it is properly directed.

These accomplishments were made possible by the dedicated efforts of the members of the American Dental Association and I highly commend you all for your efforts.

I am hesitant to discuss the next subject but it is of such importance that I must do so. You have been informed through Association publications that the Board of Trustees is recommending a $75.00 dues increase which will be carried over to the 1978 House of Delegates for action unless it is passed unanimously by this House. I call your attention to the fact that it was necessary to reduce the 1977 requests of councils, bureaus and agencies by over $1,800,000 to arrive at a balanced budget. The cuts included a number of successful ongoing programs such as $1,100,000 from the Public Education Program, $300,000 from funding of a health education program on illegal dentistry, all the ADA's health exhibits program, several new educational films that are greatly needed, and numerous other programs. Virtually no new projects are scheduled for 1977.

This dues raise is a critical issue and you must give it your serious consideration. Never in the history of dentistry have so many pressures been applied to alter our current delivery system and the practice of our profession as we know it today. It is essential that we face these challenges and try to resolve them to our benefit. Inadequate financing will adversely affect our Association in many areas of its responsibilities. We need funds to prevent an adverse impact on prepaid dental care programs, peer review, federal legislation, public information, dental students' financial needs, the prevention of the illegal practice of dentistry and many others.

It is critical that you understand that these challenges are here now and that they are not going to go away. Delays in meeting these issues for financial reasons could be calamitous since the future of each and every member of the Association is at stake. Since the Association has no mechanism to assess its members to provide emergency funds, the only way to finance the needed programs is through this dues raise or by utilizing the Association's reserves.

It must be recognized that those groups whose interests are not compatible with those of organized dentistry will not declare a moratorium on their activities until such a time as dentistry deems fit to meet these challenges. While reasonable minds may differ over the best means of meeting these challenges, reasonable minds cannot differ over the necessity of meeting them now.

I urge each of you to carefully read and evaluate pages 205 and 206 of the *Supplement*. It is your future that is at stake. While I may be naive and it may be wishful thinking on my part, I believe if you honestly and conscientiously look at the situation and if you truly have the best interests of your profession at heart, you will see the importance of acting on and passing Resolution 88 at this session of the House of Delegates. Gentlemen, I warn you, tomorrow may be too late.

Before closing, I would like to make an additional point. I have discussed many of the challenges facing our profession today but there is an additional one that I think is very important and that is- -the challenge of being a health professional. In 1969 the Department of Labor issued a Bulletin stating there were 21,741 occupations and professions available to the classes graduating from our universities. Today, there are probably more. As we think about these 21,741 occupations and professions we must ask ourselves how many give to their members the right to do what we can do. How many convey the right to operate on living tissue, the right to prescribe drugs for a human being, and the right to relieve the pain and suffering of one's fellow man. There are not very many—medicine, dentistry, osteopathy, podiatry and optometry. There are perhaps a few more, but it is less than ten. For this reason health professionals are a group apart, they are different than other people and great responsibilities fall on their shoulders. Much is expected of them. There is no place for mediocrity in the healing arts. The patients we treat are someone's loved ones and we must treat them with skill, dignity and compassion. We must do unto others what we would want done to ourselves in similar circumstances. We must work diligently to keep abreast of new developments so our patients will receive the best of care.

We must realize that no one can do dentistry except dentists. We are providing an essential service and we are doing an outstanding job in bringing the finest care to our patients. We must always remember that we will be judged as individuals and as a profession by the people we serve, our patients. If we treat them well and keep their interests foremost in our minds, I am confident that we have little to worry about in the future. If we take the proper care of our patients in the end they will take care of us.

Dentistry has come a long, long way in the 200 years we have been a nation. In bringing our profession to its present state of excellence the dentists who preceded us were faced with many problems that required solutions. Most of their problems were in the scientific and professional area; however, this matters little, they were problems that were solved. Today the current generation of dentists is faced with additional problems. These problems are different for they are primarily in the socio-economic and political areas. Nevertheless, they are problems that require solutions. Do we, the current generation, have the same intelligence, imagination, initiative and integrity that was demonstrated by our forefathers to solve these current problems?

Two hundred years from now undoubtedly a President of the American Dental Association will be standing at a similar podium reporting to the House of Delegates. He will undoubtedly be looking back two hundred years as we are doing today and evaluating the performance and achievements of the dental profession in 1976. I pray that we are not found wanting.

Any accomplishments made this year have been the result of the efforts of many individuals. It would be impossible for me to identify and thank them all. I am deeply indebted to my fellow Officers and the Trustees for their guidance, advice, and counsel. I am most grateful for their understanding and patience. I assure you

the affairs of the Association are in good hands and you are fortunate to have such a dedicated, hardworking and capable group of Trustees looking after your affairs. I am also indebted to Dr. C. Gordon Watson and the fine staff he has assembled. They are knowledgeable individuals and working together they make an efficient team. Our Association is blessed by having such an outstanding and efficient staff and I thank them all for their loyal support. Beyond all else, I am indebted to you, the members of the Association for the confidence you have placed in me. I have tried my best. I hope I have represented you well and that you have not found me wanting. Thank you for your loyal support.

We are all indebted to Dr. Louis Hendrickson and his local arrangements committee. They have provided us with a truly wonderful meeting which will be an experience we will all remember. We realize the great effort that went into the detailed planning and the endless hours they devoted to this project. We are deeply in their debt. I wish to particularly thank Dr. Robert Morrison for his efforts in arranging for the President's Reception and Dinner Dance. I know it will be a delightful affair. So, Dr. Henrickson, on behalf of all the dentists attending this meeting, I salute you and your committee and extend our sincere thanks for your efforts in our behalf.

It has been a rare privilege to serve as your President. I could not have had a successful tenure without the understanding, support and love of my wife Eileen. She has stood by my side through thick and thin and has always been my strongest supporter. Earlier in my career when I was so active as a clinician I was frequently away from home. The fact that our three daughters grew up to be the lovely ladies they are, and of whom we are very proud, is due to Eileen, not myself. When I should have been home helping raise our family, I was away working for my profession. I can never repay my lovely lady for all she has done for me.

I am extremely proud to be a dentist and am extremely proud that I could serve you in this high office. I assure you I will continue my efforts for organized dentistry and I will be "standing by" ready and able to fulfill any task that you may wish to assign to me in the future.

In closing, I want to repeat my call for unity. If there ever was a time that we needed to display a united front it is now. So let us all lay aside our petty differences -our individual desires, and concentrate on what is best for our profession.

I wish to leave you with the words Jesus spoke to his disciples on the evening of the last supper. They were gathered in the Upper Room and were about to partake of the food that had been prepared. Jesus turned to the disciples and said: "Listen, fellows, we had better all get together on the same side of the table or we won't all fit into the picture."

And I say to all segments of the dental profession: "We had better all get together on the same side of the table or we won't all fit into the picture."

Thank you.

Council on Dental Care Programs

Lentchner, Emil W., New York, 1976, chairman
Davidson, Ellwood F., Washington, 1976, vice chairman
Booth, William A., Pennsylvania, 1976 (ad interim)
Breaud, Polyet M., Louisiana, 1978
DiStasio, Joseph G., Massachusetts, 1976 (ad interim)
Francis, Sidney R., California, 1977
Hahn, Roger M., Florida, 1978
King, Duncan A., Kentucky, 1977 (ad interim)
Larson, Gerald A., Wisconsin, 1978 (ad interim)
Lauer, Robert E., Ohio, 1978
Moran, Bernard J., Nebraska, 1977 (ad interim)
Ticknor, Robert C., Arizona, 1977 (ad interim)
Truono, Eugene J., Delaware, 1976 (ad interim)
Weil, Lewis L., Illinois, 1977 (ad interim)
Bishop, Eric M., secretary
Hardyman, Stephen A., assistant secretary
Marshall, James Y., assistant secretary
O'Donnell, John F., assistant secretary

Meetings: The Council met on November 19-21, 1975, January 28-30, 1976, and April 22-24, 1976. Three additional meetings are scheduled for 1976. Representatives of the American Dental Trade Association, Health Insurance Association of America, Delta Dental Plans Association, Blue Cross Association, National Association of Blue Shield Plans, Public Health Service Division of Dentistry, Office of the Assistant Secretary for Health and the Bureau of Quality Assurance, Department of Health, Education, and Welfare, and consultants Drs. William G. Schmidt, Frank L. Shuford, Jr., and F. Gene Dixon were also in attendance at one or more of the meetings.

Dr. Lloyd J. Phillips, seventh district trustee, attended the November and April meetings at the invitation of the Council as the Board of Trustees representative.

Dr. Coleman Gertler, ninth district trustee and former Council member, attended the November meeting as a Board of Trustees observer. M. Keith Weikel, PhD, commissioner, Medical Services Administration, Department of Health, Education, and Welfare, addressed the Council at the January meeting on the role of dentistry in Medicaid. The Council wishes to express its appreciation to Dr. Weikel for his most informative presentation.

Personnel: At the November meeting, Dr. Ellwood F. Davidson was unanimously elected vice-chairman.

Conferences: The Council cosponsored with the Council on Dental Health the National Dental Health Conference held in April 1976. In addition, the Council has scheduled a Dental Care workshop conference for September 1976.

Peer Review Workshops: Peer review workshops involving 33 constituent societies have been conducted since September 1975. These one-day workshops, held at the invitation of state societies, featured the film "Peer Review: A Dialogue for Dentists," as well as panel discussions responding to audience concerns. The "Peer Review Procedure Manual" provided the central focus for discussing procedures and emphasized the importance of establishing uniformity nation wide. As of June 1976, 23 constituent societies had substantially adopted a uniform approach to peer review as suggested in the Manual. The workshop format is informal, designed to foster active interaction by all attendees.

The peer review workshop programs will continue into 1977 on a limited basis, responding to those additional states that express interest. Regional meetings are being planned to serve as a follow-up to the initial state peer review workshops.

"Code on Dental Procedures and Nomenclature": As requested by the 1975 House of Delegates (*Trans.* 1975:648), the Council reviewed all suggestions submitted by dental organizations and individuals and approved the latest revision of the *Code on Dental Procedures and Nomenclature*. The revised *Code* was subsequently published in the March 1976 issue of *The Journal of the American Dental Association*. Copies are available on request from the Council.

Study of United Auto Workers/Automotive Program: The study of the effects of the UAW--automotive dental benefits program, begun in 1974, continues under the direction of the Division of Dentistry (HEW). Council members are among those functioning as ad hoc consultants to the study. In January and February 1976, in consultation with members of its project review panel, comprising representatives of the profession and the health insurance industry and independent consultants, the Division undertook a revision of the project that would broaden the study base to include dental benefits plans in addition to the UAW—automotive program, thereby expanding the study population considerably beyond the 3 million automotive industry employees and their dependents originally included.

In May, the Division was nearing completion of a Request for Proposal which will detail the objectives of this expanded study. It is expected that the 12-member project review panel, which includes the Council chairman and three other Association-designated members, will continue to serve as consultants under the revised project format.

Carrier Communication: An ongoing activity of the Council on Dental Care Programs has been to review and comment on third-party carrier form letters used to communicate with insureds and providers. These letters on occasion serve to polarize the patient and dentist due to careless wording regarding benefit determinations.

In an effort to eliminate this problem, the Council has been requesting from the major carriers samples of their basic letters. Submissions are being reviewed by Council members so that modifications and improvements may be urged on the carriers.

Position Statement Regarding "Office Audit": A House of Delegates resolution (*Trans.* 1975:657) states opposition to any attempt by third-party prepayment mechanisms to preempt professional review functions through such methods as audits of provider office records, unless understood and provided for in a contract with the dentist. The Council has notified all appropriate prepayment agencies of this statement. The

Council is opposing the office audit concept as currently designed in specific prepayment programs.

Brochure on Dental Reimbursement Methods: The House of Delegates directed the Council on Dental Care Programs (*Trans.* 1975:661) to develop an informational brochure on established methods of reimbursement in dental prepayment programs, including the "bill payer" approaches for appropriate distribution. A draft of this brochure was reviewed by the Council at its April meeting. A final draft is being prepared for Council approval and release during 1976.

The brochure will serve as a guide to both purchasers and the general public interested in the various administrative and professional aspects of dental prepayment.

Patient Financial Understanding Form: In response to the House of Delegates resolution (*Trans.* 1975:649) directing the Council to "develop and make available a financial understanding form for those dentists desiring such a mechanism," the Council approved two forms for simple-payment plans and time-payment plans at its April meeting. The forms are expected to be available to members by summer.

Council Study of United Auto Workers/Automotive Program: As an aid to the Council's effort to provide specific information into the renegotiations of the UAW/automotive dental benefit, a survey was conducted during winter 1975-1976, which was designed to determine the impact of this program on individual dentists and their practices.

A preliminary report of the findings was reviewed by the Council at its April meeting. Further analysis was considered necessary before final reporting of the results. A final draft is scheduled for review by the Council at its June 30-July 1 meeting.

The study involved a mail questionnaire to dentists in four states which was ultimately returned by 822 dentists or 45 percent of those surveyed. The administrative impact of the program and individual carrier performance were evaluated by the dentist respondents.

Standardization of Dental Prepayment Terms: As directed by the House of Delegates (*Trans.* 1973:668) the Council prepared and published a glossary of dental prepayment terms. The glossary appeared in the February 1976 issue of *The Journal of the American Dental Association.*

The Council will consider additions to and modifications of the glossary as necessary.

Meetings with Purchasers and Insurers: The Council has maintained an active program of liaison with the purchasers and insurers of dental prepayment programs. This effort also includes meetings with groups who are renegotiating existing dental benefits in union contracts.

In anticipation of the UAW/Auto Manufacturer's contract being renewed effective October 1, 1976, representatives of the Council and staff met separately in the spring with the United Auto Workers and each of the three largest auto manufacturers. Experience with the original dental programs and suggestions for improvement were discussed at these meetings. Similar contract renewal meetings for other major dental programs will be held in the future.

Several meetings with groups purchasing dental benefits for the first time have been held this year. Included in these groups are Westinghouse Electric Corporation,

Union Carbide Corporation and E. I. duPont de Nemours and Company, Incorporated. These major employers will add nearly one million individuals to the ranks of those with dental prepayment. At each meeting, the Council representatives presented the profession's view of sound, responsible dental prepayment programs.

This year the Council on Dental Care Programs began a series of meetings with individual carriers in addition to regular attendance at the Health Insurance Association of American Dental Relations Committee meetings. Most recently, meetings have been held with Aetna, Connecticut General, Travelers, and Metropolitan Life.

Fee Reimbursement Concepts: In response to the House of Delegates directive (*Trans.* 1975:646) concerning the methods used by dental prepayment carriers to determine ranges of fees, the Council on Dental Care Programs has surveyed a representative number of carriers for their specific methodologies. Consultation with an outside actuarial firm to evaluate this material is being arranged before the Council makes further recommendations as to how best to carry out the intent of the House action.

Health Maintenance Organizations: Legislative proposals to amend the HMOs (PL 93-222) remain, as of this date, under consideration in Congress. In November 1975, the House of Representatives passed its version of the amendments; in May 1976, another version was awaiting action in the Senate. In part, these amendments would change the present law's requirements for certification of an organization as a federally qualified HMO by reducing the number of basic health services now mandated and allowing HMOs to offer supplemental health services or not, at their option.

In February 1976, the Council, in concert with the Council on Legislation and the Washington office, commented on the proposed amendments to the Committee on Labor and Public Welfare. The Association's position was reiterated in these comments that the HMO is an experimental health care delivery system of which little is known, particularly with respect to dentistry and when compared to the traditional private practice delivery system. The Association commented further that the experimental testing of an HMO's usefulness will prove valuable and will yield results of some pertinence to the American people only if the testing is designed in such a way that all HMOs are asked to compete on an equal basis with other delivery systems, rather than the present bias in favor of the "closed panel" HMO.

The Council is engaged in a program of data collection on federally qualified HMOs with respect to their dental programs. In mid May 1976, responses to a Council request for descriptive information were pending from the majority of the 13 "certified" HMOs.

As of May 1976, regulations on the advertising provisions of the HMO law had not been published nor had a date for such publication been announced. The Council is prepared to contribute to Association comment on these regulations when published.

Professional Standards Review Organizations: In May 1976, 120 PSROs were in existence, of which 65 are conditional and 55 are planning organizations. Thus, 83 of the 203 designated areas are without a PSRO. The original objective of negotiating contracts with physician groups in all designated areas by January 1, 1976 was not achieved; by amendment to the law, basically the same procedure for contract negotiations will be continued until January 1, 1978.

In another of the 1975 PSRO amendments (PL 94-182), physicians in states in

which no organization has been designated a PSRO for any area are afforded the opportunity through polling to have their state redesignated as a simple PSRO area. Proposed regulations governing this procedure were published in late April 1976.

Funding limitations remain a significant factor in the slow implementation of the PSRO law. Hearings relative to the failure to meet the original PSRO timetable nationwide were scheduled for late May 1976 by the House of Representatives Ways and Means Oversight Subcommittee.

In February 1976, the Council reviewed and developed Association comments on a proposed technical assistance document, "Suggestions for the Involvement of Non-Physicians Health Care Practitioners in the PSRO Short-Stay Hospital Review." These comments reiterated the Association's concern that within the PSRO law there is no statutory mandate that the review of dental services be performed by dentists, as well as the Association's position that this inequity will be fully remedied only through amendment to the law. The Association further pointed out, however, that this draft document was seriously in error in not specifying dentists as being among "those practitioners who have hospital admitting privileges and receive direct reimbursement." The Association's comments were accepted in the revision of this proposed document.

As of May 1976, the Association's proposed amendments to the PSRO law, which would correct discriminating aspects of the law such as the exclusion of dentists from PSRO membership, were still under consideration in the Senate Finance Committee.

Responses to House Actions: The Council's principal activity during 1976 has involved the substantial and continuing effort in response to resolutions of the 1975 House of Delegates including examination of the Association's relationship with the Delta Dental Plans Association (*Trans.* 1975:666), study of prepayment experience in states with diverse policies (*Trans.* 1975:648), consideration of the table of allowance as the preferred reimbursement mechanism in lieu of the usual, customary and reasonable concept (*Trans.* 1975:661), and the question of reimbursement differences based on the practitioner executing a participating agreement (*Trans.* 1975: 656). Reports of these projects will be submitted to the 1976 House of Delegates by way of supplemental documents to be reviewed at the Council's June 30-July 1 meeting.

Fourth-Party Closed Panel Programs: The 1975 House of Delegates approved the following resolution (*Trans.* 1975:664) which was subsequently assigned by the Board of Trustees to the Council for action.

> **Resolved,** that the appropriate agencies of the Association be directed to investigate, monitor and take appropriate action with respect to fourth-party closed panel programs, and be it further
>
> **Resolved,** that necessary resources to implement these efforts be allocated immediately, and be it further
>
> **Resolved,** that the agencies involved report on their activities to the 1976 House of Delegates.

At its January 1976 meeting, the Council approved the following working definition, as a preliminary step in the investigative phase of its activity:

> For purposes of this study, a fourth-party closed panel program is defined as a dental benefits plan, owned, managed, supervised, or otherwise directed by other than dentists, in which subscribers, in order to obtain benefits must receive covered services from specified dentists or at specified dental facilities.

In February 1976, the Council commenced a canvass of constituent societies to determine the prevalence of such programs nationwide. A 60 percent response to this survey had been achieved by mid May, with plans appealing to meet the Council's working definition being reported in four states. Descriptive information and promotional materials have been requested from the plans reported to date.

The Council intends to continue its investigative activity in order to develop descriptive profiles on such plans as defined. At the same time, it envisions the approaching need to broaden this study to include, as well, plans in which a member of the profession serves an essentially directorial function, apart from his possession of a professional degree, when such plans contain the other elements of a working definition.

A progress report with recommendations for continuing activity will be submitted to the 1976 House of Delegates.

Dental Practice Review and Department of Health, Education, and Welfare Quality Contract: In March 1976, the Association received from the Health Services Administration (HEW) a Request for Proposal for "Model(s) for Conducting Review of the Quality, Necessity, and Appropriateness of Dental Services Consistent with Requirements under Professional Standards Review Organizations." One year earlier, the Association had submitted a related, unsolicited proposal to Develop Standards and Criteria for the PSRO Assessment of Dental Care to the Office of Professional Standards Review.

The Request for Proposal states as the purposes of the contract the examination, analysis and description of past and current systems for conducting quality assurance review of dental care provided in an ambulatory setting; identification or development of appropriate models for the review of the quality and appropriate utilization of dental services, together with sample criteria; and the development of a medical care evaluation study model utilizing quality dental criteria for patients hospitalized with several different dental conditions.

The Council, in cooperation with the Bureau of Economic Research and Statistics and the Council on Hospital Dental Service, prepared for Association submission in May 1976, a proposal in response to the Health Services Administration's request.

Medicaid: The Council continues to monitor the dental components of Medicaid and of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, which is intended to provide medical and dental care to Medicaid-eligible children. This Council activity mainly involves liaison with the Medical Services Administration and individual state Medicaid agencies.

In response to a 1975 House of Delegates resolution calling for study of Dr. L. M. Kennedy's proposal to develop a legislative draft for a national program of dental care for the indigent (*Trans.* 1975:736), the Board of Trustees has directed the Council, with the Council on Dental Health, to review the *Association Guidelines for Dental Programs under Title XIX* (Medicaid) (*Trans.* 1968:53, 308) with attention to national minimum dental benefits for all categories of indigent persons and national minimum means tests. Additionally, the Board directed the Councils

to review Association policies on Medicare dental benefits with special attention to the dental needs of low income retired persons. Council staff is exploring the possibility of coordinating its examination of indigent dental care with a study being contemplated by the Medical Services Administration. A project design will be submitted to the Council for review and approval at its June 1976 meeting.

The Council is reviewing the Medicare-Medicaid Administrative and Reimbursement Reform Act (S. 3205), preparatory to contributing to Association testimony at Senate Committee on Finance hearings expected to be held in June 1976. The bill was introduced by Senator Herman Talmadge (D-Georgia), chairman of the health subcommittee of the Senate Finance Committee.

Health Insurance Study: This Rand Corporation project, being funded by the Department of Health, Education, and Welfare, to determine the effects of varied health insurance plans on the health of the population, the cost and quality of health care provided and the existing supply of medical and dental services is now operating at two sites, Dayton, Ohio and Seattle, Washington. Enrollment in the study's other two sites, Fitchburg, Franklin County, Massachusetts, and Charleston, Georgetown County, South Carolina, is expected in the summer and fall 1976, respectively.

Glen Slaughter and Associates, Oakland, California, the subcontractor administering the project, has adopted a policy of selecting local dentist consultants at each of the four sites with the advice of the concerned dental societies.

A Rand Corporation representative estimated that, by mid 1976, the first meaningful data on dental claims will have been collected.

RESOLUTIONS

This report is informational in nature and no resolutions are presented.

COUNCIL ON DENTAL CARE PROGRAMS: SUPPLEMENTAL REPORT 1

UCR and Table of Allowance: The 1975 House of Delegates referred the following Resolution 884 (*Trans.* 1975:661) to the Council for study and report back in 1976:

> Resolved, that the American Dental Association adopt as a preferred reimbursement mechanism the table of allowance and indemnity type schedules in place of the UCR concept, and be it further
> Resolved, that all spokespersons for the Association promote these concepts in their consultation with management, labor and government organizations.

Present Association policy states that provision for payment on the basis of the dentist's usual, customary, and reasonable fee is the preferred reimbursement method in third-party programs.

The *Standards for Dental Prepayment Programs* (revised November, 1974—*Trans.* 1974:639) state, in part:

> 21. The usual, customary and reasonable fee reimbursement method is preferred but various methods may be allowed. A capitation reimbursement should not be imposed.

As defined in the *Glossary of Dental Prepayment Terms,* prepared by the Council and published in the February 1976 *Journal of the American Dental Association,* the two methods under study are:

> usual, customary and reasonable fees:
>
> **usual fee:** The usual fee is that fee usually charged, for a given service, by an individual dentist to his private patient, that is, his own usual fee.
>
> **customary fee:** A fee is customary if it is in the range of the usual fee charged by dentists of similar training and experience, for the same service within the specific and limited geographic area (socioeconomic area of a metropolitan area or of a county).
>
> **reasonable fee:** A fee is reasonable if it meets these two criteria or in the opinion of the responsible dental association's review committee is justifiable considering the special circumstances or the particular case in question (*Trans.* 1973:665).
>
> Private insurance carriers do not commonly utilize the term "usual" in contract language but incorporate the concept of "usual" in their definition for customary and reasonable.*
>
> **table of allowances:** A list of covered services that assigns to each service a sum which represents the total obligation of the plan with respect to payment for such service, but which does not necessarily represent the dentist's full fee for that service (*Trans.* 1965:84, 354). Synonyms: Fee schedule, schedule of allowances, indemnification schedule.

In its consideration of this resolution, the Council accepted three premises as fundamental to the Association's policy on payment or reimbursement mechanisms in dental prepayment programs:

a. such policy should be preferential;

b. any judgment of preference must recognize the interests of the public as well as of the profession;

c. any preference, to be persuasive, must be made in the context of marketing and administrative realities.

Proceeding from these premises, the Council canvassed representatives of the profession as well as of major purchasers, employee-group representatives, insurers, and insurance brokers to elicit evaluations of the viabilities of these two payment concepts, based on experience in dental prepayment. It was suggested that the respondents address each method with respect to the following considerations: acceptability to major prospective purchasers; susceptibility to quality assurance and appropriate

*The Council notes that private carriers of late are employing the term "reasonable and customary" without further explanation in describing a reimbursement method that is identical or extremely similar to the UCR method.

cost control mechanisms and capability of providing individual beneficiary satisfaction. The Council also solicited opinions on the acceptability of each new method to organized labor nationwide; the means utilized by insurers in presenting these systems of reimbursement to subscribers; facility of administration in the dental office and the perceived effects of each mechanism upon dentist-patient relationships.

In addition, the Council extracted relevant opinion from the fall 1975 *Survey of Dentists* conducted by the Bureau of Economic Research and Statistics and accepted for consideration expressed opinions of the two systems' relative strengths and weaknesses as they have been experienced over time by practicing dentists.

Respondents to the Council survey provided thoughtful evaluation of the two concepts, as well as compelling arguments to support a preference for each.

In substance, those favoring a reimbursement system based on the dentist's usual, customary and reasonable fee pointed to the emergence of this system over the history of health benefits plans as the one best suited to the needs of the sophisticated purchasing group, a group that has reached a consensus as to the apparent and real effects of benefits plans of varying design upon the group's financial base.

Ordinarily, this consensus has been achieved through experience of extended length and primarily in medical benefits programs. Early in these programs' history, allowances were employed with considerable frequency. Because allowances can, at best, respond to rising costs only incrementally, the market for plans employing this concept has been diminishing among these purchaser groups. The UCR system, being self-adjusting in a fluctuating economy, serves to stabilize dental benefits not in the sense of fixed dollars but as purchasing units.

On the other side, some respondents noted that programs employing the table of allowance mechanism are popular with some purchasers in that they facilitate the predictability of costs, afford the opportunity to increase the allowances when the purchaser is in a position to do so, and provide the purchaser the advantage of being perceived by his employees to be increasing their benefits when he improves the table. These purchasers believe that they lose control of the program when it employs a UCR mechanism and that increased costs over the term of the contract are not easily recognized by employees as representing increased benefits to them.

Additionally, there was substantial agreement among respondents that table programs are at least slightly easier to administer and simpler to explain to beneficiaries.

The Council observed a paradox in the theme of the response with respect to the respondents' perception of the interests of purchasers and beneficiaries. Central to this paradox, it seems to the Council, is the scope of experience of the purchaser and the beneficiary with regard to dental prepayment. No one among the respondents contended that the apparent benefits of table programs offered more relief from the patient's dollar burden of dental care costs than did the more complex--and thus less apparent—benefits of UCR programs. In fact, it was pointed out that, while the table approach may protect the carrier and the purchaser from adverse experience, this is done by transferring the risk to the patient. And, finally, it was noted that employee-group representatives experienced in the financing of health care through negotiated benefits strongly support the UCR concept over the table of allowance alternative. For these reasons, it is the Council's judgment from the responses received that the marketplace attraction of table of allowance programs diminishes as purchaser group familiarity with health care programs increases.

From the profession's point of view, it was noted that dentistry, through the early dental service corporations, promoted the UCR mechanism as that which permitted

the soundest benefit to the patient while acknowledging the varied, continuing influences of costs upon dental fees. Objections to programs based upon this concept focus more upon failures in the proper utilization of this reimbursement mechanism, which may cause patients to conclude that the fees being charged are excessive. Further, some support for the table of allowance program is founded in the fact that the benefit is readily understood by the patient, being presented as a fixed dollar amount.

The results of the fall 1975 *Survey of Dentists* demonstrate a substantial preference among dentists for the UCR method. In response to the question, "What is your opinion of the following reimbursement methods under dental prepayment plans?", 78.3 percent considered the UCR method "adequate", while 54.9 percent considered the table of allowance method "adequate." Of this sampling, 50.3 percent considered the UCR method "good" as compared to 21.3 percent for the table approach while 38.2 percent thought the table method "inadequate" as opposed to 19 percent who thought the UCR method "inadequate."

The Council observes that all dental prepayment plans, irrespective of the reimbursement mechanism utilized, can be ineptly administered. Responsible design is capable of minimizing this potential and, thus, reducing the incidence of undue interference with the delivery of dental care. Foremost in the elements of responsible program design should be a commitment by the administrator to absolute clarity in presenting the program's benefits to the purchaser group. Eligibility requirements, financial constraints and benefit limitations should all be explicitly detailed, as should be the relationship of the payment mechanism, whatever it may be, to the dental fee. This latter element would require clearly delineated methodologies for determining customary fee ranges and prevailing fees, as well as specifying in the publication of allowances that the dollar amounts listed represent allowances toward dental fees and not the fees themselves. When additional cost control factors are introduced to modify the benefits significantly, these factors should be presented prominently in the program's descriptive materials.

An example of this process, which is common in the structure of orthodontic benefits, is the introduction of a maximum lifetime benefit set at a relatively low level in a UCR program. This effectively converts the orthodontic benefit portion of the UCR program to a table of allowance.

Clearly described benefit plans, in the Council's view, will be instrumental in developing an informed beneficiary population, the key to responsible dental benefits plans. The Council acknowledges that the UCR reimbursement mechanism, a considerably more complex method of determining benefits, requires more careful explanations. Plans utilizing UCR have an increased responsibility to ensure that benefits are properly determined and that the terms of the programs are clearly understood by the beneficiaries. Acceptance of the responsibility for competent administration and clear program description is essential to the success of any prepayment program.

The aggregate response from all facets of dental prepayment noted merit in each of the two methods under consideration. In the Council's opinion, well-administered, clearly explained programs employing either mechanism will well serve the dental health of the populations involved in group purchases. The Council noted the advantages of the table of allowance mechanism as expressed by the respondents: facility in administration by the insurance firm and in the dental office; simplicity in describing it; and more visible evidence of benefits being provided through it. However, as discussed above, the vast majority of respondents in every area acknowledged that the UCR method possesses the capability of providing the more substantial benefit to the patient, other factors of prepayment being equal.

Because the UCR method has the dental fee as its core element, that is, as the point from which the benefit determination proceeds, it possesses the capability of adjusting dental benefits in any type of economy so that those benefits represent stable purchasing power to the beneficiary, not simply dollar amounts of changing value.

The Council concludes from its study that the intent of existing Association policy, stating a preference for the UCR method, though not to the exclusion of other methods, is clearly in the interests of patients. It is concerned, however, that the language of existing policy, in not specifying the table of allowance method among the "various methods," may be misinterpreted by some as meaning that this method is not "acceptable." Accordingly, in order to preserve the intent of existing policy and provide policy recognition to the table of allowance method, the Council recommends that a new resolution, appended to this report, be substituted for 1975 House of Delegates Resolution 884.

The Council wishes to express appreciation to the following individuals who contributed their considerable experience and knowledge to this study: Mr. Bernard B. Berkov, Western Benefit Plan Consultants, Inc.; Mr. Robert E. Caffrey, Connecticut General; Mr. Lawrence P. Carrington, American Telephone and Telegraph Company; Mr. Thomas S. Coyne, Jr., Eli Lilly and Company; Dr. F. Gene Dixon, California Dental Service; Mr. Thomas F. Duzak, United Steelworkers of America; Dr. Joseph Hagan, Missouri Dental Service; Mr. C. Donald Hankin, Occidental Life; Dr. Anthony R. Kovner, United Auto Workers; Dr. Donald S. Mayes, Pennsylvania Blue Shield; Mr. Charles H. Meyer, Equitable Life Assurance Society; Mr. Robert L. Patrick, Prudential Insurance Company; Mr. Thomas G. Patzau, Johnson and Higgins Insurance Brokers; Mr. G. R. Schade, Jr., Aetna Life and Casualty; and Mr. Martin R. Wiseman, Aerojet-General Corporation.

RESOLUTION

44. **Resolved,** that the *Standards for Dental Prepayment Programs* (revised November, 1974—*Trans.* 1974:639) be amended by substituting the following standard for Standard 21:

> 21. A properly administered usual, customary and reasonable fee reimbursement method is preferred. However, with proper administration, various methods of reimbursement, such as a table of allowance, are acceptable.

COUNCIL ON DENTAL CARE PROGRAMS: SUPPLEMENTAL REPORT 2

Delta Dental Plans: The 1975 House of Delegates referred Resolution 889 (*Trans.* 1975:664) to the Council to study and report back its findings:

> **Resolved,** that the Council on Dental Care Programs be directed to reexamine the relationship of the Association and the Delta Dental Plans Association in

order that, consistent with its responsibility to the public, the Association shall be better able to encourage and support the Delta Dental Plans in responding to the needs, interests and wishes of the profession, and be it further,

Resolved, that the Council on Dental Care Programs report back to the 1976 House of Delegates.

In an effort to review all aspects of the resolution, the Council has investigated the Association relationship with Delta as it is reflected both nationally and at the respective state levels. The Council solicited information and comment from all interested parties, including specific requests to every constituent society and to each Delta Plan.

Additionally, a special committee of the Council attended the Delta Dental Plans Association (DDPA) Spring Directors Meeting in Oklahoma City, Oklahoma, on March 14-16, 1976. On this occasion, Council representatives met with the DDPA Executive Committee and, during the meeting, requested specific items of information, including the number of dentists in each state who are participating dentists in each Delta Plan. The information received from DDPA is shown in Appendix I. The Council also encouraged DDPA to submit to it any additional information it thought would be helpful. A formal statement from DDPA constitutes Appendix II.

The Council has also met individually with many interested individuals and parties and reviewed written testimony, articles, other publications pertaining to the subject, and Association resolutions. Existing Association policy of particular pertinence, in the Council's view, is in Appendix III to this report.

The Association's Creation of Delta and of Dental Service Plans Insurance Company: The 1957 House of Delegates of the Association adopted policy recommending establishment of dental service corporations by societies that may anticipate a need for organized plans for the group purchase of dental care. It was the clear expectation of the House that this mechanism could represent the dental profession's ideas and concepts in a growing prepayment marketplace, an expectation dating back to 1949 when the House said (*Trans.* 1949:264) that "voluntary prepayment and postpayment plans consistent with sound experience should be developed as rapidly as possible."

In 1964, the House of Delegates recognized the need for a national organization to help organize and develop the state-chartered Plans as a group into a viable competitor in the national dental prepayment marketplace. The National Association of Dental Service Plans (later renamed Delta Dental Plans Association) was formed for this purpose. As outlined by the 1965 House of Delegates, the functions of DDPA were anticipated to be:

1) Provide assurance that the character of private dental practice not be adversely affected in the development of dental prepayment plans at the national level;

2) Make technical assistance available to existing and developing dental service corporations;

3) Conduct research programs and provide a mechanism for the exchange of information in order to minimize the duplication of costly pilot projects;

4) Provide active liaison with other national agencies in the field, such as the national agencies of Blue Cross and Blue Shield plans;

5) Serve as a coordinating agency in developing acceptable methods for fostering multistate dental prepayment plans. . . . (*Trans.* 1965:271)

Clearly, events since 1965 have been such that not all of these principles would necessarily be enacted or similarly expressed, today. If taken literally, the first principle, for example, is impossible. No one can provide such absolute assurance as is sought in it and, in any case, it is dentists themselves who will have to take the lead in doing so.

As far as principle 4 is concerned, the Council feels that its Bylaw obligations place responsibility for national liaison for the profession on it and the Council has acted accordingly over the years. It understands that DDPA acts as liaison with other marketing agencies on behalf of Delta Plans.

These principles passed in 1965 are not cited as being merely of antiquarian interest or to engage in retrospective criticism of the members of the 1965 House of Delegates. They are a legitimate and necessary part of the history of the Association's relationship with Delta and, perhaps more to the point, a measure of the intensity of change that has taken place in a mere decade.

As public interest in dental prepayment has changed, as dental practice with respect to prepayment has changed, and as federal involvement in dental care generally has changed, one can hardly be surprised if Delta itself has changed and evolved during that same period. What is relevant to the Association's consideration is the purpose of and the nature of such change.

In 1968, to continue the historical review, the House saw the need for the formation of yet another corporation to further the concept of the dental service corporation. Dental Service Plans Insurance Company (DSPIC) was formed to provide the Delta system with underwriting capabilities that would aid in the procurement of contracts that were multistate in scope. DSPIC was formed as a stock insurance company with the ability to underwrite prepaid dental plans in a state where no Delta plan exists or a state where the Delta plan was undercapitalized relative to its marketplace needs.

Along with DSPIC's creation came the continued growth of state-chartered Delta plans. Today, only three states lack a Delta Plan: Connecticut, Indiana and Texas.

The Delta Concept Compared with Commercial Carriers and Blue Plans: The service corporation concept was pioneered by the Blue plans, and Delta today is patterned to an extent after these original provider-sponsored service plans. Delta is, of course, the only prepayment carrier evolved directly by action of the dental profession in each of the respective states by vote of the members of the state dental society. In most instances, policies are formed by a board of directors elected to serve by the dentist members of the plan. This Board is subject to the wishes of these dentist members at the annual meeting, where each is entitled to a vote. As in other elections, the opportunity to vote is the furthest step an organization can take in preserving a broad and democratic nature. Those who neglect to act on that opportunity to vote provided to them are in an ambiguous position when later protesting policies passed by a majority vote.

In addition, a Delta Plan is the only carrier that is based fundamentally on offering dental service benefit programs, which translates into the selling of services, guaranteed by the participating dentists, as opposed to the administration of monies allocated toward dental services. Without the participation of the practicing dentists, Delta Plans could not exist. The participation concept and the service benefit concept are literally inseparable. This is the alternative approach to having substantial reserves of funds sufficient to guarantee the viability of the indemnity approach.

The major commercial carriers are incorporated either as mutual companies or as stock companies. Mutual insurance companies are not organized for profit and have only two entities, the insuring company and the policyholder. The stock companies are operated for profit and consist of three entities: the company, the policyholder and the stockholder. Neither necessarily provides for direct inclusion in policy-making by the professional health practitioner nor do they have a contract with the dentist to provide service benefits.

The Nature of the Relationship Between DDPA and the Association: The Association and DDPA are wholly separate, not-for-profit corporations. They have no legal relationship. Each Delta Plan, moreover, was formed through the direct initiative of each constituent society within the framework of each state's laws and insurance regulations. Once formed, however, that plan too becomes a not-for-profit corporation separate from the state dental society. Obviously, this in no way precludes licit cooperation between the two organizations on a range of matters but their legal separateness is important to recognize.

Since 1965, the Association has provided financial aid to DDPA in the form of loans and grants to help it become an effective national coordinating agency. To date, the interest-free loans total $389,366, with that amount still outstanding. Grants to DDPA, since 1965, total $259,756. The following chart indicates the annual record of financial transactions:

Loan and Grants to Delta Dental Plans Association by the Association for the Years 1965 thru 1975:

Year	Received at End of Year	Loan	Grant
1965	—0—	—0—	$ 25,000
1966	—0—	—0—	25,000
1967	$ 7,404	$ 7,404	31,655
1968	55,529	48,125	33,481
1969	68,177	12,648	35,322
1970	133,814	65,637	19,586
1971	216,164	82,350	26,436
1972	274,746	58,582	23,318
1973	328,117	53,371	19,568
1974	368,429	40,312	13,419
1975	389,366	20,937	6,971
TOTALS:		$389,366	$259,756

It is noted that no requests for grants or loans were made in 1976 or for 1977. In addition to this financial aid to DDPA, the 1972 House of Delegates authorized the purchase of $550,000 worth of shares in DSPIC. This purchase enabled DSPIC to increase its capitalization from $600,000 to $1,200,000 in order to qualify for admittance as an insurer in critical states where underwriting capabilities were needed. To date, DSPIC is licensed in 13 states and is actively involved in underwriting in all 13 of these states involving 19 programs.

DSPIC has recently applied for a license in Indiana and Texas, neither of which has a Delta plan, and is in the process of filing in Connecticut, which also lacks a plan. At present, the ADA still owns $394,480 worth of DSPIC shares, having sold the rest of its original investment.

Obviously, these are not small sums of money and the cumulative total financial transaction is not to be taken lightly. At the same time, it is relevant to note that these sums -greatly abetted by amounts given and loaned in similar ways to individual Delta plans by state societies- -should be considered in the light of the success Delta has enjoyed in securing, in competitive bidding, the position as carrier of various prepayment programs where the reimbursement to dentists for services rendered has conservatively amounted to more than $2 billion.

The Association's House of Delegates, then, has established a long and consistent record recommending the development of Delta plans by constituent societies and directing the Association to help form and finance DDPA and DSPIC. These actions substantiate the view that the profession intended Delta to play a role in dental prepayment and to do so in a way that would reflect high professional standards in such programs, leading to improved dental health of the public.

The House of Delegates, at the same time, also created internal agencies concerned with prepayment and enunciated the policies under which they were to operate. In 1966, the House created the Council on Dental Care Programs and entrusted it with various areas of responsibilities, including carrier relations. To this end, the Council has been directed to implement House policy as embodied in the *Standards for Dental Prepayment Programs,* the preface of which reads: "For the purposes of these *Standards,* the term 'carrier' is intended to include all types of dental prepayment programs and the term 'insured patient' is intended to include all those eligible for the benefits of such programs."

This wording, in the Council's view, makes it clear that the Council should interact with all "carriers" on an equal basis, without preference for, or discrimination against, a particular category of carrier. The Council has consistently attempted to do so while, at the same time, recognizing the fact that the Association has a special relationship with Delta. The Council sees no direct contradiction necessarily present in this respect. The House of Delegates establishes policy with respect to dental prepayment under which the Council operates. In the view of the Council, the House expects those policies to be implemented in an evenhanded way among all carriers. At the same time, the House has assisted Delta to become a viable competitive factor in the dental prepayment marketplace. It is, as the Council understands it, the House's view that Delta should be competitive while paying due regard to the prepayment policies espoused by the profession. It expects precisely the same from all other categories of carriers and, thus, expects the Council to apply policy evenhandedly.

Now, the House has directed the Council, the appropriate Association agency, to study DDPA and to recommend possible steps that could be taken by either party or by both to solve any present difficulties and improve the existing relationship. Previous Houses, it should be noted, have taken action with other carriers active in dental prepayment that are not wholly dissimilar.

Problem Areas Identified by the Council Study: During the Council investigation, various areas of concern were identified. This report will attempt to summarize the major ones with suggestions for the resolution of the complaints and misunderstandings. It must be pointed out, and clearly kept in mind, that the majority of formal, written reports received by the Council from the constituent societies indicated that their relationships with the respective state plans were excellent. The existence of unquestioned difficulties in various areas or with various state Deltas should not

obscure the fact that a broad area of satisfaction was recorded by the majority of constituent societies in written communication with the Council.

A. Predetermination of benefits

1. Specification of Problem: This is a procedure whereby a dentist submits to the carrier a proposed treatment plan which, when returned, indicates the patient's eligibility; covered service amounts payable; application of appropriate deductibles; co-payment factors, and maximums.

> A number of practitioners have stated that they view this solely as a cost-control mechanism, originally developed by the Delta system and utilized by it to apply lower-cost alternate benefits irrespective of the professional judgment of the attending dentist.

2. Council Comment: The Council does not consider predetermination of benefits to be intrinsically objectionable. It is aware that a number of dentists share the view that it is helpful to the dentist and patient alike. It makes clear, prior to any treatment being performed, precisely what the liability of the carrier and patient will be. It is an aid to the dentist in that co-payment and deductibles are indicated, along with the annual limitation.

Predetermination is, as well, a cost-monitoring mechanism that assists the carrier to determine its liability prior to treatment and to inform the dentist and patient when an alternate benefits level of payment is being applied.

Such action does not necessarily infringe upon the professional prerogative of the dentist, which is precious not for the dentist's sake but for the patient's. But it may well do so in some instances. Where the attending dentist believes that it does so, he should clearly communicate his professional reservations to the patient and indicate to the patient that the peer review process is available for adjudication of the dispute. In such cases, predetermination is also advantageous to the dentist since it alerts him to objectionable action by the carrier prior to the beginning of treatment and enables him, at that point, to take up the matter with the carrier and, if necessary, the peer review committee.

Where a carrier, be it a Delta plan or any other, displays a pattern of objectionable use of the alternate benefit payment provision, the local and state Councils on Dental Care Programs should be in quick communication with it, an effort in which this Council is always ready to assist.

Additionally, because only a certain amount of funds are allocated for a dental program, mechanisms such as the alternate benefit clause can be said, when properly utilized, to provide for more comprehensive coverage and, at the same time, benefit by some payment for treatment mutually decided upon by the attending dentist and the patient.

B. Prefiled fees

1. Specification of Problem: This is the submission of a participating den-

tist's fees to a dental service corporation for the purposes of establishing a customary range of fees for that geographic area, to facilitate the payment of participating dentists on an accurately computed usual, customary, and reasonable fee basis.

Prefiled fees are objected to by some as a mechanism to control individual dentist's fees by rejecting their application to become participating dentists unless their fees as submitted fall in the then existing customary range, thus freezing the customary at a level below the true marketplace determination. In a time when the costs of conducting a practice have soared while fees have remained moderate, this can be a serious problem.

2. Council Comment: The concept of fee prefiling is highly important to the functioning of a service benefit plan since, when the dentist files a listing of his usual fees on a confidential basis, it enables the plan to compute better its total exposure and set a premium level that will permit payment to the dentist for services provided on the basis of his usual fee.

This can be viewed as an advantage to the profession in that it is a method well designed to elicit the actual fees being charged, given accurate filing by dentists and competent actuarial work by the plan, as opposed to a determination based on the number of charges received.

In essence, it is the dentists participating in the plan who, by filing their usual fees, determine the customary fee through their individual, independent judgment. In many plans, prefiling is a condition of membership because, in agreeing to prefile fees, it allows the plan to determine more accurately its costs.

In addition to the customary fee aspect, the prefiling of fees allows the plan to develop more accurate actuarial data which may result in a competitive edge in bidding on new dental contracts. The Council feels that prefiling of fees as a concept is valid.

It is also essential, in the Council's view, that the statistical gathering mechanism of a Delta include *all* fees filed by dentists in the area, even though an individual dentist may be excluded from membership because of his fees, in order that the fee profile consistently reflect reality and be adjusted in a timely fashion consonant with current conditions.

The Council notes that Delta plans in general publicly state that their calculation of a customary fee employs a 90th percentile ceiling or "cap."

"Percentile" should not be confused with "percentage." On the basis of the 90th percentile, at least nine out of every ten dentists would receive the usual fee he charges in his practice. Normally, as many as 94 to 96 out of a 100 dentists would receive his usual fee.

The Council calls to the attention of the House that there is no present policy respecting a ceiling or "cap." The Council is not persuaded that policy is, at this point, imperative. At the same time, it should be clear to anyone that, as prepayment programs come into being covering hundreds of thousands of beneficiaries and involving hundreds of millions of dollars, no prudent manager of the funds is going to be content to write a blank check for the program. A mutually agreeable maximum exposure will always be sought and will be achieved. The 90th percentile seems, in the

Council's view, a reasonable device for this purpose. The Council notes that this approach serves at least 9 out of 10 dentists precisely as they would wish and would further note that innumerable other devices can well be invented that would be infinitely less satisfactory.

All of this, of course, is posited on the assumption that the carrier -including Delta Plans- -does its actuarial work fairly and competently and that it updates its statistics on a consistent basis. Dentists who are participating members of a particular plan are, by virtue of that membership, in an excellent position, individually or jointly, to have disclosed to them the methodologies employed and to call for such corrections as prove necessary. The Council, in support of that, is conducting a study on methodologies currently in use and hopes to issue a report in the reasonably near future.

C. Participating dentist

1. **Specification of Problem**: This is any licensed dentist with a contractual agreement to render care to covered subscribers with a service corporation at a rate of reimbursement not to exceed prefiled levels.

The problems connected with the participating agreement that the Council has perceived stem largely from the reimbursement difference between participating and non-participating dentists. The question of reimbursement difference is discussed in Supplemental Report 3 and the comments there apply to Delta carriers as well as to all others. With respect to the intrinsic concept of the participating agreement, however, the Council feels that some comment is necessary in this report.

2. **Council Comment**: The participating agreement is, as noted, essential to the functioning of a service benefits plan. As previously discussed, the difference between a service benefits plan and a commercial carrier plan is the actual marketing of dental services as opposed to administering of monies allocated for a dental plan. This basic difference is the cornerstone upon which the Delta concept is built.

There must be a significant number of dentists in a state willing to participate in the plan and agreeing to provide certain dental services to subscribers under the rules enacted by that particular plan and accepted by the individual dentist. The Delta plan is then acting as a marketing agent and administrator for those participating dentists' services.

In addition, in many cases, the participating dentists accept underwriting risk and, in states where a withhold is utilized, agree to help build reserves for that particular plan.

The Council feels that, since membership is open to any licensed dentist within the agreed limitations as promulgated by the participating dentists themselves, that freedom of choice for the individual practitioner is not fundamentally infringed. Obviously, a majority vote binds the group as a whole but this inhibition is present in any democratic group action. In this context, each dentist can decide to participate and, thus, allow the Delta plan to market his services under certain specified, contractual limitations. This is one of the many aspects of the free enterprise system and

is, therefore, acceptable as embodied in the concept of the service benefit corporation.

D. Communications: Association-DDPA and Constituent Society-State Delta Plan:

1. Specification of Problem: This is the single most severe problem the Council encountered in its research. Inadequate communication was evident at all levels, both nationally and at the constituent levels. It was evident on all sides.

2. Council Comments: Because of the relationship that does exist between a constituent society and the service corporation, as discussed earlier, dialogue should be an ongoing process in order to promote understanding and cooperation. This clearly is not now happening in a number of places. The reasons are varied and the Council's information is not such in most instances to apportion blame, which is of little importance in any case.

One possible solution is the formalized exchange of consultants between the constituent society's Council on Dental Care Programs and the service corporation. At the national level, this Council has suggested such an arrangement for some time between DDPA and itself though nothing has yet eventuated. This would provide an ongoing dialogue that is crucial to the profession's acceptance of Delta concepts in a burgeoning prepayment market plan.

At present, for example, this Council and the Dental Relations Committee of the Health Insurance Association of America (HIAA) exchange consultants to provide a better dialogue in solving problems. It has proved on many occasions to be of mutual help. Since the Delta concept professes to represent most closely the viewpoint of the profession, dentists naturally expect greater professional understanding from it. An exchange of consultants at both the constituent and national levels should do much to minimize many existing misunderstandings.

During the Council study, a number of suggestions were made concerning the internal operations of Delta Plans. These are raised here for information only, with the thought that Delta Plans may wish to investigate them and consider changes.

One of the prevailing areas of concern was the lack of consistency found in the administration of the various plans. This inconsistency became most apparent in discussing the Delta concept with state representatives and the discovery that there are widely variant administrative procedures.

It was suggested also that DDPA, the national association, needs to be more responsive to the problems of the small and/or developing plans. In this regard, many of the smaller plans feel that the weighted voting system, based on premium dollars, tends to minimize their influence to the vanishing point and thus the degree of emphasis needed to aid developing plans is unduly muted. The Council understands that the weighted voting system is the opposite coin to the greater financial support afforded DDPA by the larger plans. The level and intensity of complaints on this matter is such, however, that the arrangement might, with advantage, be reviewed.

It was obvious to the Council that effective and continuing communications is a priority if improvement in the relationship between the profession and Delta is to be achieved as the Council and, judging from the resolution, the House wish. Exposure of differing opinion through free, open dialogue should ease many misunderstandings and misconceptions.

The quality of consistency of administration by individual Delta plans was also a subject raised with sufficient frequency to warrant notice in this report. These complaints touched such basic matters as speed of turnabout time for precertification forms; speed of reimbursement; promptness of response to inquiries, and in some cases, lack of courtesy in responses. Also in question is the history of some plans in making full and timely disclosure of the business aspects of the plan's operations to participating dentists.

These complaints, it must again be emphasized, were not lodged against a large number of plans. They were, however, sufficient in volume to be disquieting and, the Council believes, to warrant some attention by DDPA's governing body.

At the same time, the Council would express the view that individual participating dentists, or groups of them, do have clear avenues of redressing such difficulties and it is far better to make use of them as vigorously and often as necessary rather than to complain afterwards about the administrative direction the plan has taken.

Delta exists to serve group purchasers competently and fairly as a first priority and dentists must expect to balance what they would ideally like in a given instance against what Delta can do and remain true to that priority, much less viable in the marketplace.

Nevertheless, Delta, as well as the dentist, is party to the participating agreements and can be expected to be sympathetic and responsive to inquiries or suggestions from its members. Since some Delta plans perform this task quite well, there is little reason, in the Council's view, why all of them cannot do so.

Delta's Past and Future Importance: Since the inception of Delta, the concept has been instrumental in program design, not only in the plans marketed by Delta but also those now being marketed by others. This program design has had great impact on fundamental aspects of contracts such as comprehensive benefit packages made possible by the use of co-payment rather than deductibles; emphasis on preventive measures and payment of these benefits at the 100% level, and the use of the usual, customary and reasonable payment method (which later enables the patient to receive increasing benefits commensurate with the cost of practice over a specific contract period). All of these aspects are presently included in most of the large multi-state contracts providing comprehensive dental care. If it can be said that one of Delta's chief roles is to exercise an influence in the marketplace in favor of high professional care standards being incorporated into standard programs, then it has had considerable success.

The basic interest of the profession is the delivery of high quality dental care on a comprehensive basis to its patients. Prepayment has been instrumental in providing financial assistance which has enabled a larger segment of the population to avail themselves of comprehensive dental care. At this time, the Delta system is covering

35% of those with dental prepayment plans. Delta plans serve 11 million individuals and provide a major impact in the prepayment field. Besides the sheer numbers involved in Delta coverage, the concept offers an alternative in the marketplace in the form of a service benefit program. The Council believes that a competitor in the prepayment arena with professional leadership is highly desirable for the reasons stated.

The Delta system is presently hampered in its efforts to compete for national contracts due to the lack of underwriting capabilities in some states. The Council feels that, since Delta does offer an alternative within the free enterprise system, it should be given the opportunity to succeed or fail on its own and that barriers ought not to be placed in the way of it being able to compete for business in each and every state, something that becomes especially vital with respect to multi-state contracts. Delta, of course, has no "right" to success, but surely it has a right to compete.

In accordance, then, with the directive of the House and subsequent to its investigations, the Council makes the following summary observations and recommendations, noting that, in large part, they are applicable to any or all carriers:

1. The service benefits concept embodied by Delta has a significant role to play in benefitting the public's access to high quality, comprehensive care in the prepayment marketplace;

2. Delta's ability to be a viable competitor is chiefly the responsibility of the managers of the individual plans and of DDPA, not a responsibility of the profession;

3. If the profession agrees with the Council, however, that the Delta concept deserves a continuing opportunity to be active, then state dental societies and the American Dental Association should be actively responsive to requests for assistance that are presented in a business-like way, are properly documented and are clearly within the legal and professional restraints that affect the relationship. Claims by Delta for assistance solely on the basis that it is "dentistry's own" are clearly insufficient now, even if there was any past validity to that claim;

4. Delta plans should seek out and employ managers with the appropriate insurance and marketing expertise to direct the daily operations of the plan;

5. DDPA should play a far more active and inventive role in assisting small or weak plans to become efficient and effective. Given a sound proposal with which to deal, the Council believes that the American Dental Association, through its Board of Trustees and House of Delegates, may be able to play a role, consonant with legal realities and appropriate professional considerations, in helping DDPA to expand its operations in this regard;

6. Individual Delta plans should, above all, have well-conceived, smoothly operating communications with the dentists in the state on whom they so clearly depend for participating agreements. High standards for turnaround time of precertification forms, prompt payment of monies owed to the dentist and close attention to the inquiries and complaints received from dentists, be they participating members or not, should be maintained;

7. DDPA should respond as soon as possible to this Council's request for a formalized arrangement, similar to that the Council has with the Dental Relations Committee of the Health Insurance Association of America. Similar con-

sulting arrangements should be made between each constituent society and the individual Delta plan;

8. In fairness to the vast majority of dentists across the nation, Delta should be afforded the opportunity to compete in the total marketplace. Those dental societies in states where there now is no Delta plan may wish to reassess their position and permit Delta to investigate the possibility of establishing itself competitively in those states. At the same time, Delta should not expect a state society that has doubts about the Delta concept to proffer large sums of money to assist beginning operations. Other arrangements will need to be explored in candid conversation between the state society and Delta. This Council will assist in those explorations if invited to do so by both parties;

9. Dentists as a group and individually must understand clearly that Delta was not created nor does it exist to be the unquestioning servant of the profession. It has clear responsibilities to its beneficiaries, the management with which it works and the public at large. The interests of those groups are not necessarily inimical to the interests of dentists and, in the Council's view, ought to be largely the same. Clearly, negotiation of specific issues is going to be necessary and will often be intense. Such negotiations should not be escalated into bitter battles over Delta's very existence;

10. Delta's intrinsic administrative devices--including precertification, prefiling of fees, payment at the 90th percentile and participating agreements --are sound and unobjectionable in concept. The administration of them must, however, be scrupulously accurate and fair;

11. Dentists who sign participating agreements should take their membership in the plan seriously, should pay close attention to the plan's activities and be quick to raise questions when matters seem to be unsatisfactory. Each Delta plan has an obligation, in the Council's view, to provide a timely flow of information to each member dentist sufficient to enable him to carry out his membership responsibilities;

12. The relationship between the Council on Dental Care Programs of the Association and DDPA or an individual Delta plan must be carried out on the same basis as the Council's relationship with all carriers or carrier groups in the interest of the profession's overall role in dental prepayment activities. The Council would recommend that its constituent counterparts adopt the same posture.

APPENDIX I

(Figures in Column II supplied through DDPA; those in Column III represent total number of ADA member dentists, not necessarily limited to practitioner members.)

I Year	II Participating Dentists	III ADA Member Dentists
ALABAMA		
1971	200	900
1972	200	919
1973	200	933
1974	150	968
1975	150	999
ALASKA		
1975	137	123

I Year	II Participating Dentists	III ADA Member Dentists
ARIZONA		
1973	0	748
1974	469	789
1975	375	850
CALIFORNIA		
1971	10,004	10,792
1972	10,946	11,160
1973	11,646	11,454
1974	12,468	11,835
1975	13,206	12,292
DISTRICT OF COLUMBIA		
1975	630*	544
FLORIDA		
1974	40	3,182
1975	272	3,390
GEORGIA		
1972	660	1,434
1973	813	1,497
1974	1,075	1,560
1975	1,104	1,618
HAWAII		
1971	419	457
1972	434	474
1973	456	484
1974	486	516
1975	517	528
IDAHO		
1975	284	351
ILLINOIS		
1971	2,852	5,350
1972	2,875	5,387
1973	2,958	5,417
1974	3,075	5,479
1975	3,299	5,494
IOWA		
1975	876	1,347
KANSAS		
1971	0	909
1972	0	901
1973	542	895
1974	549	907
1975	557	940
KENTUCKY		
1975	1,161	1,304
LOUISIANA		
1975	649	1,272
MAINE		
1972	258	362
1973	258	377
1974	258	403
1975	267	411
MARYLAND		
1971	1,220	1,429
1972	1,343	1,558
1973	1,397	1,606
1974	1,479	1,708
1975	1,533	1,765
MASSACHUSETTS		
1971	1,872	3,192
1972	2,139	3,226
1973	2,432	3,320
1974	2,850	3,424
1975	3,100	3,482
MICHIGAN		
1971	2,870	4,001
1972	3,029	4,064
1973	3,167	4,145
1974	3,733	4,228
1975	3,858	4,308
MINNESOTA		
1975	1,826	2,474
MISSISSIPPI		
1975	464	552
MISSOURI		
1975	1,564	2,036
MONTANA		
1975	245	381
NEVADA		
1975	196	269
NEW HAMPSHIRE		
1971	0	318
1972	0	344
1973	356	357
1974	395	382
1975	412	398
NEW JERSEY		
1971	2,600	3,881
1972	2,600	3,842
NEW MEXICO		
1975	214	361
NEW YORK		
1971	8,200†	12,894
1972	8,200†	12,957
1973	8,200†	12,982
1974	8,200†	13,011
1975	8,200†	13,202

*630 participating dentists includes dentists practicing in Southern Maryland.

†These numbers have not changed since 1963. A new filing is presently being prepared but is not available at this time.

I Year	II Participating Dentists	III ADA Member Dentists
NORTH CAROLINA		
1971	543	1,453
1972	936	1,567
1973	1,073	1,622
1974	1,088	1,715
1975	1,015	1,775
OHIO		
1975	3,100	4,588
OKLAHOMA		
1973	307	937
1974	507	953
1975	588	956
OREGON		
1971	1,260	1,349
1972	1,360	1,350
1973	1,420	1,373
1974	1,490	1,429
1975	1,450	1,472
PENNSYLVANIA		
1974	2,943	5,442
1975	3,520	5,490
RHODE ISLAND		
1973	0	451
1974	420	458
1975	422	470
SOUTH CAROLINA		
1971	0	609
1975	647	753
SOUTH DAKOTA		
1971	96	227
1972	121	235
1973	133	243
1974	162	250
1975	167	250
TENNESSEE		
1975	1,050	1,559
UTAH		
1971	510	601
1972	549	611
1973	597	636
1974	619	684
1975	679	724
VERMONT		
1974	148	277
1975	154	260
VIRGINIA		
1973	1,185	1,754
1974	1,185	1,865
1975	1,185	1,953
WISCONSIN		
1971	1,200*	2,261
1972	1,200*	2,274
1973	1,200*	2,310
1974	1,200*	2,364
1975	1,200*	2,405
WYOMING		
1971	154	148
1972	154	147
1973	154	145
1974	154	152
1975	154	162

*A new participating agreement is planned for September.

APPENDIX II

STATEMENT OF THE DELTA DENTAL PLANS ASSOCIATION TO THE PROJECT-ORIENTED COMMITTEE ON DELTA RELATIONS OF THE COUNCIL ON DENTAL CARE PROGRAMS OF THE AMERICAN DENTAL ASSOCIATION MAY 1976

The Delta Dental Plans Association appreciates this opportunity to prepare a statement for review by the Council.

The Delta Dental Plans Association is the national coordinating agency for the nation's dental society-sponsored, not-for-profit service corporations, the creation of which was directed by the House of Delegates of the American Dental Association in 1965, under its original name, the National Association of Dental Service Plans. The organization adopted the name and service mark of Delta Dental Plans Association in 1969.

The object of the Delta Dental Plans Association is "to increase the availability of dental services to the public by encouraging the expansion of dental prepayment programs administered through

dental society-approved dental service corporations, and by providing the means for active or associate members to cooperate with the Association in providing multistate and national group coverage."

The Delta Dental Plans Association is incorporated in the State of Illinois as a not-for-profit trade association. Its categories of membership include the four following classes: Active Member Plans (active dental service corporations), 42; Associate Member Plans (inactive dental service corporations), 1; Constituent Society Members, 27; Affiliate Members (dental service corporations in other countries), 4.

The Delta Dental Plan system of dental service corporations, which have been formed in 47 of the 50 states and the District of Columbia, today covers approximately 11 million people under both private and publicly funded dental care programs. Delta Dental Plans, as part of the historic tradition of provider-sponsored prepaid health service corporations, reflect the social concerns of their sponsoring profession. The Association is aware that for a good many years, dental health care has been the "stepchild" of the health care field in the United States. Today, however, this picture is rapidly changing as dental care becomes more and more important in the eyes of Americans as part of the maintenance of good general overall health.

History of Dental Prepayment

Today, nearly 30 million Americans have some form of dental care coverage under group health programs.

Little more than a decade ago, there were only a few thousand people in a handful of states that had this protection for themselves and their families. In the coming decade, it has been estimated that the number of Americans receiving dental care benefits through private and public group health programs will reach 75-100 million.

Once thought "uninsurable," dental care is now joining hospital and medical and surgical coverage as a standard benefit in the employee health care "package." As protection against the cost of the more catastrophic forms of illness has become more widespread, the interest of purchasers has turned to other high-priority health care services, such as dental care.

In any study of prepaid dental care benefits in the United States, it should be noted that there was no significant activity in this area by the commercial insurance industry until that period in the mid-1960's when the pioneering efforts of the dental society-sponsored service corporations had proved the underwriting "safety" of prepaid dental care through experience and trial-and-error activity over a decade.

Dental care programs, because of high utilization by employees and their families, have proven their value as a significant health service. Analysis of dental care programs has demonstrated that employees and dependents appreciate and use their dental benefits. In many instances, the existence of a dental prepayment program has enabled a subscriber and his family to seek and receive adequate care for conditions previously neglected for financial reasons. Unlike other forms of health care coverage, dental care benefit programs can be used at once, and frequently.

Prepaid dental care programs, as offered today in the private health care sector, differ in many ways from traditional hospital and medical care coverage.

This is because dental disease, in addition to its virtually universal occurrence, is also cumulative in its effect. Continued dental neglect inevitably leads to tooth decay and diseases of the gums and supporting tissues, which, in turn, progress to loss of natural teeth and other oral complications.

Well conceived and effective dental prepayment programs will, therefore, stress two important factors: (1) they will provide benefits that will include all necessary services for the eradication of existing dental disease; (2) they will include benefits that emphasize prevention of dental disease, thereby keeping the subscriber's oral health at a routine maintenance level once dental disease has been eradicated.

The Dental Service Corporation Concept

More than 20 years ago, the American Dental Association and individual state dental societies, aware of the massive amount of dental care needed by the American public, began encouraging the formation of dental service corporations to provide group programs in the various states. Since then, dental societies in nearly every state have taken steps to obtain the necessary legislation to incorporate and activate such corporations.

These corporations, which adopted the "Delta Dental Plan" name and symbol in 1969, are presently underwriting or administering dental care programs covering approximately 11 million people.

Delta Dental Plans are independent, not-for-profit service corporations, formed and sponsored by constituent dental societies to bring the benefits of better dental health to the public.

While formed and sponsored by state dental societies, dental service corporations are separate prepayment organizations under the jurisdiction and regulation of state insurance commissioners or attorneys general. As such, Delta Plan boards of directors are highly cognizant of their multiple responsibilities to program purchasers and subscribers in addition to the providing dentists who have contracted to deliver care under the terms of Plan programs. Evidence of this concern can be seen in the composition of Delta Plan boards, most of which include substantial lay and consumer representation.

Delta Dental Plans, as a result of their direct endorsement by the dental profession and their unique contractual relationship with dentists in private practice, provide "service" benefits to covered subscribers in contrast to indemnity dollars or fee schedule payments to cover the cost of care.

Delta Dental Plans design their programs to provide maximum dental care benefits at reasonable cost. No portion of the Delta income dollar is held for dividends to shareholders. All funds received by Delta Dental Plans are used for pay for services rendered to covered subscribers and their dependents and for administration of the program.

These unique characteristics of the Delta Dental Plan system have captured the interest and attention of informed purchasers in private industry and the international labor unions, as well as governmental agencies at the local, state and federal levels. There is a reason for this: Delta Dental Plans, as provider-sponsored service Plans, have demonstrated that, both on an intrastate and multistate basis, delivery of dental care programs covering all of the basic services necessary to eliminate and prevent dental disease could be available. In addition, Delta Plans make available, on an optional basis, prosthetic and orthodontic services.

Moreover, the Delta system successfully pioneered the "usual, customary and reasonable" fee concept based on filed fee profiles of participating dentists which, in effect, guarantee that a greater proportion of the patient's treatment costs would be covered by a Delta Plan than any other form of prepayment.

The Delta Plan system has held as its guiding principle the provision of program benefits meeting the accepted definition of the dental profession for necessary care, i.e., benefits that stress preventive care and eradicate existing dental disease. This includes examinations and diagnosis, prophylaxis (cleaning), endodontic (root canal), periodontic, restorative and oral surgical services.

In addition to these basic services, Delta programs also offer prosthodontic services (bridges, full and partial dentures) and orthodontic services in order to make possible a full scope of dental care programs.

Rather than offer selected benefits on a piecemeal basis, Delta Plans prefer to provide the widest possible scope of benefits to subscribers on a service basis, introducing, where necessary, such cost-sharing mechanisms as annual maximums, copayment factors or low-level deductibles in order to keep program rates within the resource capability of the buying organization.

It should be stressed, too, that Delta Plan administrative techniques, which have evolved from a firsthand awareness of the "elective" character of much dental treatment, embody a cost containment philosophy most visible in the determination of covered benefits by Plan dental directors and consultants.

Basing their claims processing policies on professionally accepted standards of dental care, Plan professional personnel are able to supervise effectively areas of program overutilization, and potential abuse, thereby exercising a level of cost-effectiveness in program administration not presently available from other carrier entities. Collaterally, this activity serves to minimize public antagonism toward the profession based on assumed avariciousness.

In addition to serving millions of Americans as the administrators or underwriters of dental care programs for corporate employees and union members and their dependents, the Delta Dental Plan system has also been responsible for the administration and delivery of care to eligible recipients of public assistance under a variety of tax-supported health care programs.

For many years, the Delta system has been the fiscal intermediary for numerous publicly funded programs throughout the country which have made possible the delivery of needed dental care in the private office setting, without necessitating the expenditure of tax dollars for the construction of costly financial facilities in order to serve this segment of the public.

Delta Dental Plans in some 23 states are covering nearly 4½ million people for dental benefits under state and local programs ranging from Title XIX (Medicaid) to Job Corps, Project Head Start and Community Action Programs.

In terms of size, the Veterans Administration Program (29,000) and the Denti-Cal Program (Title XIX—2.4 million people) administered by California Dental Service, the largest of the Delta Plans, constitute the most dramatic examples of how a not-for-profit service Plan can utilize the resources of the private sector in providing care to those covered under government programs. More than $70 million has been paid by CDS for necessary dental services rendered to covered beneficiaries of both programs in each of the past years.

The Denti-Cal Program has been the subject of close observation by many state and federal agencies, including the Department of Health, Education, and Welfare, with respect to its potential as a model for future cooperative ventures between the private prepayment sector and government in the delivery and financing of needed health care.

Certainly the statistics generated by the Denti-Cal Program in the past two years have been impressive. For example, after CDS took over the administration of the program from the state, the percentage of claims requiring prior authorization dropped from 85 percent to 15 percent—eliminating an enormous and costly clerical workload without compromising the cost or quality of services delivered.

In the first year of its operation under CDS, utilization of benefits by eligible recipients increased by 20 percent for adults and 40 percent for children—with utilization by children in the critical 6-12 year age category increasing by 47 percent.

The increased cost efficiency of the Denti-Cal Program has been frequently cited. The program is being operated by CDS with an administrative cost of less than 6 percent. In other words, 94 cents of every Denti-Cal dollar received by CDS is expended for actual dental care for the eligible recipients. This is far more actual dollar benefits than could be financed and administered by any other private or public agency.

In 1973, the State of California spent $58 million for dental care services for its medically indigent population. This amount increased to $69 million in 1974 and is projected to reach $74 million in 1975. Estimates for 1976 costs are approximately $83 million.

In general, the CDS-administered Denti-Cal program has been proven to be an excellent example of how more care can be delivered to increasing numbers of individuals, with the cooperation of providers, and with the result that increased dollars are expended for care and less for administration. Here, too, the control of those who would abuse the program is within the profession, thus minimizing the potential for dramatic exposé-type publicity in the media which is so damaging to any profession.

The ADA-Delta Relationship

In any attempt to place the past, present and future relationship of the American Dental Association and the Delta Dental Plans Association in a meaningful perspective, it is useful to review the past history of the policies of the ADA in connection with dental prepayment in general and the dental service corporation movement in particular.

The American Dental Association has recognized its responsibility in directing the growth and development of dental prepayment for more than a quarter of a century. Some of the Association's relevant policies go back as far as 1949. In that year a lengthy statement adopted by the Association on "A Dental Health Program for the Community, State and Nation" urged that "voluntary

prepayment and postpayment plans consistent with sound experience should be developed as rapidly as possible."[1]

On methods of payment for a community dental health program, this 1949 document urged further that "experimental prepayment plans for dental services should be inaugurated by dental societies." It was not until 1954-55, however, when constituent dental societies in Washington, California and Oregon launched prepayment programs for children of members of the International Longshoremen and Warehousemen's Union that the first dental service corporation came into being and the era of the service corporation began.

Other ADA policy statements adopted in the early predental service corporation period place dental prepayment in the context of an experiment, but in 1953 the Association adopted basic principles which are still valid with later additions and revisions. These principles set down the first ten of the later expanded "Principles for Determining the Acceptability of Plans for the Group Purchase of Dental Care."[2]

The first principle stated was that "the plan should be developed, maintained and promoted to the public with the advice of authorized representatives of the local and state dental societies." Other principles called for high standards of dental treatment, *not-for-profit status if direct service benefits are provided,* conformance with the *Principles of Ethics* of the ADA and local societies, maintenance of the dentist-patient relationship, and allocation of responsibility in the administration of programs with particular emphasis on control of professional phases of the program by professional personnel.

Other principles cover the patient's freedom of choice of dentist, the eligibility of all ethical, qualified dentists to participate, a mechanism for adjustment of complaints, adequate financial reserves to assure continuity, and a sound program of dental health education for subscribers.

In 1954, an ADA policy statement called on constituent and component dental societies "to conduct informational programs for their members relating to labor unions' interest in and proposals for dental care programs." Prophetically, the statement encouraged the societies "to develop guiding principles that will lead to the development of soundly conceived dental programs in their respective areas in the event the dental societies are approached by labor unions for such programs for their members and their families."[3]

Ten years later, in 1964, the ADA took a major step analogous to that encouraging the dental societies a decade earlier. This step was to work with the AFL-CIO to develop joint principles for dental prepayment programs for affiliates of the labor federation. These ten principles were based on the whole body of ADA prepayment policy that had been built since 1949.

It has been the policy of the American Dental Association that dental prepayment can best prosper through the full development of both the not-for-profit professionally sponsored service corporations and the private insurance industry. As dental service corporations are professionally sponsored, however, it has been acknowledged that the ADA has some responsibility in bringing about the full development of this method of prepayment.

Dental service corporations, as a mechanism for prepayment, are grounded in two statements of ADA policy. To guide constituent societies in the development of dental corporations, the House of Delegates adopted this principle in 1961:

> A dental service corporation should be a legally constituted, not-for-profit organization sponsored by a state dental society to negotiate and administer contracts of dental care.[4]

An earlier statement adopted in 1957 is more descriptive of this method of payment and contains a directive for action:

> Constituent societies which may anticipate the development of sufficient demand for organized plans for the group purchase of dental care should give consideration to the establishment of a dental service corporation but only after consultation with competent legal counsel.[5]

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[1] *ADA Trans.* 1949:264.
[2] *ADA Trans.* 1953:226.
[3] *ADA Trans.* 1954:279.
[4] *ADA Trans.* 1961:252.
[5] *ADA Trans.* 1957:390.

The ADA Council on Dental Health, the association agency responsible for prepayment matters prior to the establishment of the Council on Dental Care Programs, drafted the following statement in 1964:

> The present policy of the Association is to urge all constituent societies to establish dental service corporations so that this instrument will be available to the public if and when there is a group demand for dental health services. The Association also takes the position that at this stage of development of dental prepayment programs, advantage should be taken of every feasible mechanism in order to make dental health services available on a group basis.[6]

Association action authorized at the 1964 annual session in San Francisco constituted a major forward step for the dental service corporations, putting them on a par with commercial insurance in the nationwide dental insurance market. This forward step was the authorization of a national coordinating agency for dental service corporations of cooperating constituent societies as an agency independent of the ADA. The resolution read:

> **Resolved,** that a national coordinating agency for dental service corporations of cooperating constituent societies as an agency independent of the ADA be established, and be it further
> **Resolved,** that the bylaws of the agency stipulate that a majority of the Board of Directors of the agency be composed of ethically and legally qualified members of the dental profession, and be it further
> **Resolved,** that the bylaws and other supporting documentary material relating to the agency be presented to the 1965 session of the House of Delegates for its review and acceptance.[7]

The National Association of Dental Service Plans was incorporated on January 7, 1965, under the general not-for-profit corporation act of the State of Illinois. The functions of NADSP, as listed in the report of the Reference Committee of the ADA House of Delegates were to:

> 1. Lend assurance that the character of private dental practice will not be adversely affected in the development of prepayment plans at the national level.
> 2. Make technical assistance available to existing and developing dental service corporations.
> 3. Conduct research programs and provide a mechanism for the interchange of information in order to minimize the duplication of costly pilot programs.
> 4. Provide active liaison with other national agencies such as the national agency of Blue Cross and Blue Shield.
> 5. Act as a coordinating agency in developing acceptable methods for fostering prepaid multistate dental programs.[8]

The creation of NADSP recognized a fact of life of the prepaid health insurance marketplace: that nearly 70 percent of the market involves group purchasers with employees or members in more than one state. The commercial insurance industry is organized to write coverage on a nationwide basis. The creation of NADSP made it possible for the not-for-profit, profession-sponsored Plans to participate in multistate and national contracts.

In its annual report that year, the Council stated its firm belief "that there is no suitable alternative to the creation of a National Association of Dental Service Plans. Without such a national association, purchasing groups seeking nationwide coverage could be denied use of dental society-sponsored nonprofit plans."[9]

In stressing the preference of some major purchasers of group coverage for not-for-profit mechanisms for providing benefits on a service basis, the Council pointed out that there are two types of not-for-profit plans: closed panels and dental service corporations. The Council also stated that "if professional sponsored programs do not become available, the development of closed panels will

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[6] *ADA Reports of Officers and Councils*, 1964:25.
[7] *ADA Report of Reference Committee on Public Health*, 1964.
[8] *ADA Report of Reference Committee on Public Health*, 1965.
[9] *ADA Reports of Officers and Councils*, 1964:28.

undoubtedly be encouraged, together with self-insured programs in which the dental profession does not have active representation."

The continuing interest and concern of the American Dental Association in fostering and guiding the destiny of dental prepayment through the dental service corporation movement and the creation of a national coordinating agency for the state Plans has been evidenced in many ways since 1965. From 1965 until 1975, the American Dental Association supported the program and activities of the Delta Dental Plans Association financially through a combination of direct grants and loans totaling $633,200.78.

In addition, the Association purchased $550,000 worth of shares in the stock of the Dental Service Plans Insurance Company in 1972 in order to facilitate the creation of an adjunctive stock insurance company—as urged by the House of Delegates in 1968—to assist the Delta system in underwriting national and multistate programs.

Based on the previously cited actions of the Association, it is evident that there has been a long history of close association between organized dentistry at the national level and the dental service corporations in the United States, both individually and as a national system. It is logical to expect, therefore, that the Association, cognizant of the importance of the profession maintaining a direct voice in the field of dental health care prepayment through dentistry's own dental service corporation system, will continue to provide appropriate moral and fiscal support to the Delta Dental Plan system.

Unfortunately, respect for the logic of that expectation does not permeate the profession. In fact, some members of the profession, acting out of antagonism or naivete, suggest that the dental service corporations may have fulfilled their assigned responsibilities, in proving the "insurability" of dental care expenses and establishing dental benefits as a desirable benefit of employment, and therefore, might justifiably be phased out of existence. The advocates of this hypothesis, for whatever reason, appear to have overlooked or disregarded the continuing policy position of organized labor in favor of each member of the work force having available a "dual choice" between (1) service benefit health care programs provided through profession-sponsored service corporations and (2) group practice prepayment plans based on the capitation principle. This powerful component of society has rejected, and continues to reject, as a matter of published policy, the involvement of the commercial insurance industry in the prepaid health care field. The fact that many group health care programs are handled by commercial insurance companies should not be construed as indicating any lessening of support for that policy within organized labor. More impressively, it should be read as a barometer of labor's relative dissatisfaction with the hospital and medical service corporation approach as being not notably different today from the commercial insurance company approach, in terms of producing meaningful cost and quality integrity. Labor's strong support of federal legislation in behalf of Health Maintenance Organizations demonstrates the truth of this conclusion, as does its continuing vigorous advocacy of National Health Insurance. The dental profession, through the dental service corporations, has not yet been embraced within the indictment of fee-for-service medicine that these attitudes reflect. Metaphorically, the jury is still out. Abandonment of the dental service corporation concept, however, will see the profession instantly incorporated under that indictment. It is suggested that the Association's relationship with the Delta Dental Plans Association should be predicated in part upon this realization.

Another major factor that should enter into the Council's consideration is the tendency among many members of the profession to lump dental service corporations, commercial insurance companies and other health service contractors—such as the Blues—into a single category: "carriers". This may be a useful term of convenience in generalized discussions. It is a habit on which both of the latter components of the industry have capitalized in their dialogue with the profession. Further, it is intellectually fallacious. The distinctions among the three categories are substantive and deep, and those distinctions must be recognized and sharply maintained by the Council and by the Association if the efforts of the constituent societies in relation to dental service corporation creation and support are not to be undermined, perhaps terminally.

The distinction cited is intrinsic, not superficial, and must be consistently highlighted in order that the validity of the discrete administrative modalities utilized by the dental service corporations, exemplified by the Participating Dentist Agreement and the commitments which it embodies, are to be understood and accepted. A dental service corporation contracts to deliver dental *services*, not dollars. In fact, under many enabling statutes, indemnity payments are specifically described as permissible only to the extent that they are merely incidental to the corporation's fundamentally service benefit obligation.

By common statutory restraint, dental service corporations cannot deliver dental services directly; they may do so only through the medium of written agreements with licensed providers. Accord-

ingly, those who urge the elimination of Participating Dentist Agreements are urging, despite occasional pronouncements to the contrary, the elimination of the dental service corporation. Similarly, but less perceptibly, those who argue against the commitments embraced in the Participating Dentist Agreement—as contrasted with the Agreement itself -would, if successful, so gut the substance of the Agreement as to transform the dental service corporation into just another type of indemnity organization which, in turn, would lead just as surely to the demise of the service corporations.

These considerations should be carefully weighed by the Council, it is urged, in its deliberations on the inter-organizational relationship that should pertain between the Association and the Delta Dental Plans Association. As an ingredient in those deliberations, as they relate to these arguments, it is suggested that the Council look seriously at adjusting the *Standards for Prepayment Programs* to enable the promulgation of two distinct sets of standards, one relating to service corporations and the other to commercial insurance companies. This, it is urged, for the reasons cited, is a valid and intellectually supportable position for the Association to take, as well as one that would prove of considerable assistance to the constituent societies in their efforts to emulate the Association. Agricultural science does not assign the same set of criteria to horses and cattle, though both are species of quadrupeds. Neither, should dental service corporations and commercial insurance companies be measured by the same criteria, though both are "carriers".

APPENDIX III

PERTINENT RESOLUTIONS AND POSITIONS REFLECTING ADA POLICY: DENTAL SERVICE CORPORATIONS, DELTA DENTAL PLANS ASSOCIATION, AND DENTAL SERVICE PLANS INSURANCE COMPANY

National Coordinating Agency for Dental Service Corporation (*Trans.* 1960:233)

Resolved, that the Council on Dental Health be requested to (1) provide guidance to constituent dental societies on the organization and operation of dental service corporations; (2) provide a mechanism for interchanging information to minimize the duplication of costly pilot programs; (3) effect the development of interstate and national coverage that will be adaptable to the needs of the individual states and regions; (4) establish standards for the recognition of dental service corporations as official agencies; (5) provide guidance in the development of cooperative administrative arrangements with Blue Cross and Blue Shield agencies for the administration of claims, payment, sales and promotion; (6) develop effective liaison with national Blue Cross and Blue Shield agencies.

Dental Service Corporations (*Trans.* 1957:390)

Resolved, that constituent societies which may anticipate the development of sufficient demand for organized plans for the group purchase of dental care should give consideration to the establishment of a dental service corporation but only after consultation with competent legal counsel.

Dental Service Corporation (*Trans.* 1961:251)

Resolved, that a dental service corporation should be a legally constituted not-for-profit organization sponsored by a state dental society to negotiate and administer contracts for dental care.

Informational Brochure on Dental Service Corporations (*Trans.* 1963:289)

Resolved, that the appropriate agency of the American Dental Association prepare an informational brochure on dental service corporations and that this informational brochure be made available to all constituent dental societies, association and dental service committees.

Role of the American Dental Association in the Development of Dental Service Corporations (*Trans.* 1963: 286)

Resolved, that the statement "Role of the American Dental Association in the Development of Dental Service Corporations," be approved.

1. The Council should continue to develop and maintain a clearing house of information for dental service organizations.
2. The Council, with the assistance of appropriate Association agencies, should collect, process, correlate, interpret and make available statistical data to all interested constituent societies and constituent-society-sponsored service organizations.
3. The Council should publish a concise handbook on procedures for establishing and implementing dental service organizations, including a glossary of terms.
4. The Council, with the cooperation of the active service organizations, should assume responsibility of developing standard nomenclature, coding, reporting forms and other pertinent materials to facilitate the exchange of information among dental service organizations and interested constituent societies. However, policy for prepaid dental care should be determined by the state service organization in cooperation with the constituent dental association involved.

National Association of Dental Service Plans (*Trans.* 1964:272-273)

Resolved, that a national coordinating agency for dental service corporations of cooperating constituent societies as an agency independent of the American Dental Association be established, and be it further
Resolved, that the bylaws of the agency stipulate that a majority of the Board of Directors of the agency be composed of ethically and legally qualified members of the dental profession, and be it further
Resolved, that the bylaws and other supporting documentary material relating to the agency be presented to the 1965 session of the House of Delegates for its review and acceptance.

National Association of Dental Service Plans (*Trans.* 1965:359)

Resolved, that the National Association of Dental Service Plans, through its Board of Directors, be requested to present notice of its amendments of its "Bylaws" to the House of Delegates of the American Dental Association for review, and be it further
Resolved, that the National Association of Dental Service Plans submit a report of its activities annually to the American Dental Association House of Delegates for review.

Solicitation of Contracts by Dental Service Corporations (*Trans.* 1965:353)

Resolved, that the statement "Solicitation of Contracts by Dental Service Corporations" be approved.

Solicitation of Contracts by Dental Service Corporations (*Trans.* 1965:87)

In order to make the benefits of a service corporation available to as many persons as possible, the active solicitation and promotion of dental prepayment plans by dental service corporations is encouraged within the policies established by the sponsoring constituent society and the individual dental service corporation.

NADSP Bylows (*Trans.* 1965:347)

Resolved, that the "Bylaws of the National Association of Dental Service Plans" be accepted.

NADSP Membership Standards (*Trans.* 1965:351)

Resolved, that the "Membership Standards of the National Association of Dental Service Plans" as amended, be accepted.

The Functions of the National Association of Dental Service Plans (*Trans.* 1965:87)

1. Provide assurance that the character of private dental practice will not be adversely affected in the development of dental prepayment plans at the national level.

2. Make technical assistance available to existing and developing dental service corporations.

3. Conduct research programs and provide a mechanism for the exchange of information in order to minimize the duplication of costly pilot programs.

4. Provide active liaison with other national agencies in the field, such as the national agencies of Blue Cross and Blue Shield plans.

5. Serve as a coordinating agency in developing acceptable methods for fostering multi-state dental prepayment plans.

Definition of Dental Service Corporations (*Trans.* 1965:86)

A dental service corporation should be a legally constituted not-for-profit organization sponsored by a constituent dental society to negotiate and administer contracts for dental care.

Establishment of Dental Service Corporations (*Trans.* 1965:86)

Constituent societies of the American Dental Association should give consideration to the establishment of a dental service corporation so that this not-for-profit mechanism will also be available when there is a group demand for dental services.

Administration of Dental Service Corporations (*Trans.* 1965:86-87)

Dental Service corporations may find it desirable to seek assistance in handling administrative, actuarial and fiscal procedures, and such assistance may be obtained from Blue Cross and Blue Shield plans or from commercial insurance carriers. Any affiliation of the dental service corporation with these organizations, however, should be limited to administrative procedures, since the dental profession should remain in complete control of policy and program development.

Establishment of New Council on Dental Care Programs (*Trans.* 1966:317)

Resolved, that Chapter IX, Councils, Section 110, Duties, of the "Bylaws," be amended by redesignating subsections B through P as subsections C through Q and inserting the following new subsection B:

B. Council on Dental Care Programs. The duties of the Council shall be:

a. To formulate and recommend policies relating to the planning, administration and financing of group dental care programs.

b. To study, evaluate and disseminate information on the planning, administration and financing of group dental care programs.

c. To assist the constituent societies and other agencies in developing programs for the planning, administration and financing of group dental care programs.

Resolved, that in view of the amendment of the "Bylaws" relating to the duties of the Council on Dental Health and to the establishment of the Council on Dental Care Programs, the following resolutions of the House of Delegates be rescinded:

Transactions, 1960:233 Resolution 37-1960-H and *Transactions* 1963:40, Role of American Dental Association in Development of Dental Service Corporations (Res. 29-1963-H).

Dental Service Corporations (*Trans.* 1966:299)

Resolved, that the "Statement of the American Dental Association on Dental Service Corporations (1966)" be approved.

Statement of American Dental Association on Dental Service Corporations (1966)

In 1957, the House of Delegates of the American Dental Association adopted a statement (*Trans.* 1957:390), which urged constituent societies to establish dental service corporations so that this mechanism would be available in the event that a group wished to purchase dental care through the organized dental profession of the state.

During the short span of years following the adoption of this statement, the dental profession has witnessed a determined effort by the federal government to participate in health care programs. With the passage of the amendments to the Social Security Act in 1965, the inclusion of dental benefits in government sponsored health programs was assured.

Under the Kerr-Mills law all states must, by 1975, make provisions for substantial dental care benefits for all public aid recipients. Dental care programs financed by the Office of Economic Opportunity and Children's Bureau are being increased. Interest in a federally sponsored program to provide dental benefits to dependents of military personnel has been revived.

The Council on Dental Health emphasizes the need for professional leadership and direction and the administration of present and future dental care programs financed by government. The Council believes that unless the dental profession has a mechanism available in each state to administer dental care programs, other methods will be used that may not be acceptable to the profession. Dental service corporations in the states of California, Washington, Ohio, Colorado, Michigan and Kentucky have arranged with official agencies to provide dental benefits under programs acceptable to the dental societies.

The Council, therefore, urges constituent societies without dental service corporations to: take cognizance of federal legislation that has an application to dental care, recognized the necessity of professional direction in the administration of programs developed under such legislation and take steps to develop a dental service corporation so that a professionally sponsored mechanism will be available to assure that group dental care programs financed by private or public funds meet the standards set by the dental profession.

Administration of Federally Funded Dental Programs: (*Trans.* 1966:311)

Resolved, that the American Dental Association encourages the participation of constituent society sponsored dental service corporations in the administration of the dental elements of all publicly funded health care programs wherever such participation is feasible.

The Council (on Dental Health), therefore, urges constituent societies without dental service corporations to: take cognizance of federal legislation that has an application to dental care, recognize the necessity of professional direction in the administration of programs developed under such legislation and take steps to develop a dental service corporation so that a professionally sponsored mechanism will be available to assure that group dental care programs financed by private or public funds meet the standards set by the dental profession. (*Trans.* 1966:50)

Need for National Underwriting Agency Recognized (*Trans.* 1968:310-311)

Resolved, that the American Dental Association recognizes the critical need for the establishment of a national agency in the form of an insurance company wholly owned by dental service plans and other not-for-profit segments of the organized profession to underwrite group dental care programs in states where dental service corporations do not exist and in states where dental service corporations are unable to generate sufficient underwriting capital through their own resources, and be it further

Resolved, that the Board of Trustees be requested to cooperate with the National Association

of Dental Service Plans to the end that the formation of this needed agency, to serve as an adjunct to the dental service plan system, can be effected at the earliest practical date.

Representation in ADA House of Delegates for National Association of Dental Service Plans (*Trans.* 1968: 242)

Resolved, that access to the floor of the House of Delegates be granted to two officials of the National Association of Dental Service Plans for discussion of the report of this agency and be it further

Resolved, that the constituent society or dental service corporation in each state be urged to initiate the confidential prefiling of fees to enable the accumulation and determination of reliable fee data for the development of sound private and public care programs utilizing the usual, customary and reasonable concept of reimbursement for professional services. (*Trans.* 1968:305)

Report of National Association of Dental Service Plans (Delta Dental Plans Association) (*Trans.* 1969:322-323)

The Committee commented as follows:

The Committee has studied the annual report of the National Association of Dental Service Plans and notes that it is informational in nature. On June 16, 1969, this organization legally changes its corporate name to the Delta Dental Plans Association. The Committee notes that the number of active dental service corporations increased from 22 to 27 since the last annual report and the number of active member plans rose from 14 to 17. Concurring in the DDPA's belief that many of the active nonmember plans can meet the annual dues requirement to achieve full. financial participation in the organization, the Committee urges these active nonmember plans to assume full responsibility and participation in DDPA. The Committee is gratified to note that the member organizations of the DDPA presently represent about 80 percent of the organized dental profession in the nation.

Authorization to Purchase Shares of Stock in Dental Service Plans Insurance Company (*Trans.* 1970:359)

Resolved, that the American Dental Association is hereby authorized to purchase a sufficient number of shares but not more than can be purchased for $49,545 of the capital stock of the Dental Service Plans Insurance Company to enable the capitalization of that company with the understanding that subsequent investors in that company will be instructed by the incorporators of that company to purchase the stock held by the Association to the end that the Association may by relieved by such investment at the earliest opportunity.

Request for Investment in Stock of DSPIC (*Trans.* 1971:462)

Resolved, that the House of Delegates recommends that the Board of Trustees at its March, 1972 session consider, in the exercise of its discretion as the managing body of the Association's affairs, investing an amount, from available surplus funds of the Association, in the capital stock of the Dental Service Plans Insurance Company.

A mechanism for prepayment, preferably a dental service corporation, should be established by the constituent dental society in every state. (Guidelines for Dentistry's Position in a National Health Program: October 1971)

Dental societies or service corporations, or both, should be eligible along with other groups to qualify as dental components in health maintenance organizations. (Guidelines for Dentistry's Position in a National Health Program: October 1971)

Investment in Stock of Dental Service Plans Insurance Company (*Trans.* 1972:422)

Resolved, that the sum of $550,000 be transferred from the Operating Division to the Re-

serve Division for investment in the capital stock of the Dental Service Plans Insurance Company.

Investment in Stock of Dental Service Plans Insurance Company (*Trans.* 1972:422)

Resolved, that subsequent investors in Dental Service Plans Insurance Company be instructed by the Company, after the new offering of 10,000 shares of stock having a total value of $600,000 has been sold, to purchase $490,000 worth of stock held by the American Dental Association, to the end that the Association be relieved to that extent of its investment at the earliest possible opportunity.

Disposition of Monies Recovered from Sale of Stock of Dental Service Plans Insurance Company (*Trans.* 1972:439-440)

Resolved, that all of the monies recovered from the sale of $490,000 worth of capital stock of the Dental Service Plans Insurance Company held by the American Dental Association be placed in the General Fund in short term certificates to be utilized for future operating expenses at the discretion of the Board of Trustees.

COUNCIL ON DENTAL CARE PROGRAMS: SUPPLEMENTAL REPORT 3

Fee Reimbursement Differences: The 1975 House of Delegates referred the following resolution (*Trans.* 1975:656, Resolution 46) to the Council for study and report in 1976:

Resolved, that the freedom of choice statement adopted by the House of Delegates in 1965 (*Trans.* 1965:354) and cited in the 1975 booklet, "Policies on Dental Care Programs," page 14, be amended by deleting the phrases "within the agreed limitations of the plan" and "within the same limitations" and adding the following sentence:

> To assure the patient's freedom of choice of dentist, the Association considers it improper and unacceptable to the dental profession anytime a third party limits reimbursement in any way due to a dentist not signing a contractual agreement.

and be it further

Resolved, that this statement be included in all appropriate policy statements of the Association (e.g. in "Policies on Dental Care Programs": General Statements on Prepayment, pages 15-16; Methods of Payment, pages 26-27; and Joint Statement of AFL-CIO and ADA, pages 44-45).

The Council requested that Delta Dental Plans Association (DDPA) solicit respective statistical formulae utilized by their member plans in arriving at the percentile figures for reimbursing patients of nonparticipating dentists. Blue Shield of Pennsylvania, Blue Shield of Greater New York, and Ohio Medical Indemnity--the three Blues Plans that underwrite the majority of dental insurance in the Blues system—were also requested to provide similar information.

Based on information received from DDPA, the Council discovered that, within the Delta system, patients of nonparticipating dentists are being reimbursed on a wide variety of statistical methods. In Massachusetts and Idaho, they are reimbursed at 80 percent of the 50th percentile, while patients of nonparticipating and participating dentists alike in Pennsylvania and Kentucky are reimbursed at the same customary fee. However, the vast majority of Delta Plans are presently reimbursing patients of nonparticipating dentists at the 51st percentile, which conforms to DDPA policy with regard to inter-state contract provisions. When sufficient data are involved, the "real" 51st percentile represents a fee higher than the usual fee of one-half of the practicing dentists in a geographic area and this fact should be kept in mind.

Within the three Blues Plans cited earlier, Pennsylvania does have a participating agreement but there is no differential in fee reimbursement between participating dentists and patients of nonparticipating dentists. Blue Shield of Pennsylvania takes the position that the direct receipt of payment by the dentist is the most attractive incentive to become a participating dentist and that, thus, reimbursement differential is not a critical matter in soliciting participation. During the last fiscal year, 74 percent of the dollars paid for dental benefits by Blue Shield of Pennsylvania were to participating dentists. In contrast, Ohio Medical Indemnity does not utilize a participating agreement at all, but, it must be noted, that it is incorporated as a stock company and not as a service corporation. Blue Shield of Greater New York does utilize a participating agreement where patients of the nonparticipating dentist are paid the "average of the customary fee", which statistically places reimbursement to those patients at approximately the 55th percentile. According to the National Association of Blue Shield Plans, the majority of their member plans reimburse patients of nonparticipating dentists and 80 percent of the customary fee.

In considering this information, it should be remembered that the nonparticipating dentist is free to recover additional monies from the patient while the participating dentist generally is not free to do so.

In reviewing the concept of a service benefits plan, it should be understood that, in essence, the service corporation contracts with dentists to market their services and, in return, these dentists agree to comply with the corporate rules that are established to ensure fiscal stability. Depending on the particular Plan, a participating dentist may, for example, agree that the service corporation can withhold a certain percentage of benefits paid. This device enables the Plan to maintain sufficient reserves to operate within that state.

When prefiling of fees is a part of the Plan's contractual agreement, participating dentists submit their fees per procedure to the service corporation for the purpose of determining the customary fee. The service corporation finds this method to be preferable to that of the commercial carrier, which determines customary fee by the frequency of the claims submitted for each procedure. In the latter approach, claims only reflect the frequency of the procedures performed--*not* necessarily a cross section of dental fees in that geographic area for the same procedures. Another reason why the service corporation prefers its method is that it provides sounder actuarial data in an immediate way to aid in preparing accurate proposals for prospective purchasers.

Another facet that may be included in a participating agreement of a service corporation is the acceptance of a limited "risk" by the participating dentist. This means that should the service corporation deplete its financial reserves, the participating dentist remains responsible for absorbing part or all of his outstanding accounts re-

ceivable- past and present. He is not responsible for any other type of financial liability incurred by the corporation.

A service corporation feels a fee reimbursement differential between a participating and nonparticipating dentist is justified by the services and obligations -such as financial support and data information—provided by the participating dentist. This contractual relationship and its attendant provisions gives service corporations, many believe, an opportunity to gain a competitive edge in the marketplace.

The participating dentists may, in various Plans, be asked to assume a number of obligations, such as prefiling of fees, a withhold, limited risk, fee verification, binding peer review, adherence to given processing policies, customary and reasonable fee determinations and posttreatment review.

It is the Council's opinion that when such obligations, not necessarily all, are present in a contractual agreement, a reimbursement difference between participating and nonparticipating dentists can be justified.

In the Council's judgment, in the absence of such provisions obligating the participating dentist in particular ways, a reimbursement difference between participating dentists and patients of nonparticipating dentists is far more open to question.

Even though the Council acknowledges the justification for reimbursement differences under the circumstances outlined above, it has far greater difficulty in rationalizing the great range of difference between the present designated percentile- -such as the 51st percentile or 80 percent of the customary fee- largely utilized by the majority of service corporations to reimburse patients of nonparticipating dentists. In the Council's opinion, this differential can create undue economic leverage on those dentists who choose not to participate.

The Council is most concerned that such a differential affects the insured patient economically when he seeks treatment from a nonparticipating dentist. That portion of the charge the patient is responsible for may be proportionally higher than if treatment had been rendered by a participating dentist. Obviously, this economic fact may affect the insured patient's choice of dentist, something that the Council believes the profession and the public both wish to preserve as a high priority.

The Council urges each service corporation to review its formula for determining reimbursement of a patient of a nonparticipating dentist and to consider whether its existing differential raises the question of adverse impact on the patient's freedom of choice.

In summary, then, the Council recognizes the essential rationale and appropriate place of participating agreements as being necessary to the service benefits plan concept. (The need to preserve that concept is developed at greater length in the Council's report on the Delta Dental Plans Association.) It believes that the services provided by the participating dentist, and the obligations that he frequently accepts, justify the existence of a differential in reimbursement between the participating and nonparticipating dentist. The Council is deeply concerned when the differential becomes so wide that the patient and his freedom-of-choice prerogatives become involved.

On this basis, and because the resolution directed to it by the 1975 House of Delegates directly attacks the participating agreement itself, the Council believes that resolution to be unwise and recommends that it be postponed indefinitely.

RESOLUTIONS

46-1975. **Resolved,** that the freedom of choice statement adopted by the House of Delegates in 1965 (*Trans.* 1965:354) and cited in the 1975 booklet, "Policies on Dental Care Programs," page 14, be amended by deleting the phrases "within the agreed limitations of the plan" and "within the same limitations" and adding the following sentence:

> To assure the patient's freedom of choice of dentist, the Association considers it improper and unacceptable to the dental profession anytime a third party limits reimbursement in any way due to a dentist not signing a contractual agreement.

and be it further
Resolved, that this statement be included in all appropriate policy statements of the Association (e.g. in "Policies on Dental Care Programs": General Statements on Prepayment, pages 15-16; Methods of Payment, pages 26-27; and Joint Statement of AFL-CIO and ADA, pages 44-45).

COUNCIL ON DENTAL CARE PROGRAMS: SUPPLEMENTAL REPORT 4

Diverse Prepayment Policies Report: The 1975 House of Delegates referred Resolution 873 to the Council to study and to report back its findings:

> **Resolved,** that the Council on Dental Care Programs be directed to undertake a study of the prepayment experience of dental practices in states with diverse policies, and be it further
> **Resolved,** that the result of this study be reported to the 1975 House of Delegates.

In approaching this study, the Council was aware of the range of issues involved that might be defined as diverse. The Council's decision to focus on policies relating to radiograph submission, assignment of benefits and use of dental consultants for this particular study was predicated on the fact that other Council reports to the 1976 House of Delegates deal directly, in detail, with policies relating to the service corporation, fee reimbursement differences and the relative merits of the UCR and table of allowance payment mechanisms. In pursuing some of these other studies, the Council did solicit opinion from all constituent societies.

The Council determined that there were two basic sources from which the needed information for this study could be derived. One would be a survey, conducted by the member companies of the Health Insurance Association of America, to determine the office practices of those dentists treating patients covered by the various contracts in selected states. The HIAA has agreed to provide limited information concerning its member firms' experiences in four states when that information is available.

In the Council's opinion, however, the preferable source of information would be practicing dentists themselves. The Council, in fact, considered it mandatory to seek

information from this latter source since Resolution 873 specifically refers to "dental practices in states with diverse policies".

In conjunction with the Bureau of Economic Research and Statistics, a questionnaire was developed to be utilized in a survey of randomly selected dental offices in four states. It was the Council's intention that this questionnaire be structured in such a way as to allow the dentists surveyed to relate in a concise manner the actual practice followed in their respective offices. The survey developed is included with this report as Appendix I.

When considering methods of studying diverse policies as reflected in the actual dental practice, the decision was made to conduct a telephone survey in four selected states. The use of a telephone survey for such a study is a standard, accepted technique widely used in surveying and directed toward soliciting candid responses concerning personal views and knowledge. The telephone survey is a technique successfully utilized in other ADA studies. It was well suited for the purposes of this project for several reasons: it enables the dentist to communicate openly to the trained interviewer the nuances and strengths of his feelings; it enables the dentist to ask for clarification of questions to assure his genuine opinion is recorded and it affords the dentist the opportunity to elaborate as he wishes on those matters of particular concern to him.

The Texas Dental Association and Indiana Dental Association were selected as two of the four states to be used in the study based on the fact that they are states with diverse policies in some or all of the subject areas to be covered. Their participation was considered essential if any meaningful data were to be gathered from this study.

The selection of Michigan and Missouri as the control states was based on an examination of characteristics of a number of states which determined that those two were closely matched to Indiana and Texas in terms of size of dental population, impact within the state of prepaid dental programs and a consistent attitude as reflected in their policies toward prepaid programs.

On completion of the questionnaire and selection of the four states, verbal permission was requested and received from the states involved to conduct a pretest of the survey. The purpose of a pretest is to identify ambiguities in the questionnaire and correst them prior to beginning the actual survey. In addition, a pretest affords an opportunity to estimate the approximate time needed to conduct the interview. Based on the results of the pretest, minor changes were made in the questionnaire and it was determined that 12 to 15 minutes would be required to conduct each telephone interview.

A formal request for permission to conduct the survey was sent to the dental societies of Texas, Indiana, Missouri and Michigan on April 27, 1976. A random sampling of 10 percent of the member dentists in Texas and Michigan and 25 percent in Missouri and Indiana was drawn by BERS. This was determined to be a statistically valid sample that would reflect the attitudes of dentists practicing in the selected states. Permission to proceed was received from the Michigan Dental Association and the Missouri Dental Association. Permission to proceed was denied by the Texas Dental Association and the Indiana Dental Association.

The present refusal of the Texas Dental Association and the Indiana Dental Association to allow the ADA to conduct the survey negates the Council's effort to determine the attitudes of the practicing dentists toward prepayment issues in these two states. Copies of the letters withholding permission, and the Council's responses to them, are found in Appendices II and III.

The Council is, of course, disappointed that it is unable at present to respond to the directive of the House of Delegates. The information gathered, in the Council's opinion, would have been extremely valuable to the House in considering future policy of the Association as well as to the Council when implementing these policies.

Because the preliminary activity in a study of this kind represents a substantial expenditure of Association resources, the Council will continue discussions with the Texas Dental Association and the Indiana Dental Association in an attempt to reconcile any problems which might exist in the survey with the hope that this study might be conducted during 1977.

APPENDIX I
TELEPHONE SURVEY

Interviewer: Good morning Dr. Smith, this is Jane Jones calling from the American Dental Association in Chicago. The Council on Dental Care Programs is trying to obtain a profile of activities in the dental office related to dental prepayment. I would like to ask you a few questions about how prepayment affects your practice. The total questionnaire should take about 15 minutes to complete. If this is not a good time for you, could we schedule an appointment when I could call you back?

Interviewer: Before we pursue the subject of prepayment, it will be necessary for me to ask some preliminary questions to obtain some statistical background information.

1. Do you know of any dental insurance plans in the community where you practice?
   Yes 1
   No 2

2. What is the approximate population of the city or town in which you practice?
   under 2,500 1
   2,500-25,000 2
   25,000-100,000 3
   100,000-1 million 4
   over 1 million 5

3. *Approximately* what percent of your patients are currently covered by dental prepayment insurance, excluding those covered by government programs? (medicare, VA, etc.) (if none, skip to 10a) ..... _____%

4. About how many patients are treated in your office during an average day? (you and your auxiliaries) ..... _____

5. On the average, how many days a week do you work? ..... _____

6. How many of the following types of personnel work in your office? (total office)
   dentists (including self) ..... _____
   laboratory technicians ..... _____
   hygienists ..... _____
   chairside assistants ..... _____
   secretary/receptionists ..... _____
   (other) ..... _____

7. Do you usually use radiographs as an aid for diagnosis?
   Yes 1
   No 2

8a. Do you ever submit radiographs to third party carriers?
   Yes 1
   No (skip to 8c) 2

8b. (If yes) Do you submit them:

routinely? 1
on request? 2
for pre-operative? 3
determination of benefits? 4
for certain other cases?
(please specify) 5

8c. (If no) What were your reasons? (Please comment briefly.)

9a. Have you ever refused to submit radiographs?

Yes 1
No (skip to 10a) 2

9b. (If yes) What % of the time roughly do you refuse to submit radiographs?

..... _____%

9c. Did you receive any communication from the carrier?

No 1
Yes, Call 2
Yes, Letter 3
Other (specify) 4

9d. Do you know if the patient involved received any communication from the carrier?

Don't know 1
No 2
Call 3
Letter 4
Other (specify) 5

10a. Could you describe *briefly* your personal feelings toward the policy of submitting of radiographs:

10b. Do you think your attitude on this subject is the same as most other dentists in your area?

Yes (skip to 11a) 1
No 2

10c. (If no) What do you think the differences are?

11a. Are you aware of any existing policy of your state dental association or the ADA regarding the submission of radiographs?

Yes 1
No (skip to 12) 2

11b. (If yes) What are your feelings regarding these policies?
State Dental Association
ADA
(Follow-up: How do these policies affect your practice?)

12. Do you accept assignment of benefits from insured patients?
(Follow-up: Do you accept checks directly from insurance companies?)

Yes 1
No 2

13. Comparing insured patients to other patients, what is the average time between the mailing of a claim form or bill and receipt of payment?

	For your Insured Patients	*For your Other Patients*
under 1 week	1	1
one to two weeks	2	2
two to three weeks	3	3
three to four weeks	4	4
more than four weeks	5	5

(Follow-up: Want time between mailing of claim form and reimbursement by insurance company.)

14a. Are you aware of any existing policy of your state dental association or the ADA regarding assignment of benefits?

Yes 1
No (skip to 15) 2

14b. (If yes) What are your feelings regarding these policies?
State Dental Association
ADA
(Follow-up: How do these policies affect your practice?)

15a. Do carrier consultants ever contact you?

Yes 1
No (skip to 17) 2

15b. What is the *most* common reason for carrier consultants to have contacted you:

To obtain radiographs 1
To question fees 2
To question treatment plans 3
Other, please specify 4

16a. Have you ever received copies of correspondence from the carrier to the patient?

Always 1
Sometimes 2
Never (skip to 17) 3

16b. How do you find these form letters:

Are they acceptable
(clear, and accurate information) 1
or are they unacceptable
(language detrimental to the
dentist/patient relationship)? 2

17. Have you ever had a need to contact a carrier consultant?

Yes 1
No 2

(If yes) What were the reasons?

18a. Are you aware of any existing policy of your state dental association or the ADA regarding the use of dental consultants by insurance firms for the review of claims?

Yes 1
No 2

(If no) Thank you very much for your assistance in our research.

18b. (If yes) What are your feelings with regard to these policies?
State Dental Association
ADA
(Follow-up: How do these policies affect your practice?)

Thank you very much for your assistance in our research.

APPENDIX II

May 24, 1976

Dr. Joe C. Carrington, Jr.
Secretary-Treasurer
Texas Dental Association

Dear Doctor Carrington:

This is to acknowledge with thanks your letter of May 6 in which you relay the refusal of the Texas Dental Association to allow the Council to carry out a telephone interview of a scientifically selected sampling of Texas dentists concerning the effect of "diverse policies" on the practices of individual dentists. A similarly selected group of dentists from Indiana, Michigan and Missouri were also to be included. I'm sure that the Texas Dental Association regrets as deeply as the Council the substantial damage the refusal does to our attempt to be responsive to a directive from the Association's House of Delegates concerning "prepayment experience of dental practices in states with diverse policies. . . ." The Council believes it is clear that "dental practices" means individual practitioners and that direct communication with them is the best way to elicit facts about their experience.

It is good of you to offer the results of the survey recently taken by the Texas Dental Association and it will, of course, be circulated to all Council members. Regrettably, it does not meet the same purposes as the work we had planned to do. A multi-state sampling population is essential for our project because of the clear directive of the House. Time frame is, of course, always a consideration and we would have to carry out any study in the other states and, again, in Texas, at approximately the same time. Again, there must be some comparability between the characteristics of the sample in each state in order to achieve the desirable survey validity. For all of these reasons, at a minimum, the study you kindly sent does not answer, in our view, the House purposes.

I hope, as you reviewed our request, that you did feel satisfied that the Council undertook this work not as an attempt to vindicate any particular point of view, whether it be national policy or state policy. Nor is the Council interested in the slightest in attempting to arrive at prior judgments and then seek evidence to support them. Instead, we are trying to gather information from the "grass-roots" member.

We didn't want to ask the leadership—either national or state—to tell us what they thought the members think. We wanted to find out from the members themselves. We wanted to hear it candidly and directly and be able to report it straightforwardly to the House of Delegates for its use. I wish we had been allowed to proceed; I think it would have been useful, whatever the results may have been.

As you perhaps recall from your conversations with Eric Bishop during the TDA annual session in Galveston, we are inviting TDA representatives to meet with the Council during its next meeting. Perhaps, prior to that meeting, something can be done to rescue this project for a later date since two states did invite us to proceed. Truly, none of us has anything to fear from hearing what the members understand and believe. Again, thank you for your letter.

Emil W. Lentchner, D.D.S.
Chairman
Council on Dental Care Programs

May 6, 1976

Dr. Emil W. Lentchner, Chairman
Council on Dental Care Programs
American Dental Association

Dear Dr. Lentchner:

The Executive Committee of the Texas Dental Association feels that because of the many diverse conditions that exist within the State of Texas that the random sampling proposed in your letter of April 27, 1976 would not give results with any degree of accuracy.

The Association has just completed a survey which covers virtually the same topics. Response

was from 59% of the membership. The Executive Committee feels that these results will present a truer picture of the experiences and feelings of the members of the Texas Dental Association.

A copy of the survey with a compilation of the results in percentages is enclosed.

If we can be of any further assistance, please call on us.

Joe C. Carrington, Jr., D.D.S.
Secretary-Treasurer

TEXAS: DIVERSE POLICY STUDY

The Texas Dental Association urgently needs your assistance in allowing us to measure various aspects of third party dental plans. The questionnaire is "anonymous" and you are not required to identify yourself. It is imperative, however, that we receive completely objective answers.

The information and data acquired on this survey of our entire membership will provide the individual Responsibility Committee and the TDA Board of Directors the information necessary to represent you in a responsible, professional manner in dealings with the Texas State Insurance Commission, the insurance industry of America, and businesses and industries acquiring dental plans for employees.

Please answer each question accurately and return immediately by folding address side out. No stamp is necessary. Please staple or seal with scotch tape. Thank you.

		Results
1. What percentage of your practice is "third party?"		0- 10%...31.4% 10- 20%...24.0% 20- 30%...20.0% 30- 40%...12.0% 40- 50%... 3.5% 50- 60%... 4.5% 60- 70%... 1.5% 70- 80%... 1.7% 80- 90%... 0.7% 90-100%... 0.2%
2. Do you routinely provide X-rays with insurance company claim forms?	☐ Yes ☐ No	4.5% 95.5%
3. Do you ever provide X-rays to insurance companies?	☐ Yes ☐ No	33.0% 67.0%
4. Do you use any claim form other than the Uniform Claim Form?	☐ Yes ☐ No	61.5% 38.5%
5. Do you use any claim form provided to you by a patient or carrier?	☐ Yes ☐ No	71.4% 29.6%
6. Do you always use the Uniform Claim Form and only this form?	☐ Yes ☐ No	31.5% 68.5%
7. Do you ever attach a narrative or chart of pre-existing condition with the claim form?	☐ Yes ☐ No	48.0% 52.0%
8. Have you been contacted frequently by an insurance company?	☐ Yes ☐ No	23.5% 76.5%
In respect to treatment?	☐ Yes ☐ No	33.0% 67.0%
In respect to fees?	☐ Yes ☐ No	9.0% 91.0%
9. How do you measure the insurance industry in the processing of claims for your patients: Please check off		

Never have any problems	☐		9.4%
Infrequent problems	☐		70.0%
Contacts border on abuse	☐		14.5%
They become impossible to deal with	☐		6.1%
Remarks: _____			
_____			
Please check one or more below			
10. As a standard of practice we do not accept assignments.	☐		56.0%
11. We accept assignments only in very special instances.	☐		56.5%
12. We will take all assignments.	☐		16.5%
13. Do you understand what the "hold harmless" provision of some dental contracts means in respect to your charges?	☐ ☐	Yes No	28.0% 72.0%
14. Have you encountered any difficulties in patient's misunderstanding their dental plan benefits?	☐ ☐	Yes No	71.0% 29.0%
15. Do you subscribe to and employ the TDA Guidelines on Third Party administrative office proccdures?	☐ ☐	Yes No	87.0% 13.0%
16. Do you prefer the TDA Designated Consultant System over the routine submission of X-rays?	☐ ☐	Yes No	94.0% 6.0%
17. Have you ever been contacted by an insurance company consultant?	☐ ☐	Yes No	34.0% 66.0%
18. Can you report any patient reactions to insurance company turnaround time on benefit payments?			
Have not heard of any problems	☐		29.0%
Have heard only a minimum of complaints	☐		52.0%
Have heard of many complaints	☐		19.0%
19. Do you take an active part in your local society's affairs?	☐ ☐	Yes No	75.0% 25.0%
20. Did you submit a pledge card to abide by TDA individual Responsibility Guidelines?	☐ ☐	Yes No	82.0% 18.0%
21. In respect to Third Party Guidelines, do you believe present TDA policies are			
Just right	☐		68.0%
Too tough on the insurance industry	☐		4.5%
Not strong enough (too lenient to the insurance industry)	☐		27.5%
22. Please list here any suggestions you would like to make to the TDA individual Responsibility Committee and the TDA Board:			
_____			
_____			
_____			
_____			
_____			

APPENDIX III

May 25, 1976

Robert M. Stetzel, D.D.S.
President and Chairman
of the Board of Trustees
Indiana Dental Association

Dear Dr. Stetzel:

Thank you for your May 7 letter informing the Council that the Indiana Dental Association refuses our request to conduct an interview with a scientifically selected group of dentists that would include some in Indiana concerning the impact on individual practices of "diverse policies" in various states. The Council naturally regrets this refusal which makes it extremely difficult for it to be truly responsive to the House of Delegates with respect to 1975 Resolution 873.

I note that one of the objections raised in your letter relates to a telephone survey. The Council did not, of course, choose that procedure lightly nor without expert advice from the Bureau of Economic Research and Statistics. We are quite convinced that the phone survey is appropriate for a number of reasons. It enables the dentist to communicate freely to a trained interviewer the nuances and strength of his feeling; it enables him to ask for clarification of questions where there is any doubt whatever so as to assure that his genuine opinion is being recorded, and it allows him to elaborate as he wishes on the rationale for his feelings. Probably, face-to-face interviews are ideal for an investigation of this sort but time, money and logistics militate against them. Beyond that, a phone survey in this instance is a superior technique in the view of qualified experts because it is well suited to elicit responses concerning expressed behavior as related to personal views and knowledge. Phone surveys of members by the profession have been quite successfully done before and I can't agree, therefore, that members in general object to them.

The purpose of the survey, of course, was not to prove or disprove the validity or popularity of any policy, state or national. It was to find out as best we can what the individual member's view is—direct and unfiltered by leadership belief—and to give that information to the House for its use, letting the chips fall where they may. I wish it could have been done.

Your letter also raises the question of selecting states as "controls" that have a Delta corporation. It would be difficult, as I am sure you are aware, to find a state that fully meets the appropriate characteristics for the survey and does not have a Delta plan since the overwhelming majority of states do have one.

As you know, the Council is, at the direction of the House, undertaking a study of Delta and its relationship to the Association. On February 20, 1976, a letter was sent to the Indiana Dental Association asking for their views with respect to the question. Your response has been taken most carefully into account. Many of the specific points you raise in your letter are, in fact, part of that study.

With respect to your criticism that there were too few example subjects contained in the questionnaire, I can only note that those chosen seemed, after pretesting of a draft questionnaire, to be more than sufficient to exemplify the attitude of the dentists interviewed as validly as any, that these three are in fact central to diverse policies as such and that the listing of ten or twelve items would increase the questionnaire to an unbearable length without significantly increasing the validity of the results.

Some of the items you list as additions are too ambiguous in content to be the proper subject of a valid questionnaire, such as "dentist responsibility," "patient responsibility" or "third party responsibility". Whether face-to-face, or on the phone or on a mail questionnaire, these are susceptible to a myriad of interpretations, making impossible any accurate reporting of response. Others, such as "in-office audit" are not, of themselves, the object of diverse policy to the best of our knowledge.

In a time when the voice of the "grass-roots" dentist is one that we are all anxious to hear and heed, the Council was most hopeful that this survey would have been as welcome to all states as it would be to the Council and the Association.

Perhaps there is still some possibility of carrying it out, though it would not now be possible to

perform it in time for normal transmission to the House. I would be glad to receive any thoughts from you in that regard.

Emil W. Lentchner, D.D.S.
Chairman
Council on Dental Care Programs

May 7, 1976

Dr. Emil W. Lentchner, Chairman
Council on Dental Care Programs
American Dental Association

Dear Dr. Lentchner:

This is a follow-up to your April 27, 1976 letter sent to Mr. Coons. You requested the Indiana Dental Association's written approval of the telephone survey which was described and enclosed with the April 27 letter.

The Indiana Dental Association's Board of Trustees met on Tuesday, May 4, 1976 and discussed this matter at great length. The I.D.A. Trustees firmly believe that the survey as outlined does not represent the true intent of Resolution 873. It does not include the categories needed to make this a valid survey. Too, the Board believes a survey of this length is impractical for a busy practitioner to leave patients and answer via telephone. Therefore, the Association does *not* endorse the telephone survey to be conducted in Indiana.

In order that you might have some background and understanding of this position, we offer the following information.

The Board believes that if the A.D.A. intends to conduct a study it should not be via the telephone. This mechanism is not only costly and an inconvenience to both dentists and patients, it does not provide the time for a dentist to really relate his dental practice experience in the area of prepayment.

In addition, the Trustees expressed their concern that only three areas, as noted in your letter, were selected to be questioned in the survey. The Board believes it is clear that when one speaks of three areas (i.e., radiographs, dental consultants, assignment of benefits) one should also include and address the following:

1. Participating vs. nonparticipating dentists
2. In-office audit
3. Posttreatment review
4. Prefiling of fees
5. Different reimbursement methods
6. Fee withhold
7. Predetermination
8. Alternate treatment concept
9. Uniform claim form in conjunction with the hold harmless concept
10. Patient responsibility
11. Dentist responsibility
12. Third party responsibility

The Trustees regret they cannot endorse the survey for the Association as it is now written but believe that additional thought must be given to the study if it is to provide any meaningful information.

Robert M. Stetzel, D.D.S.
President and Chairman
of the Board of Trustees

COUNCIL ON DENTAL CARE PROGRAMS: SUPPLEMENTAL REPORT 5

Fourth Party Closed Panel Programs: The 1975 House of Delegates approved the following Fourth Trustee District resolution (*Trans.* 1975:664), which was assigned to the Council on Dental Care Programs for action by the Board of Trustees.

> **Resolved,** that the appropriate agencies of the Association be directed to investigate, monitor and take appropriate action with respect to fourth party closed panel programs, and be it further
> **Resolved,** that necessary resources to implement these efforts be allocated immediately, and be it further
> **Resolved,** that the agencies involved report on their activities to the 1976 House of Delegates.

Action Plan: The Council's activity was founded upon the current Association policy, approved by the 1972 House of Delegates (*Trans.* 1972:670). In its preliminary planning, the Council developed the following working definition:

> For purposes of this study, a fourth party closed panel program is defined as a dental benefits plan, owned, managed, supervised, or otherwise directed by other than dentists, in which subscribers, in order to obtain benefits, must receive covered services from specified dentists or at specified dental facilities.

To the extent necessary to fulfill the intent of the House of Delegates, the Council decided also to include in the study those plans in which a member of the profession serves an essentially directorial function, apart from his qualifications of professional degree, when those plans meet the other terms of the working definition.

In addition, the Council designed the investigative phase of the study to comprise a canvass of constituent societies to determine

a. the extent of defined activity in each state.
b. applicable state law relative to the defined activity.

Subsequent to completion of this canvass, it was planned that each reported plan would be requested to provide a description of its design, benefit structure, marketing policy and method of providing care, as well as samples of the informational or promotional materials utilized. After evaluation of responses, it was planned that requests to visit a selected number of plans would be issued in order that detailed descriptions of representative types of "fourth party closed panel programs" could be developed.

It should here be noted that the Council, while sharing the sense of urgency implicit in the Fourth Trustee District resolution, for some time had perceived this project as one of a continuing nature and views this report, in compliance with the third resolving clause, as essentially the first in a series of status reports on alternative delivery modes and benefits plan activity.

Responding to the Council's canvass, constituent societies reported five plans which appeared to meet the working definition, as well as eight plans directed by a dentist serving in a managerial capacity exclusively and therefore essentially complying with the terms of the definition.

Additionally, the California Dental Association reported 36 closed panel plans in

operation in that state without distinguishing between those directed by a dentist and those directed by a layman.

Among the states responding, there appeared to be some disagreement as to whether state laws specifically prohibit the defined activity, with 20 societies reporting no legal prohibition of fourth party closed panel plans, but at the same time providing sections of their dental practice laws which appear to exclude directorial participation of non-dentists in dental plans through their definitions of the practice of dentistry. However, with regard to this report, it is the Council's view that an entity which substantially constitutes a fourth party closed panel program is capable of establishing itself legally in every state without undue corporate restructuring.

Investigation: The Council, as a result of its canvass, wrote directly to nine plans which appeared to meet the working, or expanded working, definition, requesting descriptive data and promotional materials. Two responded, one cooperatively; the other, North American Dental Plans, Inc., Wayne, Pennsylvania, advised that it did not wish to comply with the request, in view of the Association's assistance to the New Jersey Dental Association in pursuing its complaint that North American Dental Plans is engaged in the practice of dentistry in that state in violation of the New Jersey Dental Practice Act. A description of North American Dental Plans, constructed from information provided by the New Jersey Dental Association, is on file in the Council on Dental Care Programs.

In addition to the one plan responding favorably to the Council's request, liaison was established through the California Dental Association with four plans of varied design in that state and with two other plans in other states through the initiative of the plans themselves. The detailing of similarities and differences in these seven plans comprises this report of the Council's investigative activities for 1976.

In visiting each of these seven plans, Council representatives sought information relative to the plan's corporate structure, delivery component (e.g., a clinic, a single group practice, an association of practices, etc.) basic benefits design, payment mechanism or mechanisms, number of programs offered, subscriber groups, beneficiaries, active patients; eligibility criteria of beneficiaries, standards for dentists (if contractural arrangements exist with providers); average first-visit scheduling time, average completion time for a treatment plan, marketing policy, safeguards against discontinuation of service, mechanisms for resolving complaints and reviewing the quality and appropriateness of care rendered.

Plan personnel were informed at the commencement of the visit and interview that it was not the purpose of the Council's study to approve or disapprove or in any way critically evaluate the cooperating plans, but rather to obtain sufficient information to provide to the Association membership, through its House of Delegates, a description of several dissimilar benefits plans which collectively constitute an alternative to the traditional method of delivering dental care and the conventional dental prepayment plans which support that method of delivery. Further, Council representatives advised plan personnel that specific design or operational characteristics of plans, of interest to the Association, would be described in the report but would not be identified as peculiar to any particular plan.

With regard to corporate structure, only two of the cooperating plans generally met the primary working definition of a fourth party closed panel program, the other five being in all significant respects controlled by dentists, albeit in some cases dentists functioning in an exclusively managerial capacity. However, in both types of fourth

party closed panel plans, the plan components delivering dental care were under professional direction.

The types of delivery components in the seven plans ranged from the single facility to 22 group practices individually contracting with one union trust.

Services Covered: The services covered in the seven plans were generally comprehensive, with most plans having no excluded services other than orthodontic care (in four plans).

Significantly different opinions were expressed with regard to the preferable relationship of the plan director and the dentists providing services. One view held that a conventional employer-employee relationship with reimbursement on a salary basis was necessary in order for the plan director to maintain control of the delivery component. It was explained that in this relationship a salaried dentist's production of dental services is established as a dollar value, based on specific monetary values assigned to all dental services. If the services provided, stated in dollars, regularly are lower than the dentist's salary, the dentist is replaced. This strict control relationship was advocated by one of the fourth-party plans.

An opposite view of the preferred director-dentist relationship was presented by the dentist administrator of a plan whose delivery component is 22 separate group practices with which a union trust contracts on a separate contract basis upon the recommendation of the plan administrator. This recommendation is based on an evaluation of each group conducted either by the administrator himself or by independent dental practice evaluators.

A variation of the director-dentist-as-employer-employee relationship, which is worthy of note, is one in which reimbursement is based upon an annual salary plus a share of profits, with the degree of profit-sharing being determined by the accumulation of relative value units assigned to each procedure performed, the more extensive, time-consuming services being assigned greater relative values. As explained by the plan director (dentist/employer) this system was designed by the dentist/employees and serves to strike a balance between the practicing dentist's cost-consciousness (inasmuch as the plan's failure to produce a profit would eliminate any bonus whatever), and his recognition that the accomplishment of a more extensive procedure will act to award him an increased share of the profit realized.

An equally distinct difference of opinion emerged with regard to mixing capitation plan patients with fee-for-service patients, one view holding that a dental practice with a mixture incurs the danger of neglecting the capitation patient in favor of the fee-for-service patient; the other contending that dental practices should never rely upon capitation plans for the major source of income due to the stress which a single contractual change or reversal is capable of exerting upon the practice. Among the plan directors holding this latter view, it was the consensus that a mixture of approximately ⅓ capitation, ⅔ fee-for-service is desirable.

Marketing Policy: The marketing policy commonly referred to as "dual choice" was another matter of controversy among the plans visited. Five of the seven plans offered programs on a dual choice basis with periodic opportunities for re-election, several stating that this policy was strongly preferred inasmuch as it preserved to some degree the patient's prerogatives. Two plans, each of which provided a single program to a single subscriber group, did not offer a choice. One plan manager advised that, while he understood the reasoning of the Association in supporting the dual choice concept,

he would not accept a contract on that basis because of the uncertainty of the plan's population, hence the uncertainty of the capitation payment, and because of the "adverse selection" factor.

"Adverse selection", which for the purposes of this report would be defined as extremely high utilization and the need for extensive dental treatment among those choosing the closed panel in a dual choice situation, was acknowledged by representatives of all plans. One single facility corporation, whose active patient population is composed of approximately ⅔ fee-for-service patients and ⅓ beneficiaries of dual choice closed panel plans of one to two years maturity, advised that some of these plans experienced utilization in excess of 90 percent in the first year and that, because of this and the high incidence of severe dental disease among the beneficiaries, the plans were not expected to become self-sufficient until at least their third year. This contrasts sharply with the experience of plans marketed on a sole source basis. In these, because the risk is distributed over the entire nonvoluntary, eligible population, utilization will tend to be comparable to conventional prepayment programs. Because the closed panel plan offers a usually less convenient means of obtaining dental care, utilization would tend to be reduced. In the two plans visited, the beneficiary population's demographic characteristics indicated traditionally low utilization of dental services. This was borne out in the experience of the plans which were being utilized by approximately 25 percent of the eligible population in one plan and by about 10 percent in the other.

Utilization in this context is defined as the number of eligible beneficiaries who receive at least one dental service during a twelve-month period, expressed as a percentage of the total eligible population.

Plan Funding: All of the plans were primarily funded through capitation systems with one exception. This was a union trust plan in which a dual choice is offered to the membership: a UCR program of conventional design or a closed panel program in which the participating dentists are reimbursed by the plan on the basis of services provided at fees agreed upon in the contract, i.e., a fixed fee schedule. A unique feature of this plan is that each beneficiary remains throughout his period of eligibility free to select either program and the act of selection does not commit the beneficiary to a program for any length of time. It should be noted, however, that this approach to "dual choice" seems practicable only in circumstances in which the programs offered share a single funding source and a single administrative mechanism.

None of the plans visited was a pure capitation plan, i.e., one in which all covered services are provided at a single rate per beneficiary or beneficiary/family. Every plan employed an additional funding mechanism, most commonly surcharges on precious metal restorations, crown and bridge and prosthetic services. These surcharges are expressed usually as dollar amounts which generally approximate laboratory costs. In fact, in one program a system is employed in which actual laboratory charges are separated out and billed to the patient. However, in one or another of the plans visited, surcharges were instituted on virtually every service including preventive services, although this was clearly the exception rather than the rule. In one program within one plan, the patient participation is expressed as a percentage of the fees specified in the facility fee schedule, thus mixing conventional prepayment concepts and a capitation approach to an even greater degree.

Plan Construction: Common to most of the plans was the assignment of specific patients to specific dentists within the panel, which assignment was based upon the

preferences of patients. All plans appeared capable of scheduling initial visits and completing treatment plans in a reasonably expeditious manner. Generally, patients had the opportunity to change dentists if their initial selection proved unsatisfactory to them. All the plans included in the survey expressed a willingness to submit to constituent society peer review or grievance committee action to resolve disputes with patients.

With regard to safeguards included in the programs to protect the patients against the eventuality of the plan's delivery component failing to provide services over the term of the contract, several mechanisms were employed. In one plan, two months' capitation payment is held in escrow and is refundable to the subscriber, a union trust, in the event the plan fails to comply with the terms of the contract. In another, it was stated that the corporation's tangible net equity represented a bond which was subject to forfeiture should the plan default in its contracts with subscribers. Several other plans advised that they offered no assurance to subscribers of their ability to perform, other than their records of practice. (One of these groups had been in practice for over 20 years.)

A significant aspect of performance safeguards is the provision of the California Assembly Bill 138, the Knox Keene Health Care Service Plan Act of 1975, which states in part ". . . every plan shall maintain an agreement held unobjectionable by the commissioner, with an unrelated subsequent provider who may be an insurer, a health facility or medical service corporation, another licensed plan, or a governmental organization to provide the payment of the cost of the originally contracted health care service or to provide the originally contracted health care service in the event the plan ceases to do business because of a business failure, suspension of or revocation of its license, or any other reason."

A sentiment frequently expressed by representatives of closed panel plans during the course of the Council's investigation was that closed panel plans are clearly not for everyone. They have some disadvantages, as have conventional dental benefit plans, (which, in the view of the plan representatives are not for everyone either.) While conventional dental benefits plans support the traditional method of seeking dental care, ensure the patient's freedom of choice of dentist, and lower to a considerable extent the economic barrier to dental care, the degree of patient participation in the cost of care remains in many programs substantial enough to constitute an effective demand deterrent. On the other hand, while a pure capitation plan might eliminate all out-of-pocket expense and therefore remove the financial barrier to seeking care, the fact is that the vast majority of capitation plans are not "pure", but rather contain some copayment mixture, usually in the form of a surcharge on certain services. It should be noted here that depending upon the treatment required and the surcharge schedule in force, out-of-pocket expense might well be greater under a closed panel capitation plan than under a conventional prepayment plan with a reasonable copayment factor. Nevertheless, the proponents of capitation contend that in many circumstances such plans improve the economic availability of dental care, particularly to the working class of modest income. At this point, the Council is not in a position to confirm or deny this statement.

Continuing Investigation: Further investigation is planned for 1977, with emphasis on establishing a profile of alternative benefits plan beneficiaries as past and present utilizers of dental services for the purpose of measuring the impact of the introduction of such plans upon private practices.

In addition, the Council intends to continue its collection of information about specific plans and to conduct on-site visits, where possible, with respect to plans which represent a distinct variation in design. Information on alternative benefits plans in the Council's collection will be available to the membership upon request.

Monitoring: The Council observes that even an extremely limited investigation, such as the initial effort reported herein, is demanding in terms of fiscal and personnel resources. Further, the possible variations in plan design are virtually limitless, although, as described above, several elements are employed with great regularity over a wide-range of plans. Nevertheless, the Council recognizes that the monitoring of alternative benefit plans and modes of delivery of care is clearly its continuing responsibility. The establishment of patient population profiles based on research during 1977 is expected to improve the Council's ability to project the effects upon given population centers of the introduction of an alternative plan, particularly on a dual choice basis.

Appropriate Action: With regard to actions which might be initiated by the profession relative to alternative plans, the Council recommends that the following Association policies (*Trans.* 1972:670) be pursued vigorously at every level of organized dentistry.

> To protect patients' freedom to receive prepaid services from dentists of their choice, closed panel plans should be presented to consumers only as an alternative method of provision of dental benefits, along with a comparable plan which permits free choice of dentist. Under this dual choice system, the individual consumer should also have periodic options to change plans. There should be equal premium dollars available to both dental delivery systems in the dual choice framework. The closed panel option shall be financially capable to deliver the benefits called for in the contract.
>
> Existing closed panels and panels being formed should submit their programs to the constituent society for evaluation to determine whether the program is capable of delivering the scope of benefits called for by the contract and to determine that the program is in the best interest of the patient.
>
> Prepaid group practices or closed panels shall be under the direct supervision of a dentist or dentists legally licensed in the state, who shall conform to the *Principles of Ethics* of the American Dental Association and the local codes of ethics and shall maintain liaison with the constituent and component societies in the area.
>
> The Association reaffirms its support of the conviction long held by society that the health interests of patients are best protected when dental practices and other private facilities for the delivery of dental care are owned and controlled by members of the dental profession (*Trans.* 1974:635).

As discussed earlier, many state dental practice acts provide legal constraints on fourth party closed panel programs and, in the Council's view, it is proper that these constraints be applied. Still, the Council maintains that the more effective course of action for the protection of the public and advancement of the profession lies in a concerted effort to ensure that every benefits plan, regardless of design or corporate structure, supports a delivery system that is professionally sound and directly controlled by members of the profession.

As dental prepayment continues its growth, it is inevitable that a wider variety of systems to provide and finance care will be developed, a natural result of the dynamics of free enterprise. It is clear from experience in states where these developments have already occurred that the traditional system of delivery, through private practices

on a fee-for-service basis and supported by conventional dental prepayment, can compete successfully with any alternative. To ensure that competition remains fair and unfettered is dentistry's challenge for the future.

The Council wishes to express its appreciation to the following individuals who cooperated in this study:

Alex Bendersky, DDS, Professional Facility Corporation, Chicago
Richard L. Blomquist, Comprehensive Care, Incorporated, Oak Brook, Ill.
Bernard Corn, DDS, Los Angeles Hotel-Restaurant Employer-Union Welfare and Retirement Funds, Los Angeles
Michael D. Goodley, DDS, Group Dental Service, Encino, Calif.
James S. Kramer, DDS, Dental Programs Incorporated, Encino, Calif.
Stanley Richardson, DDS, Hotel Employees Union - Hotel Association Insurance Fund Health and Welfare Trust, Miami Beach
Richard Simms, DDS, Drs. Sakai, Simms, Simon, Sugiyama and Green, Harbor City, Calif.
Harry E. Whyte, DDS, Arizona Prepaid Dental Plan, Phoenix, Ariz.
Sam J. Young, Group Dental Service, Encino, Calif.

RESOLUTIONS

This report is informational in nature and no resolutions are presented.

COUNCIL ON DENTAL CARE PROGRAMS: SUPPLEMENTAL REPORT 6

Diverse Prepayment Policies Progress Report: The 1975 House of Delegates referred Resolution 873 to the Council for action:

> Resolved, that the Council on Dental Care Programs be directed to undertake a study of the prepayment experience of dental practices in states with diverse policies, and be it further
> Resolved, that the result of this study be reported to the 1976 House of Delegates. (*Trans.* 1975:648)

In Supplemental Report 4, (p. 60) the Council on Dental Care Programs reported that it ". . . will continue discussions with the Texas Dental Association and the Indiana Dental Association in an attempt to reconcile any problems which might exist in the survey with the hope that this study might be conducted during 1977." Accordingly, on August 3, 1976 letters were sent to the presidents of the aforementioned dental associations requesting that the appropriate committees reconsider their decisions not to participate in the diverse policies study.

On August 19, 1976 Dr. Robert M. Stetzel responded stating that the position of the Indiana Dental Association remained unchanged because the Council had failed to revise the scope of the study to include suggestions made by the IDA in previous cor-

respondence. The Council's reply on September 16, 1976 reemphasized points made previously in Supplemental Report 4 regarding "The Council's decision to focus on policies relating to radiograph submission, assignment of benefits, and use of dental consultants . . ." due to the fact that other concurrent Council studies relate directly to the service corporation, fee reimbursement differences, and the relative merits of the UCR and Table of Allowance payment mechanisms.

Dr. Robert T. Maberry responded to the Council's request for reconsideration on August 31, 1976 on behalf of the Texas Dental Association. After restating the TDA position on prepayment policies and the proposed diverse policies study, Dr. Maberry related the action taken by the TDA Board of Directors on August 22, 1976:

> **Resolved,** that a letter be sent to the ADA authorizing a telephone survey of Texas dentists by the ADA Council on Dental Care, provided that a list of those surveyed be released to the TDA for the purpose of an IRC survey of the same members.

The Council response of September 16, 1976 pointed out that the Association's Bureau of Economic Research and Statistics has achieved a great deal of success in carrying out House-directed surveys due in part to the profession's cooperation in these activities. Much of their success is attributable to the perception of dentists that the Bureau's assurance of confidentiality is strictly honored. For this reason the Council could not accept the TDA proviso that names and addresses of surveyed dentists be reported to the TDA. Copies of Council and TDA correspondence are provided in Appendix I.

The Council recognizes that there are many approaches available when conducting such a study and that no single survey will reveal everything- within rational boundaries of budget, time, and dentists' participation—about attitudes and behaviors of individual dentists with respect to different policies. However, in light of other Council studies completed and reported to the 1976 House of Delegates, the Council feels that the proposed survey is responsive to the intent of Resolution 873.

The Council is disappointed that the survey could not be executed in 1976 and in the absence of any further direction from the House, the Council will continue to pursue appropriate avenues to reconcile any problems which might exist in the study with the hope that this most important directive might be carried out in 1977.

RESOLUTIONS

This report is informational in nature and no resolutions are presented.

APPENDIX I

June 2, 1976

Emil W. Lentchner, Chairman
Council on Dental Care Programs
American Dental Association

Dear Dr. Lentchner,

The decision of the Executive Committee of the Texas Dental Association not to participate in the Council on Dental Care Program's telephone survey was arrived at after careful consideration of all the information available to us at that time.

To undertake this study of the prepayment experience of dental practices in states with diverse policies your Council elected to cover only "three basic areas", radiographs, dental consultants and assignments of benefits by a "random sampling" of 25% of the Texas dentists.

The Texas Dental Association went to considerable expense to survey all of our nearly 4,700 members. An unprecedented number of replies (59%) were received and tabulated. The TDA twenty-two part questionnaire covered the same three basic concerns on dentist relations with third parties in even greater detail. The dentists responding to the TDA survey were not subjected to any elements of bias. The survey stated "This questionnaire is 'anonymous' and you are not required to identify yourself." Certainly we must agree that a secret ballot is a more accurate expression of the grass-roots members feelings than a telephone interview where the members' identity is known to the caller.

We offered you the results of our survey, not in fear, but because we believed it to be the more accurate and valid of the two.

Another important assignment of the 1975 House directed your Council to reexamine the relationship of the ADA and Delta in responding to the needs, interests and wishes of the profession. Is this to be conducted in a like manner by telephone survey and with non-Delta states such as Texas and Indiana as controls?

If philosophies are to be compared objectively, they must be examined under the same light and by the same rules.

The TDA Executive Committee will meet at 4920 N. Interregional in Austin, Texas, Saturday June 12th at 9:00 A.M. If we are misinformed and/or incorrect in our conclusion, we welcome further communications in writing or in person on this project. At this meeting we can reconsider the question.

R. T. Maberry, President
Texas Dental Association

June 21, 1976

Dr. Robert T. Maberry
President
Texas Dental Association

Dear Bob:

I regret that your June 2 letter to Dr. Lentchner, Chairman of the Council on Dental Care Programs, arrived here too late for response to your June 12 meeting.

Emil is presently out of the country and this is necessarily a provisional response. I'm sure, though, that the Council imputes no untoward motives in the rejection by TDA of its request to carry out part of its "diverse policies" survey in Texas. It regretted the rejection because it makes it impossible for the Council to be as fully responsive to the House as it wishes always to be.

The TDA survey is a most useful one and the Council does not suggest otherwise. It doesn't, however, meet the need for a comparative study taken during the same time period among an identically selected sample based on identical questions. This is what the Council was attempting because of the thrust of the House resolution.

Perhaps there is a common meeting ground and the survey itself may be salvageable even though

it would necessarily be postponed. If you think it appropriate, Dr. Lewis and Dr. Clitheroe might be empowered to discuss it when they meet with the Council on June 29-30.

Hope all is going well with you in your Presidency.

Eric M. Bishop
Assistant Executive Director
Dental Health

August 3, 1976

Dr. Robert M. Stetzel, President
Indiana Dental Association

Dear Doctor Stetzel:

During the recent meeting of the Council on Dental Care Programs on June 30-July 1, members of the Council reviewed all correspondence regarding the diverse policy study. After considerable discussion the unanimous opinion was that every effort should be made to conduct the proposed survey, even though the results would not be available to the 1976 House of Delegates.

As a result, the Council has instructed me to contact your Association and request that its Executive Committee reconsider their decision not to participate in our study.

I look forward to hearing from you after your Executive Committee has had a chance to reevaluate the proposed survey and my letter to you of May 25, 1976. Both communications are enclosed for your convenience.

Emil W. Lentchner, Chairman
Council on Dental Care Programs

August 3, 1976

Dr. Robert T. Maberry
President
Texas Dental Association

Dear Doctor Maberry:

During the recent meeting of the Council on Dental Care Programs on June 30-July 1, members of the Council reviewed all correspondence regarding the diverse policy study. After considerable discussion the unanimous opinion was that every effort should be made to conduct the proposed survey, even though the results would not be available to the 1976 House of Delegates.

As a result, the Council has instructed me to contact your Association and request that its Executive Committee reconsider their decision not to participate in our study.

I look forward to hearing from you after your Executive Committee has had a chance to reevaluate the proposed survey and my letter to Dr. Joe C. Carrington, Jr. of May 24, 1976. Both communications are enclosed for your convenience.

Emil W. Lentchner, Chairman
Council on Dental Care Programs

August 19, 1976

Dr. Emil W. Lentchner, Chairman
Council on Dental Care Programs
American Dental Association

Dear Dr. Lentchner:

On May 7 I wrote you the decision of the I.D.A. Board of Trustees relative to the proposed diverse policy study. In that letter we made some constructive criticism of the study. We proposed certain changes that we believe will improve the study and better fulfill the intent of the House of Delegates. We asked the A.D.A. Council on Dental Care Programs to make these changes.

According to your latest letter on the subject (August 3, 1976), the Council on Dental Care Programs is unwilling to make any changes in the study. In that event, I am sure the I.D.A. Board of

Trustees would be as unwilling to change its position. Our Board will be meeting on October 1. If you have further information on the subject, please let me hear from you and I will bring this to the Board's attention for possible reconsideration of the subject. However, without the changes being made that were suggested last May, I am reluctant to ask our Board to reconsider their position on the matter.

Robert M. Stetzel, President

August 31, 1976

Dr. Emil W. Lentchner, Chairman
Council on Dental Care Programs

Dear Doctor Lentchner:

The Texas Dental Association believes that the study directed by the 1975 House of Delegates on the "payment experience of dental practices in states with diverse policies" should be of great value to the profession. It was in response to this resolution that we conducted the survey of our membership. Certainly "direct communication" with the dental practitioners as proposed by the Council's telephone survey can be a valuable (although costly to both ADA and dentist) part of the study. We offered our survey to the Council initially in lieu of participation in the ADA survey for several reasons. First, it was our sincere belief that the TDA anonymous questionnaire with its unprecedented number of replies (59%) offered a more accurate expression of the "individual practitioners" feelings. It also contains data on the TDA policies that are unique. The third consideration was economics.

A study, to be thorough, must include areas in which the subjects studied are diverse and/or unique. Policies unique to TDA in relation to dental prepayment are not covered in the ADA survey, thereby not giving the membership an opportunity to express their acceptance or rejection of such TDA policies.

The TDA policy on radiographs is more complicated than a "Do you ever submit radiographs to carriers?" question can answer. The study, to adequately reveal TDA policy, should show that third parties are given pretreatment plans including fees and narrative descriptions of all preexisting conditions that might require radiographs for predetermination of benefits by some carriers. Further, this narrative describing the radiographs themselves correlated with the present oral condition provides much more information than is otherwise discernible in the radiographs alone. A special addendum form for this purpose has been approved and sent to the membership. A signed statement by the dentist makes him more accountable for his diagnosis than the submission of a film. The medical profession is not required to submit radiographs, only signed reports of their findings.

TDA policy does permit submission of radiographs to carriers in the dentist's office or through component society approved designated consultants. Designated consultants are a TDA innovation that is working and should be included in the study.

TDA policy on assignments is "to encourage its members not to accept third party assignments whenever possible." Therefore the question "do you accept assignments" does not prove the members acceptance or rejection of state policy.

The study should also include the experiences of the carriers dealing with those diverse methods. In Texas the Individual Responsibility Council (Council on Dental Care) has and is negotiating with individual carriers and union representatives. The results of these meetings as viewed by carriers, dentists, and unions should be included.

The study should determine if the diverse policies promote the success of dental pre-payment plans, if it offers the patient a choice of treatment, if it discourages fraud against the carriers, and if it offers an effective method of cost control for the companies.

The prepayment policies of the TDA are not "chiseled in stone" and will be responsive to the interests of the patients, the profession, and the carriers.

Please let us know if the Council agrees that the study could be expanded beyond the 18-part telephone survey and in what areas.

I submit to you that the statement in the August 30, 1976 *Leadership Bulletin* "analysis of dental practices in states with diverse prepayment policies has been delayed because of difficulty in obtaining questionnaire approval from several constituent dental societies" is not completely true. Much of the blame may be shared by your Council. The Council delayed until April 27, 1976 requesting approval of the questionnaire and then with little explanation. The tabulated results of our TDA

survey were mailed to you promptly May 6, 1976. We did not know until your letter of May 27, 1976 that our survey had been rejected. My letter of June 2, 1976 raised several points about our position, and asked for guidance so that "we could reconsider the question." The letter further stated, "If we are misinformed and/or incorrect in our conclusion, we welcome further communications in writing or in person on this project." A "provisional response" was received from Mr. Eric Bishop dated June 21, 1976 but it shed no new light on either position. I received no answer from you until August 3, 1976, two months after my letter was written. None of the points raised by our Executive Committee as stated in my letter to you were answered, in fact you did not even acknowledge receipt of the letter. Nevertheless, we met three weeks after receipt of your second request and decided to participate in the survey.

On August 22, 1976 the TDA Board of Directors agreed that the ADA telephone survey could be a useful adjunct to the study as directed by ADA House. Because our survey was anonymous we cannot offer your Council the names of the participants. However, because the names of the TDA members (25%) to be contacted will be known, we believe that it would help the TDA in determining future prepayment policy to know, within a reasonable time, their names and office locations. The following resolution was passed; *Resolved,* that a letter be sent to the ADA authorizing a telephone survey of Texas dentists by the ADA Council on Dental Care, provided that a list of those surveyed be released to the TDA for the purpose of an IRC survey of the same members.

Robert T. Maberry, President

September 16, 1976

Dr. Robert M. Stetzel
President
Indiana Dental Association

Dear Doctor Stetzel:

This is in response to your letter of August 19. The Council had an opportunity to review and discuss it at its September 12-13 meeting.

Please let me assure you again that the Council carefully considered the Indiana Dental Association's suggestions for revision of the study at its June 30-July 1 meeting. Indeed, the same considerations were among the many addressed by the committee of the Council assigned to this project as well as by the Council as a whole.

Unquestionably, there is not just one way to respond to the House directive to study the prepayment experience of dental practices in states with diverse policies.

In approving the study design at its April 1976 meeting, the Council took note of the natural constraints of dentists' time, budget and common issues shared by the survey population. It also considered other House-directed activities being carried out this year and touching nearly all the issues you have raised, e.g., Delta relations, fee reimbursement differences. The present design of the questionnaire seems to the Council to be a wholly appropriate mechanism to fulfill the Council's responsibility to the House of Delegates as to the diverse policies study.

The Council arrived at the present study design with the assistance of professional staff members of the Association's Bureau of Economic Research and Statistics. As you know, from IDA's close cooperation in other activities of the Bureau, its success in carrying out appropriately designed surveys of the dental profession is nationally recognized and a great many state dental societies, other dental groups and non-dental agencies rely on the Bureau's expertise.

If, as the Council wishes, the survey is accomplished and the study completed, the full profession will have the resultant summary statistical information from the subsequent report to the House. As you know, the purpose of the study is not to vindicate existing policy of this or any other association. Neither is it our purpose to attack, directly or indirectly, any policy. What we wish to obtain is factual information concerning the personal attitudes and behavior of individual dentists, chosen through appropriate random sampling techniques and on the basis of confidentiality. We believe this information would be useful to you, to us and to all dentists.

As it is required to do, the Council will report to the 1976 House of Delegates on its activities in pursuit of this directive. We are anxious to carry out the survey and to do so with your positive support. I would be glad to continue to work toward that goal with you.

Emil W. Lentchner, Chairman
Council on Dental Care Programs

September 16, 1976

Dr. Robert T. Maberry
President
Texas Dental Association

Dear Doctor Maberry:

Thank you for your letter of August 31 regarding the Council's approach to the House of Delegates directive to study prepayment experience of dental practices in states with diverse policies.

In pursuing this study, the Council has attempted to stay in touch with the four states involved at each step of the process, including sharing the questionnaire and receiving explicit concurrence with respect to pretest of it.

In the case of the Texas Dental Association, the Council was pleased to have an additional opportunity, when Drs. Lewis and Clitheroe met with the Council during its June 30-July 1 meeting, to discuss the question informally, though we fully understand that this specific issue was not the reason TDA appointed Drs. Lewis and Clitheroe to meet with the Council. The Council would, of course, regret any lapse in communication that may have given rise to misunderstanding.

With respect to the survey design itself, I am sure that TDA and the Council can readily agree that there is more than one way to approach most questions, including this one. I would think we could also agree that there is no such entity as a single survey that will literally tell us everything—within rational boundaries of budget, time and dentists' participation—about attitudes and behaviors of individual dentists with respect to the questions posed.

There were extensive discussions held both by a Council committee and the Council itself in the process of achieving a design that would fulfill the wish of the House as the Council understands it. These deliberations included advice from the appropriate personnel of the Association's Bureau of Economic Research and Statistics. That Bureau is nationally recognized by dental and other health organizations and by private and public agencies as being an expert source of advice on the methodologies best suited to survey purposes, especially with respect to dentists' attitudes and actions and dental activities generally. We believe that the present survey instrument can accomplish the intended purposes. Because of the extensive work already done, the approval by the Council and concurrence of two of the four states, we are most reluctant to redesign it.

The Council feels an obligation to the House of Delegates, and the profession at large, to discharge the duty given it. Our purpose is not to vindicate existing policy of this or any other association. Neither is it our purpose to attack, directly or indirectly, any such policy. What the Council wishes to obtain is factual information concerning the personal attitudes and behavior of individual dentists, chosen through appropriate random sampling techniques and on the basis of confidentiality. The summary statistical information received would, of course, be shared through the House with the full profession. We believe the information elicited will prove most helpful.

At its September 12-13, 1976 meeting, the Council reviewed your August 31 letter indicating provisional agreement with respect to the survey. The proviso, that the Association report to you the names and addresses of the dentists surveyed, poses insuperable problems. The Association's Bureau of Economic Research and Statistics annually carries out an extensive program involving surveys. Most of these are initiated at the direct request of the House of Delegates. The Bureau has achieved substantial success in having members of the profession cooperate in these activities. This has come about in large part because of the perception of dentists that the Bureau's assurance of confidentiality, when extended to the dentist, is strictly honored. Given this background, I'm sure you would agree that the TDA-ADA members deserve to feel that this sense of trust and confidentiality will always be strictly honored. The Council, then, could not accept the proviso that names and addresses be reported to you; nor, I might add, will the Bureau give them to the Council.

As it is required to do, the Council will report to the 1976 House on its activities in pursuit of this directive. We are most anxious to carry out the survey and to do so with your positive support. I would be glad to continue to work toward that goal with you.

Emil W. Lentchner, Chairman
Council on Dental Care Programs

Council on Dental Education

Commission on Accreditation of Dental and Dental Auxiliary Educational Programs

*Chompagne, John R., Michigan, 1976, chairman
American Association of Dental Examiners

*Furstman, Edward F., California, 1978, vice-chairman
American Dental Association

Beier, David W., Jr., Michigan, 1977
Public Member

*Breeland, Wade H., North Carolina, 1977
American Association of Dental Examiners

*Brown, William E., Oklahoma, 1976
American Association of Dental Schools

*Farrell, Frank A., Illinois, 1977
American Dental Association

*Fortenberry, Marshall M., Mississippi, 1976
American Dental Association

Hord, Louise W., Alabama, 1977
American Dental Hygienists' Association

*Howell, Charles L., Ohio, 1978
American Association of Dental Schools

*Kentros, George A., Massachusetts, 1978
American Association of Dental Examiners

Koontz, Elizabeth D., North Carolina, 1977
Public Member

Laskin, Daniel M., Illinois, 1976
American Society of Oral Surgeons

Lynch, Denis P., California, 1977
Student Member

Lytle, Robert, Washington, D.C., 1977
Federation of Prosthodontic Organizations

*McCallum, Charles A., Jr., Alabama, 1976
American Association of Dental Schools

*Nienaber, William B., Minnesota, 1976
American Dental Association

*Redig, Dale F., California, 1977
American Association of Dental Schools

Rothstein, Ralph B., Maryland, 1976
Dental Laboratory Technology

Tuchner, Helen M., Minnesota, 1978
American Dental Assistants Association

*Wolfsehr, Gerald R., Oregon, 1976
American Association of Dental Examiners

Coody, John M., treasurer

Ginley, Thomas J., secretary

Ryan, Margaret M., assistant secretary

Santangelo, Mario V., assistant secretary

Swanson, Rolland K., assistant secretary

*Membership of Council on Dental Education

Meetings: The Council met in the Headquarters Building, Chicago, on December 5, 1975 and May 7, 1976. The Commission met in the Headquarters Building on December 4, 1975 and May 6, 1976. Review and advisory committees which provide the Council with recommendations on policy matters and the Commission with recommendations on accreditation matters, met immediately prior to regularly scheduled meetings of the Council and the Commission.

Personnel: The Council and the Commission acknowledge with appreciation the many contributions made by Dr. John R. Champagne, Dr. Charles A. McCallum, Jr., and Dr. Daniel M. Laskin, retiring members, and by Dr. George A. Kentros who is resigning to accept a teaching position at the University of Alabama. Further, they wish to express their sincere gratitude to Dr. Jack Pfister, Board of Trustees' representative, for his active participation in all Council and Commission meetings and for providing excellent liaison between the Board and these two agencies. The Council and Commission would also like to acknowlegde with appreciation the many contributions made by resigning Commissioners Mr. David W. Beier, Jr., Miss Elizabeth D. Koontz, and Mr. Ralph B. Rothstein. Resignations were tendered by the Commissioners due to outside commitments which would not enable them to participate fully in Commission activities.

The Council and Commission wish to report the appointment of Ms. Carolyn Steinwald, coordinator, Hospital Dental Service and Advanced Dental Education.

COMMISSION ON ACCREDITATION OF DENTAL AND DENTAL AUXILIARY EDUCATIONAL PROGRAMS

The Commission on Accreditation, since its establishment in 1975, serves as the recognized accrediting agency for the dental profession. No interruption in the accreditation program was evidenced with the transfer of accreditation activities from the Council on Dental Education to the Commission. The same procedures followed by the Council in conducting the accreditation program are being used by the Commission.

In keeping with the practice of a periodic self-review, representatives of the Council and the Commission as well as others having expertise in accreditation procedures will meet in the summer to determine whether present procedures can be modified or new procedures developed which will further enhance the accreditation process. Such procedures will be considered in terms of available staff resources and the administration of a qualitative accreditation program without substantial increase in cost to the Association.

Also, it should be noted that the regularly scheduled reviews of the Commission on Accreditation by the US Office of Education and the Council on Postsecondary Accreditation will take place in early 1977. Continuing recognition of the Commission as an accrediting agency will be based upon its compliance with the criteria of these two agencies.

Revision of Educational Requirements: Although the Commission on Accreditation has authority for developing and approving educational requirements, it is the intent of the Commission to seek appropriate consultation from the ADA House of Delegates and other involved agencies prior to adopting such revisions.

A revision of educational standards in two areas has been considered by the Commission during the past year. In December, the *Requirements for Advanced Specialty Education Programs,* approved by the House in 1974 (*Trans.* 1974:664), was amended by the Commission by the deletion of one sentence in the section relating to "Program Administrator." The sentence reads: "Parent organizations of the recognized special areas of dental practice may petition the Commission to make mandatory that the program director be board certified."

Since 1974, the Council and the Commission have considered several petitions from various specialty organizations requesting that board certification be mandatory as a condition for program accreditation. In each case the request has been denied. These denials were based upon the belief that board certification of program directors is desirable and should be encouraged; however, mechanisms other than accreditation should be used to stimulate interest in, and support of, the concept of board certification. The Commission's accreditation philosophy is based on determining the total quality of teaching programs rather than establishing single controlling standards.

In May 1976, the Commission considered a change in the section of *Requirements and Guidelines for an Accredited Dental Assisting Education Program* which relates to accreditation criteria for correspondence/in-residence dental assisting programs.

Since 1969, dental assisting programs with curricula which utilize courses from an accredited correspondence program in addition to instructional resources of the parent institution have been recognized as one method of providing access to educational programs for employed dental assistants. Educational institutions with an accredited day program may offer an evening program with the combined curriculum. To assure that combined correspondence/in-residence programs would meet accepted educational standards and students' needs, the *Requirements* include specific criteria for such programs (*Trans.* 1973:75). Those criteria were developed to prevent any adverse effect which an additional program might have on the regular dental assisting program offered by the institution.

When the current educational standards were developed and approved in 1973, it was stipulated that the regular day program have the accreditation status of "approval" before a combined evening correspondence/in-residence program would be considered for accreditation. The Commission has revaluated this criterion in relation to its policy that each educational program will be considered as an entity and on the basis of the extent to which it meets accreditation standards for the particular type of program.

In view of this policy the Commission believes it is no longer necessary or appropriate to stipulate that the regular day program offered by the educational institution have "approval" accreditation status before the correspondence/in-residence program can be accredited. Therefore, the Commission adopted a resolution to revise the section of the *Requirements and Guidelines for an Accredited Dental Assisting Education Program* which relates to correspondence/in-residence programs by removing the stipulation that the day program offered by the educational institution must have "approval" status. Thus, educational institutions with day dental assisting programs with "conditional approval" or "provisional approval" status could offer an accredited correspondence/in-residence evening program providing the latter does not jeopardize the day program.

If the House has any objections to the revisions identified for the educational standards, they will be considered by the Commission.

Accreditation: Accreditation actions of the Commission from June 1975 through May 1976 are summarized in Table 1. The actions indicated were taken on the basis of (1) site evaluation reports or (2) progress reports submitted by educational institutions detailing the degree to which specific recommendations included in previous evaluation reports have been implemented. The total number of accreditation actions taken during 1975-76 was 591. As indicated in Table 2, the total number of currently accredited educational programs is 1,305, representing an increase of 57 programs. Tables 1 and 2 identify all actions taken by the Commission at its December 1975 and May 1976 meetings. It should be pointed out that under the current Commission *Bylaws*, when the Commission anticipates denial or withdrawal of an accreditation classification it must inform the institution of its right to appeal the proposed action. Consequently, in such cases, the Commission will delay in finalizing the action taken on these programs.

Enrollment: Enrollment in accredited dental and related education programs during the 1975-76 academic year and the number of 1975 graduates are indicated in Table 3. The number of students enrolled in predoctoral education programs increased 3.1 percent from the previous year. Dental auxiliary program enrollment also increased 3.1 percent. While there was a decrease, 1.6 percent, in specialty program enrollment, there was an increase, 5.2 percent, in general practice residency program enrollment. Currently, 45,956 students are enrolled in dental or related programs in the United States. This represents an increase of 2.8 percent over the 1974-75 academic year.

Table 1

Accreditation Actions
June 1975-May 1976

Accreditation Classifications	Dental	Dental Assisting	Dental Hygiene	Dental Laboratory Technology	Specialties	General Practice Residencies	TOTAL
Accreditation Eligible	1	—	13	—	—	—	14
Preliminary Provisional Approval	—	20	—	8	15*	18	61
Preliminary Approval	2	—	—	—	—	—	2
Approval	20	52	39	11	78	40	240
Conditional Approval	5	43	27	7	29	17	128
Provisional Approval	3	20	9	3	19	12	66
Accreditation Denied or Withheld	—	24	1	7	8	2	42
Discontinued Programs	—	6	—	—	28	4	38
Number of Accreditation Actions	31	165	89	36	177*	93	591

*Includes four combined programs.

Table 2

Number of Accredited Programs
May 1976

Accreditation Classifications	Dental	Dental Assisting	Dental Hygiene	Dental Laboratory Technology	Specialties	General Practice Residencies	TOTAL
Accreditation Eligible	1	—	20	—	—	—	21
Preliminary Provisional Approval	—	23	—	9	55*	28	115
Preliminary Approval	2	—	—	—	—	—	2
Approval	47	189	128	28	392	202	986
Conditional Approval	6	37	26	8	27	14	118
Provisional Approval	3	24	9	3	13	11	63
Number of Programs	59	273	183	48	487*	255	1,305

*Includes four combined programs.

Table 3

Enrollment in Dental and Dentally Related Education Programs
October 1975

	Dental	Dental Assisting	Dental Hygiene	Dental Laboratory Technology	Specialties	General Practice Residency	TOTAL
First-year Enrollment	5,763	8,119	5,335	1,345	1,227	694	22,483
Percent Change	+2.6%	+3.3%	+4.2%	+12.4%	−4.3%	+5.2%	+3.5%
Total Enrollment	20,767	9,306	10,084	2,234	2,815	750	45,956
Percent Change	+3.1%	+3.1%	+3.2%	+2.7%	−1.6%	+5.2%	+2.8%
Number of Graduates	4,969	5,972	4,568	836	1,245	641	18,231
Percent Change	+10.1%	+5.1%	+6.0%	−0.3%	−2.6%	+8.6%	+5.9%

COUNCIL ON DENTAL EDUCATION

Dental Education

Curriculum Study: In 1974, the ADA House of Delegates adopted a resolution directing the Council on Dental Education to conduct a comprehensive study of curriculums of all accredited dental educational programs in the United States (*Trans.* 1974:675). The House directive stipulated further that in the study the Council focus particular attention on whether dental students are provided with adequate instruction and receive appropriate clinical experiences to render "comprehensive patient care" to the public after graduation. In compliance with the House request, in 1975 the Council provided an interim report on the progress made in implementing the study (*Trans.* 1975:51).

The Council, in supporting the project, had recognized for some time the need for conducting an in-depth review of dental curriculums. It recognizes also that such a study is essential if the Council is to be responsive (1) for meeting future educational, professional, and societal responsibilities; (2) for providing direction to the educational process for educating students in the competencies and concepts required to practice general dentistry; and (3) to increase access of the public to comprehensive oral health care.

In initiating the project, the Council recognized that a Coordinating Committee should be selected to provide advice and counsel to the Project Director and staff on such matters as general policy, planning, operations and reporting of findings, conclusions, and recommendations emanating from the study. Further, the Council was of the opinion that this Committee should also serve to coordinate the activities of the subject matter advisory panels. The Coordinating Committee is an 11-member group comprised of six practitioners, three of whom are dental examiners, three educators, one dental student, and one higher education administrator.

The Council, in developing the format for the project, was cognizant of the fact that a complete study of all components of the dental curriculum would require the Coordinating Committee to rely upon the expertise of faculty in each major teaching discipline to assist in developing the questionnaires relating to subject matter and content. For this reason, four advisory panels, basic sciences, clinical sciences, behavioral and social sciences, and students, were identified to assist in the development of the survey instruments and to develop the framework for the study. The advisory panels will also assist the Coordinating Committee in reviewing and interpreting the

data collected relative to each specific discipline. The advisory panels consist of six basic science members, nine clinical science members, and five behavioral and social science members. Four students, one of whom is a member of the Coordinating Committee, provided advice and counsel in the development of the student questionnaire. It should be pointed out that individuals from 20 dental schools have participated in the study as members of the Coordinating Committee or advisory panels.

The study is being conducted with complete cooperation from and with the full support of the American Association of Dental Schools and its member institutions. That Association has and continues to provide valuable input into all deliberations and has assisted the Council in developing the parameters of the study.

At the December 1974 Council meeting, general plans were outlined to implement the curriculum study. Early in this planning, the Council determined and the Board concurred that the study, because of its comprehensive nature, should be conducted in three phases. Phase I consisted of the appointment of a 12-member planning committee whose sole responsibility was to develop the design, to provide general direction, and to identify the scope of the study and, in turn, to develop a protocol for the study which could be transmitted to outside agencies for funding.

The responsibilities of the planning committee terminated with the development of an initial draft of the protocol which was approved in principle by the Council in May 1975. Basically, the document outlined the historical events leading to the study, the need for the study, the objectives, the methodology, the schedules, and the budget.

Phase II of the study consisted of the development, the conduct and analysis of an opinion survey of recent graduates. Specifically, the survey had as one of its chief purposes the identification of specific factors which may relate to reasons for recent graduates pursuing the various career options within the profession. The Council was of the opinion that if these motivating factors could be identified through data analysis, specific recommendations might emanate as a result of the broader curriculum study which would encourage dental graduates to pursue careers in the general practice of dentistry. The survey was distributed to dental school graduates of the years 1971, 1974, 1975, and to all dentists currently enrolled in accredited postdoctoral specialty and general practice residency programs. The findings of that study were reported in the May 1976 issue of *The Journal of the American Dental Association* (*JADA* 92:875-879).

Phase III consists of the actual conduct of the curriculum study. Specifically, the study is designed to obtain comprehensive data of dental curriculums as they exist in April-May 1976. The American College Testing Program of Iowa City has been contracted to provide the technical assistance and services in the development of the survey instruments from the content material provided by the advisory panels. This agency will also collect and analyze the data. ACT personnel have attended all meetings of the Coordinating Committee and subject matter advisory panels.

The survey questionnaires, which have been completed, consist of six separate instruments designed to document the current status of curriculums and curricular practices in United States dental schools. The survey instruments include the 150-page basic science document, 258-page clinical science questionnaire, 100-page behavioral and social science questionnaire, 51-page comprehensive patient care document, 12-page institutional questionnaire, and an 18-page student questionnaire. The comprehensive survey instruments will be used to collect quantitative and qualitative data and have been designed to (1) determine the institutional goals and objectives, structure, organization, and scope of the curricular material in the basic sciences, the clini-

cal sciences, and the behavioral and social sciences; (2) determine the extent to which students are given experiences in providing comprehensive patient care and to project the effect of such programs in preparing graduates to conduct a general practice; and (3) identify the methods by which institutions evaluate student performance.

The institutional document is designed to gather general factual information about the dental school's policies on such matters as program flexibility, promotion and graduation policies, and budget procedures. The Student Questionnaire was developed to serve as one mechanism for validating the information provided by the educational institutions.

In its effort to be responsive to the request of the House that an assessment be made to determine if students are being provided with experience in the concept of "comprehensive patient care," the clinical sciences document and comprehensive patient care document will provide, among other data, such detailed information as the number of clock hours of instruction in each clinical discipline, including subareas; the methods used for providing such instruction; the sequencing of the instruction; the methods used in evaluating instruction in the clinical sciences; information on instruction in special topics in the clinical sciences; the identification of changes in instructional emphasis on the clinical sciences during the past decade; clinical requirements in each clinical discipline; the availability of clinical support personnel; the effective teaching effort of each clinical faculty; methods used to evaluate the clinical sciences faculty; and the objectives, instruction, and evaluation of students' extramural or externship programs. Further, the comprehensive patient care questionnaire will obtain information about the average number of patients treated and completed by students before graduation; the number of patients by age groups; and the number of treatment procedures in each clinical discipline, including subareas.

The work of the Coordinating Committee and advisory panels began in the fall of 1975. Between September 1975 and January 1976, each of the six survey instruments underwent three complete revisions. The essentially completed instruments, during February 1976, were field tested at four dental schools. The schools selected to participate in the field tests included the University of Florida, The University of North Carolina, University of the Pacific, and The University of Texas Health Sciences at Houston Dental Branch. These institutions were selected because of different characteristics in their teaching programs. The purpose of the field test was two-fold: (1) to check for omissions and ambiguities in the documents, and (2) to determine whether difficulties were encountered in completing the instruments and how the instruments could be changed to minimize problems in their completion.

The faculty input from each school was impressive and it was obvious that considerable effort and time were devoted to completing the task. It was obvious that the field tests were an important component in the process of further refining the documents. As a result of the input from these four field test schools, each document was further revised by ACT into final instruments.

Early in April 1976, orientation conferences were held for the purpose of familiarizing the individual identified to serve as the dental school's coordinator with the contents of the documents and to provide the coordinators with specific details relative to carrying out the study at their schools. Each dental school has cooperated fully with the study and each school sent at least one representative to the conference. The conferences were convened in Atlanta, Chicago, New York City, and San Francisco. In addition to the schools' representatives, the Council invited the constituent soci-

eties in the host states to participate in the conferences. The Council was pleased that the States of California, Illinois, and New York did have representation at the conferences.

Subsequent to the conference, each school was provided with an adequate supply of the instruments. The collection of data at the schools was scheduled for April and May 1976. Because of the comprehensive nature of the study, considerable time was needed to collect the data. Accuracy and thoroughness are critical if the data are to be meaningful. Each school has been instructed that all completed instruments are to be returned to ACT by June 1, 1976.

During June through August of 1976, ACT will tabulate and analyze the data. Among the variables which will be used in analyzing the data are whether the dental school is private or public, the total predoctoral enrollment of the dental school, the ratio of full-time to part-time faculty, whether the school has a three or four-year program, the total number of hours in the curriculum, and whether the dental school has administrative control of the basic science departments.

When the analyses are completed, the advisory panels and the Coordinating Committee will review data and develop a preliminary report with recommendations. It is expected that the preliminary report will be completed in late 1976. The recommendations will then be reviewed and critiqued by a panel from higher education, but not dental educators. The preliminary recommendations and critique will also serve as the basis for a National Curriculum Conference. The National Curriculum Conference will be convened in Chicago in March 1977. It is anticipated the attendance will approximate 250 participants; each constituent society, state licensing board and dental school will be invited to participate. Funding for support of the National Curriculum Conference is being sought from the Division of Dentistry of the United States Department of Health, Education, and Welfare.

Development of Instructional Guidelines: Through the years, the Council has acknowledged and accepted its responsibility in enhancing the quality of and in providing guidance to dental education. Implicit in its responsibility to the profession is the need to assess, on a periodic basis, specific subject areas which are, in the Council's judgment, identified as deficiencies in the educational process.

The Council, on a number of occasions in the past, has considered the issue relating to the appropriateness of developing instructional guidelines in specific subject areas. In 1971, the Council developed and approved *Guidelines for Teaching the Comprehensive Control of Pain and Anxiety in Dentistry*. The impact of this document in improving instruction in this subject matter area at the predoctoral and postdoctoral levels has in the Council's view been significant.

To allow for curricular flexibility, it should be pointed out that the Council has consistently been opposed to the development of educational standards or requirements which would dictate specific curriculum content. On the other hand, the Council believes that it has an obligation to students, to the profession and to society to ensure that graduating dentists are competently prepared to practice all phases of clinical dentistry. In this context, the Council adopted the following policy statement relative to development and approval of subject area guidelines:

> The Council on Dental Education recognizes its responsibility to identify areas of instructional weakness in dental education. When such weaknesses are evident in a majority of educational institutions, the Council will request advice and assistance from the American Association of Dental Schools and other concerned agencies in the development of instruc-

> tional guidelines. In the absence of such advice and assistance, the Council will assume responsibility for the development of instructional guidelines in specific subject areas. Such guidelines, when endorsed by the Council, should be advisory to educational institutions and the Commission on Accreditation and will be reviewed periodically for continued need and relevancy.

Through Commission on Accreditation site visits to dental schools, the Council continues to note with concern that, on a national basis, instruction in the physical evaluation of patients and in orthodontics remains a major weakness. For this reason, the Council has developed drafts of guidelines relating to the teaching of these subject areas which will be further reviewed during the December 1976 meeting.

ADVANCED EDUCATION AND SPECIALTIES

1966 Waiver of Educational Requirements for American Board of Endodontics: Subsequent to approval of the American Board of Endodontics (*Trans.* 1964:251), the Council was requested to consider approval of waiver agreements to permit recognition by certification of an initial group of specialists in the area. Believing that the American Board of Endodontics should be permitted to initiate its activities in a manner comparable to that permitted boards previously approved, the Council in February 1965 adopted the following statement of policy (*Trans.* 1965:32):

> For a limited period of time, those candidates for certification who have devoted themselves primarily to the area of endodontics for a period of ten or more years, and who made application for examination or who were eligible to make application for examination under the *Requirements* in effect at the time of application (*Trans.* 1947:254) may, at the discretion of the Board, be accepted for examination without evidence of satisfaction of the formal educational requirements specified in the present *Requirements for National Certifying Boards for Special Areas of Dental Practice*.

Problems relating to initiation of certification activities of the American Board of Endodontics were again reviewed by the Council in May 1965 and the following policy statement was adopted (*Trans.* 1965:32):

> The Council has given serious attention to the problems relating to the creation of a new special area of dental practice in endodontics. In view of the fact that the House of Delegates, in revising the requirements for the approval of special areas of dental practice, eliminated the waiver provisions under which all specialty board programs were approved, the Council found it necessary to establish waiver provisions applicable to the special area of endodontics. When these provisions were announced, the Council had called to its attention the possibility that an inequity would ensue if the original provisions were enforced.
>
> The Council, therefore, has restated the waiver provision for the special area of endodontics to require that all candidates meeting the requirements of the American Board of Endodontics, and applying before January 1, 1967, be permitted to take the certifying examination without complying with the formal requirement of two years of formal advanced education.

In reviewing the Council's statement during the 1965 annual session, the House also considered the following resolution submitted by The Dental Society of the State of New York:

> Resolved, that in order to eliminate inequities still existing toward practitioners of endodontics who graduated from dental school during and after 1957, the requirement of two years advanced formal education should not be applied to candidates applying for certification to the American Board of Endodontics who have graduated from dental school in 1964 or prior thereto, provided such candidates meet all other requirements of the American Board of Endodontics.

The 1965 House agreed that educational waiver agreements should be terminated as soon as possible but did not wish to be unfair or arbitrary, and that under the established policies of the Council, it believed the American Board of Endodontics could function effectively even though definitive action was deferred to permit further study. For this reason, the resolution was referred to the Council for study and report at the 1966 annual session.

In 1966, the Council submitted the following statement to the House indicating agreement that there was justification for extension of the educational waiver in endodontics for a limited time but did not believe that the waiver should be extended to include graduates of 1964 and prior thereto.

> It was pointed out that such an extension would permit the American Board of Endodontics, under its present regulations, to accept candidates for examination until 1974 without the requirement of formal education. The Council recommended that there was justification for extending the waiver of educational requirements for the American Board of Endodontics until January 1, 1970. Such an extension would permit the board to accept for examination candidates who graduated in 1959 or prior thereto.

The report of the Board of Trustees (*Trans.* 1966:246) indicates that the resolution of The Dental Society of the State of New York (*Trans.* 1965:328) proposing the extension of the waiver of educational requirements for the American Board of Endodontics to include graduates of 1964 and prior thereto should be supported. The report further states, "Approval of this resolution would mean that dentists graduated in 1964 or before, the year of approval of the American Board of Endodontics by the House of Delegates, can be admitted to examination by that Board until 1974, if they have met all other requirements of the Board."

The 1966 Reference Committee reported to the House that the extension of the educational waiver in endodontics was consistent with procedures followed for other recognized national certifying boards. The resolution as submitted by The Dental Society of the State of New York in 1965 was approved. (*Trans.* 1966:346).

Until December 31, 1974, the American Board of Endodontics accepted candidates without formal training in accordance with the directive of the House.

Since the expiration of the waiver, the American Board has been asked to examine or reexamine candidates without formal training who did not apply prior to the expiration date of the waiver. Consequently, the Council was asked to interpret the 1966 resolution.

The Council agreed that the resolution as stated is open ended and in itself does not specify a cutoff date although background material as stated in the 1966 *Transactions* clearly indicates that it was the intent of the House to eliminate the waiver clause in 1974. In order to clarify the 1966 waiver agreement, the Council is presenting a resolution with this report which it believes represents the intent of the 1966 endodontic waiver agreement.

Revision of Requirements for Certifying Boards for Special Areas of Dental Practice: In

accordance with the *National Requirements for Certifying Boards for Special Areas of Dental Practice,* to achieve recognition as a special area of dental practice there must be a sponsoring organization, other than the board, responsible for the preparation of an application requesting recognition. The Council, which has bylaw authority to study and make recommendation on the recognition of special areas of dental practice, requires that the sponsoring organization of a certifying board in a recognized area of dental practice have broad representation and be recognized by the profession at large for its continuing contributions to the art and science of the specialty.

Although *Requirements* for certifying boards allude to a parent organization, it does not specifically require each board to have on a continuing basis, a sponsoring organization. Under the terms of the present *Requirements,* therefore, neither the Council, the House of Delegates, nor the parent organization has authority over a board which might arbitrarily choose not to have a sponsoring organization. Obviously, this was not the intent of either the Council or the House when the original *Requirements* were developed, but rather a technical oversight that has not been challenged. For this reason, the Council recommends that paragraph one of the *Requirements for National Certifying Boards for Special Areas of Dental Practice* which reads:

> In order to become, and remain, eligible for recognition by the American Dental Association as a national certifying board for a special area of practice, the following requirements must be fulfilled;

be revised to make the paragraph read:

> In order to become, and remain, eligible for recognition by the American Dental Association as a national certifying board for a special area of practice, *the area shall have a sponsoring or parent organization whose membership is reflective of the recognized special area of dental practice. A close working relationship shall be maintained between the parent organization and the board. Additionally,* the following requirements must be fulfilled;

A resolution incorporating this change is presented with this report.

The Council considers the following to be the sponsoring organizations of the boards:

Dental Public Health	American Association of Public Health Dentists
Endodontics	American Association of Endodontists
Oral Pathology	American Academy of Oral Pathology
Oral Surgery	American Society of Oral Surgeons
Orthodontics	American Association of Orthodontists
Pedodontics	American Academy of Pedodontics
Periodontics	American Academy of Periodontology
Prosthodontics	Federation of Prosthodontic Organizations

Definitions of Special Areas of Dental Practice: In 1973, the Board of Trustees directed the Council to review the definition and boundary of each of the recognized special areas of dentistry. In compliance with the Board directive, the Council requested each parent organization of the recognized specialties to review and submit revised definitions for its particular area of practice for consideration by the Council. These revised definitions were submitted to the Board for consideration during its August 1975 session.

The Board deferred action on this matter and directed that the Council-approved definitions be included for consideration on the agenda of the Workshop Conference

on Specialty Practice to be sponsored by the Council on Judicial Procedures, Constitution and Bylaws in 1976.

The Council noted that following an in-depth review of each definition during the Workshop Conference, only minor revisions were suggested. In each case, except in the area of endodontics, the Council is in complete accord with the suggested change. Therefore, the Council has recommended to the Board that the definition of endodontics as approved by the Council in 1975 and the remaining definitions as revised during the Workshop Conference be substituted for those approved by the Council in 1966.

Combined Specialty Education Programs: In 1975, after the 1974 House of Delegates approved a revision of Section 18 of the *Principles of Ethics* permitting the announcement of limitation of practice in more than one area (*Trans.* 1974:693), the Council informed the House that it had endorsed the concept of combined three-year specialty education programs for the training of dentists in two recognized specialty areas.

Since that time, four three-year combined programs have been granted the accreditation classification of "preliminary provisional approval" based upon the findings of evaluation site visits. The combined programs include the areas of endodontics-periodontics, orthodontics-pedodontics, and orthodontics-periodontics.

Although a moratorium was imposed on announcement in more than one specialty by the 1975 House (*Trans.* 1975:726), the Commission on Accreditation has no choice but to review combined programs being submitted for accreditation purposes. Such reviews and the resulting accreditation status are made exclusively on the basis of program quality.

Uniform Acceptance Date for Advanced Education Programs: Since 1968, the Council has had policy which encouraged program directors of advanced dental specialty programs to use January 15 as the date for distribution of acceptance letters and suggested that candidates accept or refuse the appointment not later than January 25. The policy has been unenforceable and has been disregarded by many program directors; thus, causing a loss of candidates for those directors who have complied with this recommended procedure. Therefore, at its May 1976 meeting, the Council rescinded the 1968 policy.

Transfer of Sponsorship of the American Board of Dental Public Health: In November 1975, the American Association of Public Health Dentists agreed to accept the sole responsibility as sponsor of the American Board of Dental Public Health and notified the Council of the proposed change from dual sponsorship by the American Public Health Association and the American Association of Public Health Dentists. The Council agreed that single sponsorship of the Board should improve the administrative liaison between the sponsoring organization, the board, and the Council and adopted a resolution authorizing this change.

Continuing Education Approval Program: In 1975, the House considered a resolution submitted by the Washington State Dental Association proposing the establishment of a national continuing education evaluation program and a mechanism for determining if continuing education programs are structured and functioning in conformity with the ADA *Guidelines for Continuing Dental Education* (*Trans.* 1975:707). The

resolution also stipulated that the evaluation program should be offered to states on a voluntary basis and should be conducted by the Association on a cost-sharing basis with those constituent societies and state boards of dental examiners which require continuing education of their members or licensure. The House referred this resolution to the Council for study and report in 1976.

For at least a decade, the Council has considered and made decisions on what it believes its appropriate role and responsibilities are in the area of continuing education at the national level. The Council has been steadfast in its position that no attempt should be made by the Association to validate the learning experiences of individual dentists or to structure a continuing education accreditation program. On the other hand, the Council has developed the ADA Continuing Education Registry which provides a service to the membership of participating states by recording the dentist's participation in a given course or other continuing education experience. The Association's computer, records, stores, and retrieves appropriate information on the individual dentist's participation in continuing education experiences for reporting to him and to his constituent society or state board. In addition, the Council developed, and the 1974 House approved, *Guidelines for Continuing Dental Education.* This document was structured to provide guidance to constituent societies and other organizations in developing and evaluating continuing education programs. Specifically, the *Guidelines* urge constituent societies to establish committees to evaluate continuing education sponsors within their respective geographic jurisdictions. Finally, the Council in cooperation with the staff of *The Journal of the American Dental Association,* biannually publishes a listing of continuing education courses offered by constituent and component societies, dental schools, and other dental related institutions.

The Council is keenly aware of the fact that in recent years continuing dental education has received increased attention from the profession. Presently, continuing education is required in seven states for licensure renewal and in eight states for dental society membership. Voluntary continuing education programs have been established by 16 state dental societies. Thus, it appears evident that individual state dental societies and boards have accelerated the trend toward promoting continuing education and in turn this acceleration has led to a dramatic growth in the number of course offerings available from a wide variety of sponsoring agencies.

It should also be pointed out that each state having a mandatory or voluntary continuing education program has established, to some degree, its own criteria and procedures for evaluation and/or recognition of continuing education courses or sponsors. Little or no uniformity in the evaluation process exists among states or organizations. For this reason there is some resulting confusion and duplication of effort for continuing education sponsors and participants alike.

Although the Council has attempted to be responsive to the profession in providing programs oriented to continuing education which are of assistance to the membership, it continues to receive requests from individuals and agencies urging the Association to undertake a continuing education evaluation program. For example, the 1975 House of Delegates of the American Association of Dental Schools adopted a resolution urging the Council to establish nationwide uniform criteria for evaluation and recognition of continuing education programs. Similar requests were also received from the Eastern Conference of Dental Continuing Education and from the 1975 National Conference on Dental Continuing Education.

In order to assess these requests and in its attempt to be responsive to the House directive, the Council appointed an ad hoc committee to determine the feasibility of

establishing a national continuing education evaluation program. The eight-member committee consisted of general and specialty practitioners, dental educators, dental examiners, and dental auxiliaries. These individuals were selected on the basis of their expertise in continuing education and were representatives of divergent geographic areas.

During its deliberations, the committee considered the results of a Council survey of constituent dental societies and dental schools relative to the need and desirability of a national continuing education evaluation program. Of the 50 constituent societies responding to the survey, 72 percent indicated that evaluation of continuing education and some form of recognition for qualitative programs are needed and should be implemented in the near future. Of the 59 dental schools responding to the survey, 83 percent indicated that continuing education evaluation would be desirable.

Also, information on continuing education evaluation programs gathered from several national professional health-related organizations was made available to the committee. On the basis of this information, the committee concluded that the American Medical Association and the American Nurses' Association's programs, structured on a cooperative state-national basis and oriented to the evaluation of sponsoring organizations, appear to be the most workable.

The Council wishes to express its deep appreciation to the ad hoc committee and to those constituent societies, dental schools, and national professional organizations who responded to its surveys. Because of their assistance, the Council believes it is able to provide the House with valid judgments on the need for a continuing education evaluation program and with recommendations which would allow for the reasonable implementation of such a program.

The Council recognizes that to date there has been no demonstrated evidence of a relationship between continuing education and the competence of the dental practitioner, or of a relationship between continuing education and the quality of patient care rendered. This lack of empirical evidence does not necessarily imply that such relationships do not exist, but only that they have not been demonstrated. Whether or not relationships between continuing education and practitioner competence and/or quality of patient care do exist, the Council believes that an effort should be made to improve the quality of the educational experiences offered in continuing education, and that this aim can best be achieved through some type of evaluation program.

In considering the type of program to be structured, the Council concurs with its ad hoc committee that a cooperative state-national program offers several advantages in terms of uniform standards and procedures with less duplication of effort, and increased acceptance of other states' continuing education offerings. It would also reduce the number of jurisdictional questions faced by some continuing education sponsors whose programs draw a national audience. Since communication with most sponsoring organizations would be handled through the constituent societies, more direct and accurate information could be obtained for evaluation purposes. Such a program would also provide a sharing of the administrative and financial resources involved, and might offer additional incentive for those states not now evaluating continuing education to do so.

Based on the number and variety of continuing education offerings presently available, the Council believes that the evaluation of individual continuing education courses or activities would be a task of monumental proportions, and is not feasible at this time. Rather, the evaluation program should focus on the sponsoring institution's ability to provide the elements essential to a high quality educational experience.

In the opinion of the Council, an effective program for evaluation of continuing education sponsors must also involve uniform national standards and procedures. Presumably, such standards would reduce the present duplication of effort existing in this area. To further enhance the effectiveness of such a program, it should be implemented on a nationwide basis. The Council believes that the American Dental Association is the most logical organization to provide the resources and broad-based national representation needed to administer the program.

If the House decides that the Association should conduct a national continuing education evaluation program, the Council recommends that the following basic elements be incorporated in the program.

Association involvement in the proposed program would commence with the appointment of a standing national advisory committee under the auspices of the Council on Dental Education which would develop minimum standards and procedures by which sponsors of continuing education offerings would be evaluated. A section of the standards would be oriented to criteria for approval, on a voluntary basis, of constituent societies as the Council's evaluating agencies at the state level. Such standards would be subject to House approval. Specifically, the national committee, upon request, would evaluate sponsors of programs which attract an audience of national scope, including dental schools, constituent societies and national organizations. Also, the national committee would have ongoing responsibility to monitor the entire state-national program and to develop and recommend to the Council policies regarding this program and other continuing education matters.

Any constituent society wishing to participate in the evaluation program would be requested to apply to the national advisory committee for recognition as the evaluating agency of continuing education sponsors within the society's geographic jurisdiction. Such recognition would be granted by the Council, upon recommendation of the national committee, on the basis of the constituent society's willingness to establish an approval program in conformity with the Association's standards and procedures. The function of the constituent society would be to evaluate continuing education-sponsoring organizations within its area whose programs attract a statewide or local audience, including component societies, study groups, state-level specialty groups, academies, and hospitals.

The Council recognizes that establishment and ongoing administration of state-level evaluation committees will impose additional administrative and financial burdens on the constituent societies. Nonetheless, the apparent need for, and interest in, development of a national evaluation program, and the advantages of shared responsibility between the state and national associations, appear to outweigh the cost factor. Presumably, the leadership and resources provided by the national advisory committee would help to minimize the burden to the constituent societies.

Because of the important role of the national advisory committee in the proposed program, major attention would have to be given to structuring the committee and to providing appropriate representation on the committee. It is suggested that in order to ensure efficiency of operation, the national advisory committee be a Council standing committee, limited to approximately 11 members. Although the selections would be based primarily on an individual's expertise in the area of continuing education, the Council believes that educators, examiners, and auxiliaries should be appointed to the committee, but the majority of members should be practitioners. Also, appointments should be made on a rotational basis for a specified number of years to provide for new leadership and input in the operation of the program.

While it is believed that the national committee should be kept to a workable size, there is some concern on the part of the Council that this might limit the committee's responsiveness to the concerns of the broader dental community. To overcome this concern, periodic workshops or national conferences on continuing education should be scheduled to provide direct input from constituent societies, dental organizations, and other interested groups.

Clearly, the proposed evaluation program will require substantial financial support for its operation. Based on the experience of other national health professional associations in operating similar programs, it is estimated that approximately $25,700 will be needed to develop the program during 1977. This figure assumes that present staff of the Association's Continuing Education Registry program will carry most of the responsibility for the development of the evaluation program. The proposed budget for the first year of development includes the salary of one additional clerical position but does not include salary of existing Continuing Education Registry staff. The 11-member national advisory committee is expected to meet at least three times during the first year, and these meeting expenses are part of this proposed budget. Staff travel is included in the proposed budget as it is anticipated that substantial travel will be necessary to confer with constituent societies relative to their anticipated role in the program. The budget also provides for miscellaneous office expenses.

In 1978, the estimated budget needed for support of the proposed evaluation program approximates $36,000. Addition of a second clerical position is anticipated in 1978, to assist with the expected increase in correspondence and committee activity. The estimated budget for 1978 thus includes salaries for two clerical salaries, expenses for three meetings of the national advisory committee, staff travel, and miscellaneous office expenses. In addition, it is anticipated that a national conference with representation from constituent societies and other interested organizations would be convened, to make recommendations on the standards and implementation of the proposed program.

Assuming that the standards and detailed procedures to be developed by the Council's national advisory committee are approved by the 1978 House of Delegates, the evaluation program would become operational in 1979. During that year and thereafter, budget needs for the program are expected to level off at approximately $50,000 per year. It should be pointed out that a portion of program expenses might be offset for both the Association and the constituent societies by charging a modest evaluation fee to participating sponsors being evaluated. Such offsetting income would not become available until 1979, when the approval program would become operational.

In submitting the proposal for House consideration, the Council recognizes that only the general structure of a continuing education approval program is being provided. If the House approves the concept of sponsor evaluation conducted on a cooperative basis between the constituent society and its national association, then the proposed standards, criteria, and details related to administering the program could be provided the 1978 House through the report of the Council on Dental Education. This timetable has been established because of the Council's strong belief that an effective approval program cannot be developed without substantial input from the constituent societies and other interested agencies. A resolution accompanying the Council's report provides the House of Delegates with the opportunity to decide if the Association should develop a program to evaluate continuing education sponsors.

DENTAL AUXILIARIES

Research Programs in Expanded Functions: The Council annually provides information to the House on newly initiated and completed research programs in training or utilization of expanded function dental auxiliaries. To comply with the 1973 House request that information on federal dental services' experimental programs involving expanded functions for dental auxiliaries be reported through the Council to the House (*Trans.* 1973:726), specific information on federal dental service programs is provided. The Council on Federal Dental Services assists the Council on Dental Education in complying with the House directive by requesting information on expanded function experimental programs from the federal dental services each year. The Chief Dental Officers of the Air Force, Army, and Navy; the Department of Health, Education, and Welfare; and the Veterans Administration have indicated that no new experimental programs in expanded function training have been initiated since 1973.

Several projects which were supported totally or in part by grants or contracts awarded through HEW have been completed in 1976. The five-year University of Iowa experimental program to determine the feasibility of including expanded functions instruction in a baccalaureate degree dental hygiene curriculum was completed in June 1976. The project term has been extended for six months to allow time for in-depth analysis of data and preparation of a report. The University has worked closely with the dental profession in the development and implementation of the project. The final report will be published in late 1976 or early 1977.

The Mt. Zion Hospital, San Francisco experimental program to provide information for development of guidelines for integrating expanded functions into a basic dental assisting curriculum has been completed. The project was carried out in cooperation with San Francisco City College and the University of the Pacific with the sanction of the component dental society. A review group will be formed to make recommendations for guidelines to assist program administrators in integrating expanded functions into dental assisting curricula. It is anticipated that the guidelines will be developed in late 1976 or early 1977.

A two-year intramural experimental program conducted by the Indian Health Service was completed in May 1976. The study was designed to obtain data on the feasibility and cost benefit of increasing the variety of functions Indian Health Services' dental assistants perform at chairside. All functions included in the study are reversible and were performed under the direct supervision of the dentist. The project is one aspect of the Indian Health Services' effort to explore all possible approaches to providing, and improving the level of, dental care for American Indians and Alaskan Natives. Procedures identified in the project include supportive components of restorative, endodontic, orthodontic, periodontic, prosthodontic, preventive, and postsurgical care. While the scope of the project includes experimentation in training Indian Health Service dental assistants to perform some procedures the Association believes should not be delegated, the need to alleviate American Indians' and Alaskan Natives' critical needs for primary dental care is recognized. On the basis of experience early in the project, training to perform several functions was eliminated. In general these were the more complex functions. The application of project findings will be made on the basis of thorough analysis of data on performance of the assistants and cost effectiveness of delegation of functions with direct supervision by a dentist.

In June 1974, a contract was awarded to the University of Kentucky to determine the economic feasibility of using expanded function auxiliaries in a fee-for-service private dental practice. The four phases of the program included development and implementation of research design in an actual fee-for-service dental practice; development of baseline data including economic and productivity information for a six-week period; analysis and comparison of the baseline data of the experimental practice with that from other fee-for-service private practices; and introduction of expanded function auxiliaries into the experimental practice to generate data on the effect of expanded function auxiliaries on the economics and productivity of the practice. The data are being analyzed and a report will be developed by late 1976.

A study of expanded function dental auxiliary utilization was conducted during the past year in the State of Kentucky. Questionnaires were sent with annual license renewal forms to all dentists licensed by the Commonwealth of Kentucky. The questionnaire was designed to assess the utilization of expanded function auxiliaries within the Commonwealth and provide documentation of delegation of expanded functions to dental auxiliaries in a state with legal provisions for such delegation. About 35 percent of the dentists licensed in Kentucky utilize expanded function dental auxiliaries. There is greater utilization of expanded function auxiliaries by general practitioners than by specialists.

Another study is being conducted in Kentucky to compare the time distribution and personnel cost factors when delegating tasks to auxiliaries in different dental team configurations. The baseline data have been developed and the first experimental phase has been completed. The results will be published.

In previous years, the House has been informed of the Forsyth Dental Center experimental program in teaching expanded functions to graduate dental hygienists and in determining the productivity and income of dental teams including advanced skills of hygienists and dental assistants. Endorsement of the project by the Massachusetts Dental Society was sought and received prior to its initiation, and a special liaison committee of the society participated in evaluation of the hygienists' performance. However, in consideration of the potential impact of the final report of the project, the Society believed additional outside evaluation of the study and conclusions was warranted. At the request of the Society, the American Dental Association provided supplementary financial, technical, and staff assistance to the Commission of the Massachusetts Dental Society which was formed to independently evaluate the study. It is expected that the Commission will report its findings to the Massachusetts Dental Society by fall of 1976.

Educational Standards for Dental Hygiene: As the agency of the Association with direct responsibility for assuring that standards of education approved or endorsed by the profession are maintained, the Council is obligated to inform the House of activities which present serious threats to the integrity of dental education. Through its annual report, the Council has informed the House of potential federal intervention in dental education, and activities which would undermine educational standards for dentists and dental auxiliaries. Recent activities in several states to enact legislation to recognize preceptor training for dental hygiene functions are cause for concern, and could establish a precedent that would encourage a lowering of standards of education for dentistry as well as dental hygiene as a means of responding to pressures for extending dental care to various segments of the population.

The need for formal education for dentists was recognized more than a century ago

with the establishment of the first professional dental school in 1840. The dental profession has not digressed from the precedent of this historic decision which gave American dentistry a separate system of education, licensure, and organization apart from medicine, but essentially related to it in the joint effort to provide total health care for the public.

This system, which has given unquestioned leadership to American dentistry, has been adapted to many other countries of the world. It has been successful because it is based on one of the "three unfailing characteristics of a profession, education beyond the usual level." It is one of the major achievements of American dentistry that the development of this system of formal education has largely been in the hands of the dental profession itself, through the accreditation program of the Council on Dental Education, and its successor agency, the Commission on Accreditation. In very few other countries of the world does the dental profession itself have such a controlling voice in the standards of dental education. Elsewhere, that voice is usually that of the government.

When the need for educating dental hygienists was increasingly recognized by states in the 1930's, it was quickly recognized that standards should be established for dental hygiene education. At the urging of state boards of dental examiners, the President of the National Association of Dental Examiners called for the establishment of standardized education and an accreditation program in 1937. Ten years later, 1947, the Association established as a standard, two academic years of college-level education with content in basic, biomedical, social and clinical sciences, and clinical practice. This standard dictated that dental hygiene education be provided through an academic program that includes education that is equivalent in scope and quality to those aspects of the dental curriculum which prepare the dental student for the same functions.

It is now clear that the establishment and enforcement of these standards for dental hygiene education brought into being a new cadre of dental personnel which can supplement efficiently the work force of dentists, particularly in the areas of oral hygiene, prevention, and periodontal disease. It is also extremely important to remember that the development of dental hygiene education, with delegation of certain functions to hygienists previously performed only by dentists has been carried on under the aegis of the dental profession through the Association's Council on Dental Education.

Inherent in the social changes which are characteristic of our day are many pressures on the dental profession, particularly from government, to modify or lower standards of education of practitioners without full regard for the impact of such changes on the dental health of the patient. Such a retreat from long established and productive standards of dental education, is an irretrievable step in the wrong direction and will inevitably lead to a deterioration of other standards in dental education and to the deterioration of the present high standards of dental health that have brought great benefits to this nation.

In view of recent efforts to lower or eliminate standards of dental hygiene education, the Council believes that the Association should unequivocally reaffirm its conviction that all states and relevant agencies should enforce educational standards that have been established by the House of Delegates of the American Dental Association. A resolution reaffirming this conviction is appended to this report.

Review of the Term Dental Auxiliary: The Council on Dental Education consulted

with the Council on Dental Laboratory Relations and other agencies and organizations in studying the descriptive accuracy of the term "dental auxiliary" and other terms for members of the dental health team as requested by the 1975 House (*Trans.* 1975:708). The American Association of Dental Examiners, American Association of Dental Schools, American Dental Assistants Association, American Dental Hygienists' Association, National Association of Dental Laboratories, and Division of Dentistry of the Department of Health, Education, and Welfare were asked to offer opinions and comments on terms which are used or could be used in referring to dental assistants, dental hygienists, and dental laboratory technicians.

The responses were considered by the Council in determining the need for, and appropriateness of, changing the term "dental auxiliary" as used in reference to one or more of the three categories of auxiliaries recognized by the Association and profession. Of the seven agencies and organizations consulted, only two provided information which would support use of another term for "dental auxiliary." The NADL believes a change of term in reference to dental laboratory technicians should be made as that association does not consider the commercial dental laboratory industry auxiliary to the dental profession; and therefore, does not consider technicians employed in commercial laboratories as auxiliaries. The Division of Dentistry believes that the term "dental auxiliary" does not reflect the concept of individual disciplines working together as a team in delivering dental health care and suggested that a term that more closely identifies dental auxiliaries with other parallel personnel in the health care system be considered. Specifically the Division recommended the use of the term "allied dental health professions personnel" as it implies a desirable alliance with dentistry.

Because the concern regarding accuracy of the term "dental auxiliary" specifically was expressed in reference to the dental technician employed by a commercial dental laboratory, the Council, in cooperation with the Council on Dental Laboratory Relations, gave particular attention to the applicability of the term to technicians employed in dental laboratories. As a result of these deliberations the Council adopted the following statement in May 1976.

> The Council recognizes that dental laboratory services are provided to the dental profession through commercial dental laboratories, institutional dental laboratories, and laboratories in private dental offices. Further, the Council recognizes that commercial dental laboratories differ from private and institutional laboratories since the commercial laboratory owner employs dental laboratory technicians and conducts an independent, for-profit business which is exclusively dependent upon the dentist's work authorizations for laboratory services. Although the laboratory owner is the employer of the dental laboratory technician, the work authorization represents a request for services which are a part of the dental care provided by the dentist to his patient. Regardless of employer, the functions performed by the dental laboratory technician assist the dentist in his provision of patient care.
>
> The term "auxiliary" has been defined as one who helps or assists. Therefore, the Council believes that all dental laboratory technicians, whether performing services in a private dental office, an institutional dental laboratory, or a commercial dental laboratory are auxiliaries to the dental profession and provide services which are auxiliary to the dental care delivery system.

After careful consideration of alternate terms for "dental auxiliary"; the meaning of those terms and the potential effect a change could have on national, state, and local policies and laws, and decisions on authority for education, accreditation, and licensure, the Council determined that at this time a change in term is not appropriate or desirable. Until current deliberations related to future roles of dental assistants, den-

tal hygienists, and dental laboratory technicians and the question of licensure of assistants, technicians, and dental laboratories result in definitive positions and actions, the Council believes a change in use of the term "dental auxiliary" is not warranted. Further, the role dental assistants and dental hygienists play in the provision of dental health care and the established and recognized relationship between these auxiliaries and dentistry lead the Council to the conclusion that the term "dental auxiliary" is acceptable. Because the term is widely accepted in its broad definition and accurately includes dental assistants, dental hygienists, and dental laboratory technicians, the Council recommends that the profession continue to use "dental auxiliary" when referring to more than one category of dental auxiliary personnel.

Workshop on Dental Auxiliary Expanded Functions: In response to the directive of the 1975 House of Delegates that a workshop on expanded functions be convened and that a majority of the participants be full-time practitioners who utilize auxiliaries (*Trans.* 1975:697), the Council conducted the national Workshop on Dental Auxiliary Expanded Functions on March 31, April 1, and 2, 1976. Also, in compliance with the third directive of the resolution that an appropriate agency of the American Dental Association study and further define functions which may require formal education for expanded duty dental auxiliaries and report to the 1976 House, the Council with the assistance of an advisory committee has prepared a special report to the House. The special report on education and utilization of expanded function dental auxiliaries, including recommendations that respond specifically to resolutions of the 1975 House, appears on pages 132 to 162 of the Association's 1976 *Annual Reports and Resolutions.*

EDUCATIONAL RESEARCH, TESTING, AND SURVEYS

Dental Admission Testing Program: During the 1975-76 academic year 19,230 individuals participated in the Dental Admission Testing Program. This represents a 10 percent decrease from the 21,367 individuals who took the examinations the previous year. Currently, the test is given in 185 testing centers throughout the United States and on an ad hoc basis in several foreign countries.

The Division is currently conducting a pilot study on validating a noncognitive-type motivational test for use in the Dental Admission Testing Program. The project will involve nine dental schools and be conducted on a longitudinal basis over the next eight years. It will be several years before the results of the study will be available for analysis and publication.

Annual Surveys: During 1975-76, the Division of Educational Measurements in cooperation with the American Association of Dental Schools conducted surveys of all dental and dental auxiliary education programs. From the data collected in these surveys, the *Annual Report on Dental Education,* the *Annual Report on Advanced Education,* the *Annual Report on Auxiliary Education,* and numerous supplemental reports, such as *Minority Student Enrollment* and the *Financial Report on Dental Schools,* were published.

The Division also conducted a special survey in order to determine the effect the "Guidelines for Continuing Dental Education," adopted by the House of Delegates

in 1974, has had on continuing education programs conducted in dental schools. The results of the survey were published in the June 1976 issue of *The Journal of the American Dental Association* and in a special report entitled *Continuing Dental Education Programs in Dental Schools.*

Conferences with Associations of Advisors for the Health Professions: The Council in cooperation with the American Association of Dental Schools cosponsored a conference on dental school admission procedures at each of the four regional meetings of the Association Advisors for the Health Professions. The meetings were held this year in Shreveport, Louisiana; Rochester, New York; Ann Arbor, Michigan; and Monterey, California. The conferences were well attended by predental advisors from most major universities and colleges in the United States. By providing predental advisors with accurate information on admission procedures and an opportunity to meet admission chairmen from various dental schools, many more highly qualified applicants have been directed towards dental education.

Career Guidance Activities: One of the Council's responsibilities is the preparation and distribution of career guidance material for individuals interested in preparing for careers in dentistry or its auxiliary occupations. As in the past, this has been accomplished through direct contact with guidance counselors, constituent and component detail societies, dental schools, members of the profession, and individual students. By attending four annual meetings of national associations involved in career guidance, the Council has developed an additional avenue for the dispersal of career materials to interested agencies and individuals.

Approximately 20,000 individual requests for career information were processed during 1975. This represents an eight percent increase over the number processed in 1974. Since many of these were requests for materials in volume, the number of potential students reached is considerably greater than the number of individual inquiries received. The career guidance program of the Council continues to be conducted in cooperation with the American Association of Dental Schools, the American Dental Assistants Association, and the American Dental Hygienists' Association.

RESOLUTIONS

1. **Resolved,** that in compliance with the intent of Resolution 36-1966-H (*Trans.* 1966:346) candidates who do not possess the required formal education and who did not apply to the Board for examination prior to December 31, 1974 are ineligible for examination, and be it further

Resolved, that candidates who do not possess the formal education requirement but applied for examination prior to December 31, 1974 are ineligible for reapplication upon expiration of their board eligibility.

2. **Resolved,** that the first paragraph of the *Requirements for National Certifying Boards for Special Areas of Dental Practice* adopted by the House of Delegates (*Trans.* 1959:204) be deleted and that the following be substituted therefor:

In order to become, and remain, eligible for recognition by the American Dental Association as a national certifying board for a special area of practice, the area shall have a sponsoring or parent organization whose membership is reflective of the recognized special area of dental practice. A close working relationship shall be maintained between the parent organization and the board. Additionally, the following requirements must be fulfilled;

3. Resolved, that the Council on Dental Education of the American Dental Association, in cooperation with constituent dental societies, establish a voluntary national program for the evaluation of continuing education sponsors, and be it further Resolved, that standards, criteria, and procedures related to implementation of the program be reported to the 1978 House of Delegates.

4. Resolved, that graduation from a dental hygiene program accredited by the Commission on Accreditation of Dental and Dental Auxiliary Educational Programs is the essential educational eligibility requirement for dental hygiene licensure examination.

Council on Dental Health

Meetings: The Council met in the Headquarters Building on December 9-10, 1975, and May 10-11, 1976, with all members present. A special meeting was held on December 8 for the Council's prevention consultants who formerly met as the Coordinating Committee on Preventive Dentistry. Special thanks are expressed for the assistance and support of these prevention consultants: Dr. Juliann S. Bluitt, associate dean, Northwestern University Dental School, Chicago (education and auxiliaries); Dr. Hudson D. Heidorf, Cleveland, and A. Stephen Rouss, Birmingham, Alabama (general practice); and Richard C. Oliver, Los Angeles, California (periodontics).

For their contributions at the December meeting, the Council gratefully recognizes its consultants from dental public health: Dr. Sherman Cox, Bethesda, then director, Division of Dentistry, Public Health Service; Dr. Charles W. Gish, Indianapolis, dental director, Indiana State Board of Health; and Dr. Robert Mecklenburg, Rockville, chief, dental service branch, Indian Health Service. Both meetings were attended by Dr. John C. Greene, Rockville, chief dental officer, Public Health Service.

Appreciation is also expressed to the Council consultants from auxiliary organizations: Mrs. Edith Schweikle, R.D.H., Lexington, Kentucky, representing the American Dental Hygienists' Association, and Miss Patricia Cupkie, C.R.D.A., Chicago, representing the American Dental Assistants Association.

Dr. Robert Griffiths, Charleston, Illinois, Eighth District Trustee, attended both meetings, representing the Board of Trustees.

Guidelines on Hypertension Detection: The guidelines for dentists on hypertension detection developed by the Council in response to the 1974 House of Delegates directive (*Trans.* 1974:643) were returned to the Council for revision by the 1975 House of Delegates through the following 1975 resolution (*Trans.* 1975:676):

> **Resolved,** that prior to the publication and promulgation, the *Guidelines for Dentists on Hypertension Detection in the Dental Office* shall be returned to the Council on Dental Health for reevaluation and possible elimination of specifics contained in the present *Guidelines,* and be it further

Resolved, that the Council review such other items in the *Guidelines* which establish directives rather than recommending action based on the professional judgment of the dentist, and be it further

Resolved, that the revised *Guidelines* be submitted to the House of Delegates for their approval prior to their distribution.

With the guidance of the information presented in the background statement of the foregoing resolution, the Council redrafted and retitled the guidelines to present a general rationale and philosophy for dentist participation in the National High Blood Pressure Education Program. The revised guidelines and an appropriate resolution appear at the end of this report. The guidelines reflect the Council's belief that dentists are in a unique position to detect undetected hypertension because they see on a routine recall basis "healthy" patients who do not seek physician's care on as regular a basis. For patients, this simple addition to the office routine will confirm the dentist's concern with their total health and well being.

High Blood Pressure Conference: The Council participated in the development of the second dental leadership conference on "the role of the dental profession in high blood pressure control" held on May 17-18 in the Association's Headquarters Building. In addition to the Association, other cosponsors were the National High Blood Pressure Education Program, American Association of Dental Schools, American Dental Assistants Association, American Dental Hygienists' Association, American Heart Association, and the National Dental Association. The Council expresses its gratitude to Dr. Robert Hirschi, Oklahoma City, a private practitioner active in hypertension detection in the Oklahoma Heart Association, for acting as moderator for the conference and serving on the program committee at the Council's invitation.

Some 125 dentists and auxiliaries attended the conference to hear speakers who represented dental practice, dental education, dental auxiliaries, and dental public health, as well as law, medicine, medical research, and heart associations. Keynoter was Dr. I. Lawrence Kerr, Second District Trustee, who urged dentists to assume the professional responsibility of blood pressure measurement in their physical evaluation of patients, thus underlining their role in the total health team. In a well organized office, he emphasized, auxiliaries should be able to take blood pressure readings as part of a patient health history.

National Health Planning Act: The 1975 House of Delegates recognized the importance to the entire health delivery system of P.L. 93-641, the National Health Planning and Resources Development Act of 1974, with the following directive assigned to the Council on Dental Health (*Trans.* 1975:746): "that the appropriate agency or body of the American Dental Association make every effort to participate in deliberations regarding the implementation of the Health Planning and Resources Act of 1974 and report its actions to the 1976 House of Delegates." Since the signing of the law in January 1975, the Council on Dental Health has kept state dental societies informed on the initiation and implementation of the various stages of the complex machinery created by the legislation, such as the designation of the 200 health service areas and development of the Health Systems Agencies for each health service area and regulations for State Health Planning and Development Agencies. The theme running throughout the Council's mailings is the urging of constituent societies to secure dentist representation on the boards of local Health Systems Agencies and on the Statewide Health Coordinating Council.

At the 26th National Dental Health Conference, Dr. James R. Whiteman, Warrensburg, Missouri, described Missouri's success in putting dentists on the boards of virtually all HSAs in the state and called for similar action in other states. Dr. Whiteman emphasized the control that the new network of planning agencies will have on the development and funding of health resources in each state and locality. He underlined the importance of this network in administering any type of national health program.

In addition to the local, state, and regional health planning bodies, a National Health Planning and Coordinating Agency will be formed after the lower network of agencies is created.

On behalf of the Association, the Council on Dental Health submitted comments on the development of guidelines on national health planning goals and standards, initially scheduled for completion in summer of 1976 although current predictions are that completion will be postponed. The comments covered national health program policies, prevention including fluoridation, health financing, manpower supply, and distribution along with supporting Association publications and position papers as solicited by the Office of Planning, Evaluation, and Legislation.

New Association documents relating to health planning will also be provided to the Office of Planning, Evaluation, and Legislation to continue the liaison on dentistry's position on the health delivery system.

Cosmetic Dentistry: The Council was directed by the 1975 House of Delegates to "undertake a study of the concept of 'cosmetic dentistry' with respect to its fundamental clinical and professional validity and the ramifications of the concept to prepayment programs" (*Trans.* 1975:684) with a report back to the 1976 House of Delegates. Consultation was provided by the Council on Dental Research.

Since the current concern over the use of the term "cosmetic dentistry" stems from its use in dental insurance contracts as an exclusion, the Council staff solicited information from major dental insurance carriers on the administration of this "cosmetic dentistry" exclusion. Pertinent information was received from Metropolitan, the Travelers, Aetna, John Hancock, New York Life, and the Delta Dental Plans Association. Some carriers stressed the exclusions coming under the heading of "cosmetic dentistry" were decided on a judgmental basis and that they did not have a hard and fast definition of cosmetic dentistry. Based on these responses, the Council agreed that a redefinition of cosmetic dentistry would be an academic exercise although it believes that the following definition developed by the Council and as subsequently amended, is useful: cosmetic dentistry is "defined as encompassing those services provided by dentists solely for the purpose of improving the appearance when form and function are satisfactory and no pathological conditions exist." Further action will be taken on this issue in consultation with the Council on Dental Care Programs and will be reported in the *Supplement to Annual Reports and Resolutions, 1976*.

Conference on Private Practice: The second conference on private practice has been scheduled for 1976, in response to a 1974 House of Delegates directive (*Trans.* 1974: 659) that was postponed for a year in referral to the Public Education Program before being redirected to the Council. This resolution called on the Council to "organize and sponsor in the next twelve months a Conference on the Preservation of Private Practice," and to see "that in the choice of speakers at this Conference, preference be given to those men engaged in private practice."

The first conference on private practice, July 25-26, 1974, was a conventional lecture conference concluding with an open forum session at which conferees so articulately expressed their concerns and ideas that the second conference has been redesigned as a workshop-conference. It is the Council's belief that private practitioners representing different areas of the country can analyze the characteristics and advantages of private practice and identify how these factors can meet virtually any challenge presented to a predominantly private practice-based delivery system. The product of the conference is anticipated to be a distillation of all these ideas into a report that can be widely distributed to extend the ideas further.

Dental Practice Manual: A manual on dental practice administration, developed by Council staff, is expected to be available for purchase before the end of 1976. Covering the full range of practice administrative matters, the manual will be valuable for the practicing dentist as well as the new dentist, but its early chapters are specially designed for dentists planning to enter practice. For this reason, the Council will explore means of making the manual available to graduating classes of dental schools. The development of the manual is the completion of a goal long held by the Council on Dental Health: to provide authoritative information on dental practice administration, with references to other sources of information on practice.

Identifying Dental Manpower Scarcity Areas: To assist dental societies in identifying at their local levels any areas that are dentally underserved, the Council on Dental Health called together on October 10, 1975, a group of dental society spokesmen with some practical or manpower research experience in documenting dental scarcities. States represented were Alabama, Michigan, North Dakota, New Mexico, Texas, and Wisconsin. The Council was represented by Dr. Robert E. Lamb, Texas. The result of the discussions was a checklist of factors significant in identifying scarcities, such as customary travel patterns to seek goods and services, anticipated demand, whether the community could be expected to support a dentist according to expressed demand or methods of payment, and the productivity of any dentists in the locality. The document is to be a more sensitive and valid measurement of local dental needs than the dentist/population ratio used at the national level.

The need for such a document was confirmed by the following resolution of the 1975 House of Delegates (*Trans.* 1975:683):

> Resolved, that the ADA Council on Dental Health develop and disseminate as soon as possible guidelines for local dental societies to use in identifying dental manpower scarcity areas for the purpose of evaluating proposals for placement of dentists under National Health Service Corps and educational loan forgiveness programs, and be it further
> Resolved, that the constituent and component societies be encouraged to utilize this information to improve on a voluntary basis the distribution of dentists, and be it further
> Resolved, that the Council on Dental Health in cooperation with all other bureaus and councils involved in dental manpower develop adequate criteria and guidelines for the identification of dental manpower shortage areas and extend its efforts to have these guidelines recognized and accepted by the appropriate federal agencies.

Implementation of this resolution, the Council notes, would put state dental societies in a position to assist in recruitment of dentists if necessary for underserved towns and would also provide a base of information on practice opportunities in the state. The extension of federal loan forgiveness programs for graduates practicing in scarcity areas, as well as the possibility of National Health Service Corps assignments,

indicate that this is a new program priority that constituent societies must consider.

As a direct result of that first meeting with dental society representatives and repeated consultation with government spokesmen involved in manpower placement programs in which the resulting checklist would be used, the Council refined a document titled *Suggestions for Dental Societies on Identification of Dental Scarcity Areas.*

In developing the *Suggestions,* the Council recognized their special standing, as must dental societies who use these guides. In liaison with governmental agencies, it was clear that the Council's criteria for dental scarcities appeared to be too subjective since they call for local dental society perceptions of local conditions. However, in order to make the document valid as a replacement for the dentist/population ratio, it is necessary to explore such significant but hard to document local characteristics as whether residents are accustomed to travelling long distances for dental as well as other goods and services. It is necessary to judge, too, whether an area can support a dentist on a private practice basis or whether the socioeconomic conditions would mandate some type of subsidized practice.

For these reasons, the Council has made every effort to list in the document those facets of the local delivery scene that can be documented as fact and are not merely statements of opinion. Instructions to dental societies using the document also stress the need for data to stand up to investigation. While it may be unlikely that the *Suggestions* can receive official acceptance by federal agencies, interested agencies have commended the Association for its plans to organize these data for the use of dental societies in dialog with national or local government agencies. Requests from dental societies have further demonstrated their need for this guidance.

The Council's document on *Suggestions* was disseminated to state dental societies in June, with a cover memo citing the House resolution.

National Health Service Corps: The Council has followed the progress of the National Health Service Corps in placing 83 dentists in 77 sites as of May 1976, with an additional 28 sites approved and awaiting placement and another 83 sites projected for approval. In seven early placements, the practice established by the National Health Service Corps has continued and the original dentists have remained on a private basis in three of these towns: Chateaugay, New York; Barranquito, Puerto Rico; and Celina, Tennessee.

The Council is aware of the controversy surrounding the implementation of the National Health Service Corps program in cases where communities that requested assignment of a Corps dentist on the basis of need for dental service did not have the need confirmed by the dental societies involved. In some cases, productive communications between appropriate HEW officials and Association representatives have solved the problems.

To provide some guidance to dental leaders exploring the various stages of National Health Service Corps assignments and, in addition, to underline the validity of the Corps concept in providing care in truly underserved areas, the Council has developed a position statement on the Corps which is appended to this report with a resolution.

The Council's document, *Suggestions for Dental Societies on Identification of Scarcity Areas,* will be particularly useful in providing dental societies or community groups with a framework for gathering information to document the need or lack of need for dental care in a specific area.

Preceptorship Programs: Because of its interest in providing dental care in underserved areas, both rural and inner city, and its interest in encouraging dental graduates to serve in those areas, the Council was pleased to receive a report on dental preceptorship programs presented by Dr. John Thorpe, associate dean for advanced education and research, University of Illinois College of Dentistry. Presently 32 preceptorship programs for dental students are conducted by universities or colleges in 21 states. In these programs, students provide treatment of some type, observe or work with community groups in settings ranging from migrant camps in California to inner city clinics in New York City to private dental offices in rural Illinois. Length of preceptorships range from one or two days to an entire summer.

The Council urges the development of more such programs to make dental students aware of the breadth of practice opportunities available as well as of the variety of dental needs of the public.

Community Fluoridation: On behalf of the Association, the Council has established a close cooperative relationship with the new preventive dentistry unit in the Public Health Service Center for Disease Control in Atlanta. Although additional personnel positions are anticipated, the initial staffing of the unit consists of Dr. William B. Bock, director, and Mrs. Cora Leukhart, who is well known as an outstanding resource person on community fluoridation. The Council compliments Mrs. Leukhart on the recognition in 1976 by the Public Health Service of her long efforts on fluoridation with bestowal of the PHS Special Recognition Award.

Expected before the end of 1976 is a new national census of communities with both natural and controlled fluoridation, the first such census to be produced since the end of 1969. The publication, compiled by the PHS Division of Dentistry, will provide an invaluable resource for promoting fluoridation.

During 1976, new controversy was created around community water fluoridation by the indefatigable antifluoridation group, the National Health Federation. NHF's current claim linked long-term fluoridation to various types of cancer, based on repeated misinterpretations of epidemiological data. These claims have been repeatedly refuted by official comments and reports of the National Cancer Institute. This new controversy, more than other recent antifluoridation claims, demonstrates two opposing agencies vying for the belief of the public and the concomitant need for the public to be able to recognize which is the authority and which speaks for a nonscientific special interest group.

Fluoridation Advertisements: An invaluable public relations tool for the promotion of fluoridation in local areas has been provided for the Association by the public service efforts of the New York City advertising agency, Ogilvy and Mather. As a public service contribution, Ogilvy and Mather developed a series of fluoridation advertisements which can be reproduced inexpensively for local campaigns as newspaper advertisements, handouts, or mailing pieces. From many requests for assistance from communities, the Council recognizes this type of material as the oustanding single need for help which can be provided by a national agency. Local campaigns are unable to fund public relations assistance to develop their own print materials.

The printing of the advertisement prototypes will be funded by the Association for distribution to interested community groups which can add their own names and slogans before they reproduce the material in quantity.

These ads, expected to be available mid-summer, will provide the main new component of the materials to be disseminated in response to the following resolution of the 1975 House of Delegates (*Trans.* 1975:677):

> Resolved, that the Council on Dental Health reemphasize to constituent societies and state dental directors the availability of materials from the Association on the community organization aspects of fluoridation.

The Council calls attention to the campaign manual developed by the Association, *Fluoridation for your Community and your State,* as a practical and useful guide to organize a community for city council action on fluoridation or a referendum.

Preventive Dentistry Awards: Three $1,000 awards for outstanding contributions to preventive dentistry were made in 1975, the fourth year of the ADA Preventive Dentistry Award program funded by Johnson and Johnson. The entries are judged by the preventive dentistry consultants to the Council with selected Association staff, formerly the ADA Coordinating Committee on Preventive Dentistry.

The winners of the top awards in 1975 were Dr. Abraham E. Nizel, Boston, for a manual on *How to Deliver a Comprehensive Preventive Dentistry Service which Dental Insurance Carriers can Underwrite* (*The Journal,* May 1976); the Los Angeles Free Clinic (Dr. Bertram Henick, Dental Health Education Coordinator) for a program to train volunteer health aides to deliver preventive dentistry education at the Clinic and to other groups in the community; and the Department of Oral Biology, University of Alabama School of Dentistry, Birmingham (Drs. Lewis Menaker and Carl A. Ostrom), for a teaching-demonstration curriculum that trains dental students to incorporate preventive dentistry into the practice setting.

Four meritorious awards were granted to the following: Mrs. M. Victoria Scholz, Grand Rapids, for a prevention program for Head Start centers and elementary schools; the National Dairy Council, for "Toothtown, U.S.A.," a preventive dentistry program for elementary schools; Mrs. Diane E. Huntley, Denver, for developing a preventive training manual for dental hygienists; and Mrs. Sandra L. Walker, Cincinnati, for a program to train hygienists on oral health care for aged edentulous patients.

To broaden the impact of preventive dentistry programs recognized by the Association Award, the Council and its prevention consultants decided for the 1976 program to refocus the competition to community prevention programs conducted by lay groups, such as schools and service organizations, as well as dental professional personnel. The emphasis would be on programs that could be replicated in other communities.

National Dental Health Conference: The 26th annual National Dental Health Conference was held on April 5-6 in the Headquarters Building and was attended by some 175 dentists. Areas of emphasis were new legal and legislative influences, the status of Medicaid as a "care program in crisis," the new Dental Planning Information System, and prepayment.

Of special interest also were presentations on the threat of illegal dental technicians to the dental health of the public, by Dr. Jack Harris of Houston and on dental health programs in nursing homes, on behalf of the American Society for Geriatric Dentistry–American Dental Association Geriatric Oral Health Nursing Home Program, by Dr. Kenneth A. Freedman, project director.

A special afternoon session on Medicaid was led off by M. Keith Weikel, PhD, Commissioner, Medical Services Administration, who described the status, problems, and prospects for both federal funding and state implementation of Medicaid benefits. Private practitioners involved with state Medicaid programs as consultants or in state dental society leadership capacities elaborated on Medicaid experience in Illinois (Dr. James L. Buckner), Indiana (Dr. Harvey G. Thomas), Massachusetts (Dr. Arno Bommer) and Texas (Dr. Henry M. Sorrels). Of special concern to the participants were reports that all adult dental benefits had been dropped by Medicaid in eight states with predictions that it was likely that other states will follow suit in an attempt to control state expenditures for the program.

Keynoter for the conference was Representative Dan Rostenkowski, Illinois, who told conferees that a national health program should include phased-in dental care for children.

Scientific Session Programs: To extend information on subjects within the Council's purview, two special sessions have been arranged, with the cooperation of the Council on Scientific Session, for the scientific programs at the annual session. A program on the dentist's role in hypertension detection is scheduled for Monday morning, November 15, to be moderated by Dr. James A. A. Catchings, Council vice-chairman, and a session on "the truth about nutrition and dental disease" is scheduled for Tuesday morning, November 16, to be moderated by Dr. Robert I. Kaplan, chairman.

Special Study Commission on Edentulous Patients: Dr. Hal M. Gronlund, represented the Council on the Special Study Commission on the Care of Fully and/or Partially Edentulous Patients. The Council's contribution to the work of the Special Study Commission was the development of guidelines for the profession on aftercare of patients with full and partial dentures. The guidelines emphasize the comprehensive and continued care that dentists provide to patients with full or partial dentures, a service that cannot be provided by illegal dental mechanics.

Liaison: In order to keep up-to-date on its responsibilities for practice, preventive dentistry and public health, the Council carries on liaison with a broad range of organizations including the Public Health Service Division of Dentistry and Center for Disease Control, the American Medical Association's Council on Rural Health and Section on Foods and Nutrition, the American Public Health Association, the American Society for Geriatric Dentistry, the American Dental Hygienists' Association and the Association of State and Territorial Dental Directors and its member state dental directors.

Dr. Hal M. Gronlund represented the Council at the AMA's Rural Health Conference in Phoenix and was instrumental in arranging Association cosponsorship along with other national organizations, of the first National Rural Health Week.

The Council has supported the Academy of Dentistry for the Handicapped in many projects including seeking dentist participation in the White House Conference on Handicapped Individuals to be held in 1977 and has also instituted liaison with the Commission for the Control of Epilepsy and its Consequences, both in an attempt to call attention to the special need presented by dental treatment of the handicapped.

Liaison with the Association of State and Territorial Dental Directors has indicated

the problem in many states of the state dental director losing administrative position, budget, and program control through reorganization of the health department. In its continuing contacts with state dental directors, the Council has become increasingly concerned that this downgrading of dental divisions and their directors means a serious loss or lessening of dental program resources for state and local dental societies. An energetic and effective state dental division can be helpful to constituent societies, particularly on such public health issues as fluoridation and other preventive dentistry programs, school health education curriculums, institutional dental care programs, and collecting information on dental manpower.

The Secretary represented the Council at meetings on the establishment of the American Society for Geriatric Dentistry—American Dental Association Geriatric Oral Health Nursing Home Program. The Council Chairman was gratified to be invited to provide a regular article on geriatric dentistry for *The Journal* of the ASGD.

The Council continues to respond to requests from the food industy for consultation and information. Critiques were prepared on dental information in health education brochures distributed widely to schools by General Mills.

RESOLUTIONS

5. Resolved, that the *Suggestions for Dentists on Participating in the National High Blood Pressure Education and Screening Program* be approved.

6. Resolved, that the *Statement on National Health Service Corps* be approved.

APPENDIX 1

SUGGESTIONS FOR DENTISTS ON PARTICIPATING IN THE NATIONAL HIGH BLOOD PRESSURE EDUCATION AND SCREENING PROGRAM

The National High Blood Pressure Education Program offers dentists an opportunity to provide an additional health benefit to their patients by joining the national multidisciplinary health campaign to identify undetected hypertension. Practicing dentists may be more likely than physicians to see relatively healthy persons on a regular basis and thus are in a unique position to assist in detecting previously unsuspected cases of hypertension.

For these reasons, the House of Delegates in 1974 approved a directive "that the members of the American Dental Association be urged to participate in the National High Blood Pressure Education Program" (*Trans.* 1974:643). The Association is a participating agency in this national voluntary control, public education, and screening program.

Extent of Problem: High blood pressure, frequently an asymptomatic condition, is a major cause of cardiovascular disease in the United States. One in six adults has hypertension, but only half of them are aware of it. Alerting patients to this condition and making appropriate referral to physicians may prevent heart attack, stroke, kidney disease, and other consequences of undetected and uncontrolled hypertension. Measuring the patient's blood pressure is consistent with the dental profession's priority for prevention of disease, confirms to patients the dentist's sincere interest in their total health, and underlines the dentist's participation with his auxiliaries in the community health team.

Guidelines: In response to the directive of the House of Delegates calling for guidelines on incorpo-

ration of hypertension detection in the dental office, the following suggestions are presented:

1. Blood pressure measurement for screening purposes would be appropriate on all new patients, including children, and on recall patients once a year. This procedure could be included in the office routine; for instance, as part of taking or updating a health history.

2. Dentists and dental auxiliaries can receive training or updating in the technique of taking blood pressure through consultation with local chapters of the American Heart Association or local hospitals or medical groups.

3. Blood pressure measurements can be taken and recorded by dental auxiliaries, but it might be advisable for the dentist to inform the patient of the reading, if it is considered necessary.

4. Dentists and their auxiliaries should recognize and explain to patients that their measurement of blood pressure does not constitute a diagnosis and that it is a screening procedure to assist in identifying unsuspected cases of high blood pressure as part of an ongoing national program. Patients should be informed that hypertension may necessitate changes in dental treatment as well as have serious health consequences for them.

5. A patient should be referred to a physician when, in the judgment of the dentist, the best interest of the patient will be served.

6. Referral to physicians or seeking of physicians' consultation should be based on accepted cutoff points in blood pressure levels as recommended by the American Heart Association or other qualified organizations for primary screening.

7. Recommended equipment is the standard mercury manometer, available from medical and dental supply houses, to be used with a stethoscope. Automatic devices, though easier to use, are not yet considered to have been well validated for accuracy.

8. Dentists should seek information on hypertension control medication that may be taken by patients and that may affect the provision of dental treatment or anesthesia.

APPENDIX 2

STATEMENT ON NATIONAL HEALTH SERVICE CORPS

The American Dental Association supports the concept of the National Health Service Corps as a mechanism for making dental services available in areas without sufficient dental manpower and where additional private practitioners are not available. Accordingly, the Association believes that dentist placements should be assigned to areas where a need has been clearly identified and has been approved by the state and local dental societies.

To be in a position to assist in this appropriate implementation of the National Health Service Corps, the Association calls on state and local dental societies in consultation with representatives of the Corps to identify scarcities in their purview, using guidelines available from the Council on Dental Health. State dental societies should also promptly respond, in agreement or disagreement, to listings of scarcity areas issued by federal agencies for the purpose of making National Health Service Corps placements. Scarcity areas should not be identified on solely the basis of a dentist/population ratio since this cannot take into consideration variances in dentist productivity and public demand for care. Assessment of dental manpower should also be based on customary trade areas, crossing state boundaries if necessary, rather than on separate communities.

The Association recommends that National Health Service Corps dental offices should be operated as closely as possible to a private practice fee-for-service basis to foster a transition to private practice and to encourage the Corps dentist to remain as a private practitioner. It is recognized that some of the Corps practitioners in these critical shortage areas will become self-sufficient while other areas can never financially support a practitioner and other funding provisions may be necessary for patients seeking dental care.

National Health Service Corps sponsoring agencies in the community should make periodic evaluations of the Corps practice. They should be encouraged to call upon the local dental society for consultation and cooperation.

Council on Dental Laboratory Relations

Meeting: The Council met in the Headquarters Building on October 6-7, 1975 and April 5-7, 1976 with all members present. The Council gratefully acknowledges the contributions made by Dr. Steve W. Lynch, consultant from the Federation of Prosthodontic Organizations, who attended portions of both meetings.

Dr. Coleman Gertler, Ninth District trustee, attended the April meeting at the Council's invitation as the Board of Trustees representative.

Liaison with the Dental Laboratory Industry: The Council continues to meet with representatives of the commercial dental laboratory industry. The Council met with the Professional Relations Committee of the National Association of Dental Laboratories on June 13, 1975 and on April 7, 1976. Also, the Council met with representatives of the Professional and Trade Relations Committee of the Dental Laboratory Conference on April 6, 1976. In addition, Council staff has attended meetings of the National Association of Dental Laboratories and the Dental Laboratory Conference at the invitation of association officers. Matters of direct mutual interest to both the dental laboratory industry and the dental profession were examined. Discussions on several of these topics are outlined in sections of this report.

Statutory Regulation of Dental Laboratories and Technicians: Regulatory proposals for dental laboratories and technicians which would establish separate dental laboratory regulatory boards have been introduced in Rhode Island, Massachusetts, and New York. A previously introduced regulatory proposal remains inactive in Pennsylvania. The Council has compiled data on state legislation governing dental laboratories and technicians and has summarized enacted and proposed statutory regulations. This information is available on request.

Application of the Term "Auxiliary" to Commercial Dental Laboratory Technicians: Current Association policy (*Trans.* 1972:707; *Trans.* 1975:723) stipulates that the dental assistant, dental hygienist, and dental technician are auxiliary to the dental profession. Representatives of the commercial dental laboratory industry contend that technicians employed in commercial dental laboratories should not be classified as an

auxiliary since they are employed in an independent, for-profit industry and do not have the same type of supervision associated with employees working in a dental office.

The Council discussed this issue at length to determine the merits of the arguments presented by representatives of the dental laboratory industry and to evaluate the effect which the continuation of the current policy could have on the relationship between the dental profession and the dental laboratory industry as well as possible consequences which would occur if the Association's policy were changed to coincide with that of the dental laboratory industry. The Council noted that current Association policy prompted NADL to decline participation in the Commission on Accreditation of Dental and Dental Auxiliary Education Programs. The possibility of NADL discontinuing the annual meetings with the Council was mentioned during the April 7, 1976 meeting by NADL representatives. However, the Council believes the adverse impact which a change in policy might have, namely dental laboratory groups gaining statutory regulation with separate regulatory control boards, far exceeds other considerations at this time. During its April 1976 meeting, the Council noted that the services provided by technicians, regardless of location, are auxiliary to the dental care delivery system and, therefore, those individuals providing that service are correctly identified as auxiliary to the dental profession.

Study of Denture Care: The immediate past chairman of the Council on Dental Laboratory Relations continues to serve as Chairman of the Special Study Commission on the Care of Fully and/or Partially Edentulous Patients. The Council submitted an interim report to the March 1976 Board of Trustees session outlining its progress on the implementation of assignments on denture care. A final report will be prepared and provided to the Commission in June 1976.

Assignments relate to investigating the feasibility of establishing a clearing house of law enforcement information, encouraging dental societies and state boards to strengthen dental practice acts and actively enforce those acts, exploring new methods to upgrade continuing education programs for and encourage participation by dental technicians, encouraging compliance among members of the profession with laws that require complete and accurate work authorizations and developing a public education program on denture care.

In cooperation with the American Association of Dental Examiners, the Council is developing a questionnaire to survey constituent societies and state boards designed to obtain information pertaining to dental practice acts, state board activities, and law enforcement programs. Information on successful enforcement procedures will be made available to each society and state board and used to establish an agenda for a proposed law enforcement conference.

A public education program has been jointly initiated between the Council and the Bureau of Public Information and is being implemented as a pilot project in Oregon. The program is jointly funded by the Association and Oregon Dental Association. The goals of the program are to: improve dentistry's image with the citizens in Oregon; improve the delivery of dental care, particularly denture care; prevent illegal dentistry from filling the voids presently seen, or perceived, by the consumer; and devise useful communications materials, techniques, and procedures that can be implemented by other state dental societies to achieve similar goals. Activities of the program are directed to the members of the dental profession, the general public and members of the state legislature.

Interest Expressed by the Dental Laboratory Industry in "Denturist"[1] Activities: The National Association of Dental Laboratories authorized a committee to travel to Canada to conduct an on-site survey of the effects which alternate methods of providing denture care have had on the Canadian dental laboratory industry. The committee's report indicated that commercial dental laboratories are busy, working for both the dental profession and dental mechanics or denture therapists; the Canadian dental laboratory organization suffered large membership losses due to its opposition to the legalization of "denturist" activities; and salaries of technicians working in commercial laboratories have increased, resulting in increased costs to the dental profession for laboratory services.

The Council has noted the emphasis with which the dental laboratory industry has placed on these activities. In discussing the "denturist" issue in a January 1976 article, the current NADL President said:

> Perhaps "Surprise of '76" actually began during the 1975 NADL House of Delegates meeting in Honolulu when the House turned down by a large majority a long-standing resolution confirming a policy of no patient-laboratory contact. And then a few minutes later resoundingly passed a resolution directing the Professional Relations Committee to develop a means whereby, under prescription, the patient could receive some services directly from the laboratory.
>
> In effect our House told organized dentistry to get honest. Obviously, there are times when the patient can best be served by direct contact with the dental laboratory. To say that it is harmful or injurious to the patient is ridiculous. We all know it is being done every day.
>
> Denturism[2] fever is sweeping the country. Legislative initiative from denturists-type organizations will loosen dentistry's long standing control over legislation affecting our industry. The questions about denturism seem to be shifting from "why" or "if" to "when" and "where?"

A survey conducted by the National Association of Dental Laboratories to ascertain its members' position on "denturism" indicated that respondents are rather evenly divided, with 32.7 percent advocating opposition, 30.9 percent suggesting neutrality and 31.1 percent supporting. There were no responses or opinions from 5.3 percent. A larger percentage of laboratories with more than ten employees opposed the legalization of "denturist" activities than did laboratories with fewer than ten employees. Opposition to "denturist" initiatives was the greatest in the Southeast (55 percent) and Northwest (44 percent) sections of the country. The greatest support for these activities occurred in the Northeast, with 47 percent of the respondents supporting the legalization of "denturist" activities.

Legislation to Establish Alternate Methods of Providing Dental Care: A bill was introduced in the special legislative session of Maine that would provide for the licensing of "denturists." The bill, identified as L.D. 2178, was defeated by the State House and Senate.

The proposed act would have established a seven-member licensing board composed of four dental mechanics, two dentists and a consumer which would have regulated complete and partial denture services to the public. In killing the bill, the House also

[1] The term "denturist" in the United States refers to a person who illegally holds himself out as qualified to practice dentistry.

[2] "Denturism" is the fitting and dispensing of dentures illegally to the public.

rejected a proposed alternative of allowing the "denturists" to practice under the supervision of dentists.

Although this specific bill was defeated by the state legislature, it is expected that a similar bill will be introduced to the 1977 legislature.

Activities of Illegal Dental Practitioners: In the interim since the Council's last annual report, illegal dental practice activities have increased in scope and intensity. Organizational efforts are occurring on both the national and state levels. In January, the National Denturist Association placed a four-page advertising supplement in an independent laboratory periodical soliciting membership. The organization reportedly plans to draft a model bill designed to legalize "denturists" activities, provide guidance to state organizations, develop background material for legal actions testing the constitutionality of state dental practice acts and prepare a national public education program.

The Council office has received reports indicating that organizational efforts are being made in several states, including: California, Colorado, Idaho, Illinois, Iowa, Kansas, Maine, Massachusetts, Michigan, Missouri, Nevada, New York, Oklahoma, and Oregon.

Clinics and Lectures: The Council's Sixteenth Annual Clinical Conference for Dental Laboratory Technicians was held in Chicago on October 25, 1975. In addition, the Council has continued to provide grants for regional training clinics for dental laboratory technicians in cooperation with dental schools.

To improve the efficacy of funds identified for educational purposes, and to implement assignments from the special Study Commission, the Council intends to increase its emphasis on continuing education programs conducted in dental schools. Cooperation with dental laboratory technician certification programs will be continued to determine whether joint efforts to provide continuing education programs are feasible.

Acknowledgments: The Council acknowledges with appreciation the dedicated leadership and the many contributions made by Dr. Robert L. Taylor, who resigned from the Council following the 1975 annual session. The Council members and staff wish Dr. Taylor success in his position as President of the California Dental Association. In addition, the Council wishes to express its sincere appreciation to Dr. John J. Mingenback for his service to the Council.

RESOLUTIONS

This report is informational in nature and no resolutions are presented.

Council on Dental Materials and Devices

Vining, R. V., Nebraska, 1976, chairman
Heuer, M. A., Illinois, 1978, vice-chairman
Charbeneau, G. T., Michigan, 1977
Christensen, G. J., Utah, 1976
Norman, R. D., Indiana, 1978
Patchin, R. E., Ohio, 1978
Sousen, R. E., West Virginia, 1977
Schuchard, A. S., California, 1977
Von Der Lehr, W. N., Louisiana, 1976
Stanford, J. W., secretary
Acharya, A., assistant secretary
Armstrong, L. M., assistant secretary
Fuys, R. A., director, Division of Evaluation and Standards Development

Council Meetings: The Council has held two meetings in the Headquarters Building, Chicago, since the 1975 annual report. The first was held on November 24-25, 1975 and the second on April 29-30, 1976. All members were present. Representatives of the Canadian Dental Association, the Federal Food and Drug Administration, and the National Institute of Dental Research were present at both meetings. Dr. Michael A. Heuer was reelected vice-chairman of the Council.

Liaison Meetings: Members and staff of the Council continued to serve on the liaison committee at meetings with representatives of the American Pharmaceutical Association. The Council Secretary attended the May 1975 meeting in Toronto of the Canadian Dental Association's Council on Dental Materials and Devices. The Council also met on April 29, 1976 with representatives of the American Dental Trade Association, the Dental Manufacturers of America, the Dental Dealers of America, and the National Association of Dental Laboratories.

Conferences: The Council cosponsored or participated in six conferences concerning one on hepatitis, two on dental materials, two on implants, and a conference of the American Association of Dental Editors. The Council was also represented at a meeting of the American Dental Association Ad Hoc Committee on Trace Anesthetic Gases reviewing potential health hazards in dentistry. Council members and staff will participate in a National Institute of Dental Research conference on replacement alloys for gold-based alloys and one for teachers of dental materials during 1976.

Sponsored Grants: The National Institutes of Health awarded a grant to the Council Secretary for standard test methods for biomaterials and instruments in the amount of $103,875 which includes $44,000 in indirect costs. This is the second year of a five-year project with the third year beginning June 1, 1976 in the amount of $110,010 including $45,760 in indirect costs. *This project provides support to the activities of American National Standards Committee MD156 in the formulation and evaluation of needed test methodology in the laboratories of the Council.*

Reports of Complaints and Defects in Dental Materials and Devices: The complaint reporting program of the Council has assisted members in settling complaints with industry in numerous areas and has been well received. Since the 1975 annual report, 430 complaints have been received. Included are many complaints regarding nondelivery of prepaid materials and requests for refunds. Other complaints involve delays and inconveniences of repair service and overcharges. The handpiece devices and water syringes in dental units are the source of a few complaints. Additionally, complaints include dental operating chairs, x-ray machines, dental laboratory service, u-v light, amalgam capsules, saliva ejectors, impression materials, and x-ray darkroom equipment. In every instance the manufacturer or supply company has been asked to review the circumstances with respect to the problem involved. The Council is now reviewing these complaints hoping to be able to pinpoint trouble areas associated with the clinical performance of the materials and devices used in dentistry.

Ultraviolet Light in Dentistry: The Council, in cooperation with the Bureau of Radiological Health of the Food and Drug Administration, continued its review of the use of ultraviolet activator lights in dentistry as well as materials and techniques used with these lights. After determination that approximately 95 percent of the ultraviolet activator lights had been modified in accordance with the request of the Council and FDA to eliminate all unnecessary emissions as outlined in the 1975 annual report of the Council, the Council reinstated the acceptance of products used with the ultraviolet activator light under Council programs.

The Council completed and published a series of guidelines and recommendations concerning the use of ultraviolet radiation in dentistry (*JADA* 92:775 April 1976). The guidelines include discussions of the ultraviolet spectrum, hazards from indiscriminate use of the entire spectrum of ultraviolet radiation, the useful area of the spectrum in dentistry, *contraindications to use of ultraviolet radiation and specific precautions to minimize exposure so that only the amount and type of ultraviolet radiation necessary to accomplish the clinical procedure are used.*

Implants: The Council cosponsored a conference on endosseous implants with the Council on Dental Research in December of 1975. The chief purpose was to develop a scientific mechanism for the collecting of clinical data at various stages: patient selection, surgery, placement of implant, and postoperative. The goal of the conference was reached. The specific data to be recorded with criteria to evaluate such data have been finalized and forwarded to all participants for review before publication.

The Council reviewed its position statement on endosseous implants and was of the opinion that they still require continuing scientific review. To assist in this review the Council published a clinical reporting form on use of implants. *Information derived from the centralized collection of such data should be of assistance in submitting documented reports to the Food and Drug Administration concerning the use of implants in dentistry.*

Labeling of Dental Materials: The requirement for a clear date of manufacture on products accepted by the Council has been instituted.

The Council is also considering a requirement of content disclosure in the labeling of all dental materials with priority to be given to the various casting alloys used in dentistry. *This requirement would assist the dentist and the dental laboratory in distinguishing between terms such as noble metal based alloys, semiprecious alloys, nonprecious alloys and base metal alloys, and assist in selection of desired products.*

Partially Prefabricated Dentures: The Council continued to review submissions concerning the safety and effectiveness of the partially prefabricated dentures. The Council has been assisted by the Federation of Prosthodontic Organizations in its review. The Council is of the opinion that sufficient evaluation of products and techniques has not been accomplished. Adaptation of the physical configuration of prefabricated dentures to a variety of patients, occlusal relations, tooth position over the ridge, dimensional stability, deterioration of the denture, irritation, monilia infection, or other possible changes should be investigated before reconsideration of the Council's position can be made. *On the basis of available knowledge, the Council does not presently recognize the partially prefabricated denture as suitable for the prosthodontic treatment of patients.*

Mercury Hygiene: The Council continued its review of this area and published a recommended semiquantitative mercury vapor survey procedure based upon a "film badge indicator" (*JADA* 91:610 Sept 1975). The Council's Division of Evaluation and Standards Development is preparing standards and samples of the indicator to be available upon request.

The 1975 House of Delegates adopted the following resolution with respect to mercury contamination in the dental operatory (*Trans.* 1975:742):

> Resolved, that the Council on Dental Materials and Devices of the American Dental Association recommend certain basic requirements and standards to the manufacturers of mercury and the manufacturers of both manual and mechanical instruments and devices used in handling mercury in dental offices to prevent spillage and contamination.

The Council has implemented the resolution by the establishment of new projects in ANSC MD156 to formulate standards for mechanical amalgamators, capsules, and proportioners. Drafts of such standards were reviewed at meetings of ANSC MD156 Subcommittees on March 24, 1976.

Federal Legislation, Medical Devices Amendments 1976: The device legislation discussed in the previous report of the Council passed both the US Senate in 1975 and the US House of Representatives in 1976. At the time of preparation of this report conference committee hearings on the Senate bill S.510 and the House companion bill H.R.11124 had been completed. It is the understanding of the Council that the final bill contains the inclusion of the dentist in the exemption sections of the bill related to prescription or fabrication of custom devices. The Council supports in principle the *major provisions of H.R.11124 of premarket clearance or scientific review, of standards development, and of general controls to further regulate medical devices since they are in agreement with standardization and evaluation programs of this Council which are intended to show safety and effectiveness of dental materials, instruments, and equipment.* Of the three control categories specified in the legislation the most critical control category appears to be that of physical and chemical standards. H.R.11124 provides for recognition of standards-setting organizations such as represented by the Council to establish needed standards in the future.

FDA Review and Classification Panel for Dental Devices: The Panel has completed its preliminary recommendations of control categories for existing dental products. En-

dosseous and subperiosteal implants, over-the-counter reline and repair kits for artificial dentures, and cyanoacrylates have been placed in the scientific review category—the area of most stringent regulatory control. For the 94 (160 products) generic areas of products placed in the second control category—standards, 29 Association standards exist with work nearing completion on 19 additional products. New projects for additional standards have been initiated during this period as indicated at a later point in this report. The remainder of dental materials, instruments, and equipment (160 products) will be controlled by good manufacturing practices, record-keeping requirements, labeling, and other general controls. The Panel will be required to review and make final recommendations after passage of the legislation.

"Guide to Dental Materials and Devices": The eighth edition of the *Guide* (1976-1977) will be published as one volume but the next edition will be rewritten as a two volume publication.

Evaluation Programs for Dental Materials and Devices: The Council continues to expand its programs of evaluation.

Acceptance Program: The Council included alloys of low noble metal content to extend coverage to all casting alloys. Since May 1975, the Council's actions resulted in the classification, reclassification, or renewal of classification of four powered toothbrushes, four denture adherent preparations, ten composite restorative materials, five pit and fissure sealants, three carboxylate cements, two treatment reliner materials, two resilient reliner materials, one accessory device for x-ray machines, two ultrasonic scaling devices, and one nitrous oxide-oxygen sedation device.

Certification Program: Since May 1975, certifications were accepted for 49 new materials which were added to the List of Certified Dental Materials and Devices. Thirty-five products were reevaluated and accepted in surveys. Samples of 34 products are in the process of being evaluated in the continuing survey program of the Council. New certifications for 14 materials are also in progress. There are approximately 800 materials now on the List.

The House approved (*Trans.* 1975:742) a seal or logo to indicate full acceptance of a product or acceptance of a certification which can be used by the dental industry to indicate participation in one of the Council programs. The illustrated seals along with the rules for use have been published (*JADA* 92:706 April 1976).

The Council has deleted the requirement in the section titled "Procedure for Submitting a Certification" in its Certification Program which requires the testing of a foreign product by a United States distributor when a certification is submitted by a foreign manufacturer. This change will recognize the increased adoption of international specifications in many countries and will avoid the duplication of testing facilities. The program will still require that a distributor in the United States be responsible for filing the certification and for checking the continued compliance of the product with the applicable specification.

Status Reports: These informative reports are intended to guide the members of the profession as to the safety and effectiveness of old and new products, of techniques of handling or processing materials, and to give specific recommendations regarding hazards in use of products or techniques. The Council published reports on newer

dental amalgams, pontics in fixed prosthesis, rapid processers for x-ray film, salvage of precious metal scrap, precision attachments, composite restorative materials, guidelines on use of ultraviolet radiation, hazards of asbestos in dentistry, and polyether impression materials. Reports are under preparation on endodontic instruments and materials, diamond rotary instruments, specific types of articulators, low gold-containing casting alloys, proper handling of base alloys, and porcelain-metal systems. The Council has published over 70 such reports since it was established in 1966. Copies of the reports are available upon request to the Council.

Advertising and Exhibiting of Dental Materials and Devices through Association Media: Council members, consultants, and staff reviewed approximately 500 pieces of advertising copy in assisting the Office of Advertising Review. All industrial exhibits for the annual session in Chicago in 1975 were also reviewed for acceptance prior to the opening of the session. All advertising copy and exhibit of products must conform to the Association's Advertising and Exhibiting Standards.

Division of Evaluation and Standards Development: The Division continued its evaluation of retail samples of materials certified as complying with specifications of the Association. The evaluation and/or development of test methods during this period included a creep or dynamic flow test for dental amalgam, thermal expansion instrumentation, acrylic resin teeth, dental abrasive materials, rotary cutting instruments, and a mercury vapor detection test.

Examples of ongoing projects include the corrosion and tarnish of dental amalgam, gypsum materials, the mechanism of cutting and performance testing of rotary cutting instruments, and the semiquantitative test for mercury vapor.

Corrosion and Tarnish of Dental Amalgam: The study of corrosion and tarnish mechanisms of metallic dental materials and the development of test methodology to simulate in vivo tarnish and corrosion behavior is in progress. Preliminary work in this area involved the characterization of the tarnish and corrosion behavior of various dental amalgams of different metallurgical and particulate nature. The techniques employed for evaluation of the corrosion tarnish resistance were potentiostatic polarization measurements and immersion tests in saline and sulfide-containing electrolytes. Optical microscopy, scanning electron microscopy, and electron microprobe analysis have been used to characterize the corroded or tarnished surfaces and the corrosion products. Preliminary results of both immersion tests and potentiostatic polarization tests indicate that the sulfide tarnish resistance of dental amalgams is impaired by the addition of copper. *This is significant because alloys containing amounts of copper as high as 30 percent are available.* Data obtained agree with previous chemical investigators observations that high copper-containing silver-tin amalgams are susceptible to tarnish. At this stage, it appears that a correlation may exist between in vivo corrosion or tarnish effects and the present laboratory results.

Gypsum Material: It was determined that the requirement as stated in Federal Specification US 00746C is unrealistic in terms of clinically acceptable dental stone products currently available and that the maximum setting expansion limits should remain as stated in American National Standard MD156.25 (American Dental Association Specification No. 25) for Dental Gypsum Products. *The Defense Medical Materiel Board has accepted this recommendation and revised the federal purchase specifica-*

tion giving recognition to the American National Standard formulated by the consensus method.

Mechanism of Cutting and Performance Testing of Rotary Cutting Instruments: The study of the mechanism of cutting at high speeds and the development of methodology for testing the cutting effectiveness and wear life of dental burs continues. *Information derived may result in a redesign of cutting instruments for a higher degree of effectiveness at high speeds of rotation.*

Semi-Quantitative Test for Mercury Vapor: A semiquantitative test for mercury vapor in air was evaluated. It was found that $PdCl_2$-impregnated filter paper changes color, from an off-white color to a grey or black color, when exposed to air containing mercury vapor. At this time no correlation between mercury vapor concentration in air and degree of darkening has been made. The test is useful, however, in that one may be able to detect the presence of mercury in air. *In this regard the test may find application in a dental office to serve as an indicator of a mercury vapor hazard, i.e. if the $PdCl_2$ filter paper disc turns grey the dentist could suspect that he has mercury contamination with a health problem.*

Standardization Activities: The Council continues to function as the sponsor of national standardization programs (ANSC MD156), to act as the secretariat of a working group in international standardization of denture materials (ISO/TC106/WG2), to maintain liaison with the American Society of Testing and Materials Committee F-4 on Surgical Implants, and to maintain liaison with standardization programs of the *Fédération Dentaire Internationale*.

American National Standards Committee MD156 for Dental Materials and Devices had a total of 47 active projects during the reporting period with new programs initiated on amalgamators, mercury-alloy capsules, mercury-alloy proportioners, oral hygiene devices, electrosurgical equipment, casting machines, gas furnaces, units, and chairs. This is a cooperative program between the dental profession, the dental industry, dental schools, governmental agencies, and others working to provide needed standards in dentistry. Projects initiated during the current period reflect the concerns of the 1975 House of Delegates and the Federal Food and Drug Administration's Panel on Review and Classification of Dental Devices. Projects during this period resulted in final adoption of new specifications for hand instruments, composite restorative materials, endodontic files and reamers, and nonprecious alloys for orthodontics. Substantial progress was also made in the formulation of five additional new specifications including those for syringes, electrosurgical equipment, pit and fissure sealants, and abrasive systems. The new standards for syringes and electrosurgical equipment should be completed in 1976. Revisions were completed for the existing specifications for alloy for dental amalgam and for carbide burs. Revisions of five other existing specifications should be completed in 1976. The Council also reviewed and reaffirmed 11 existing specifications during this period.

Several Council members and staff participated in meetings of ANSC MD156 in Chicago, February 1976; in Miami Beach, March 1976; and in meetings of the FDI Commission on Dental Materials, Instruments, Equipment, and Therapeutics in Chicago, October 1975. The Council co-hosted, with the American Dental Trade Association and the Dental Manufacturers of America, the meetings of ISO Technical Committee 106 with the *Fédération Dentaire Internationale* at the Headquarters Building during November 1975. Over 130 delegates from 13 countries and the FDI

participated. During its ten years of work, the Technical Committee has produced 20 International Standards. Approximately half of these are based upon American Dental Association Specifications. An additional nine draft International Standards were completed at the November 1975 meeting. The United States participates in the work of ISO through sponsorship of the Council and by annual contributions of the Association to ISO through the American National Standards Institute. Only by the active participation of the profession in the United States in the formulation of high quality International Standards can the dentist and patient be assured of high quality domestic and imported materials.

The Medical Devices Standards Management Board of the American National Standards Institute (ANSI) has completed its second year and in February 1976 undertook the encouragement of formulation and the coordination of needed standards programs in all areas of medical devices including dental in the U.S. based upon the recommendations of the 14 Review Panels of the FDA's Bureau of Medical Devices and Diagnostic Products. The Council's Secretary was reelected Chairman of the Board for 1976.

Tribute to Dr. Floyd A. Peyton: Dr. Peyton retired as Chairman of American National Standards Committee MD156 for Dental Materials and Devices at the end of December 1975. The Council as well as all members of the American Dental Association have benefited from the contributions that have been made by Dr. Peyton in the development of specifications for dental products. Dr. Peyton was the first chairman of the Dental Materials Group of the International Association for Dental Research. The Dental Materials Group which was founded in 1938 was formed primarily to bring together all areas of interest to arrive at standard test methodology to evaluate dental products. Dr. Peyton served in many capacities in the Specifications Committee of the Dental Materials Group, a committee formed in 1953 as a special consulting body to the American Dental Association in development of specifications. He served as Chairman of that committee from 1964 until 1969 when the American National Standards Committee MD (Medical Devices) 156 for Dental Materials and Devices sponsored by the Council was formed under the auspices of the American National Standards Institute. Dr. Peyton then was appointed Chairman of the new committee by the Council and has served in an outstanding manner during the past six years. The adoption of American Dental Association specifications as American National Standards through the efforts of Dr. Peyton and the subsequent adoption of these American National Standards as International Standards has established a firm foundation for high quality dental materials and devices throughout the world.

The Council recommends that Dr. Floyd A. Peyton be cited and recognized by the American Dental Association during the 1976 annual session for his meritorious contributions toward the increased quality of dental products throughout almost 40 years of research and for his administrative accomplishments in leading dental standards development in the United States since 1964.

Radiographic Materials, Equipment, and Practice in Dentistry: A survey of state regulations and codes concerning use of radiation was continued and a joint report between the Council on Legislation and the Council on Dental Materials and Devices is being planned. This will update a previous joint report made in 1968 by the two Councils.

Dental Laboratory Technology Program: This program was activated in 1975 to expand the Council's programs concerning materials and devices used in dental labora-

tory technology. The program will consist of preparation of standardized technique manuals, research on various products and techniques, handling of complaints from dental laboratories, and cooperation in the standards development program with American National Standards Committee MD156.

Visits have been made to eight dental laboratories in the Chicago area in efforts to complete a questionnaire concerning opinions and problems experienced relative to the porcelain-fused-to-metal systems. The information gained is being used to develop handling technique recommendations. The preparation of a quality control card to obtain information to identify weaknesses of specific products is being investigated.

Other Activities: Council staff attended and/or presented papers at 15 meetings not discussed or listed elsewhere in this report. In addition, there were two trainees—one from Mexico and one from Brazil—participating in laboratory programs.

Publications: There were 29 publications of the Council and staff during the reporting period and 15 other bulletins or reports prepared. The Council publications were largely revisions of and new specifications of the Association, revisions and supplements to the Lists of Certified and Classified Dental Materials and Devices, and status or informative reports. The majority of the published reports appeared in the Reports of the Council and Bureaus Section of *The Journal of the American Dental Association*. The list of published status, informative, or original research reports follow:

1. Mercury vapor levels in dental offices: a simple semiquantitative test. *JADA* 91:610 September 1975.
2. Acceptance program for rapid processing devices for dental radiographic film. *JADA* 91:611 September 1975.
3. Pontics in fixed prosthesis (a Council report prepared by Dr. D. R. Gratton). *JADA* 91:613 September 1975.
4. Status report on silver amalgam (a Council report prepared by Dr. G. J. Christensen). *JADA* 91:618 September 1975.
5. American Dental Association standard for dental terminology. *JADA* 91:853 October 1975.
6. Precious metal scrap: what it is and how to handle it. *JADA* 92:434 February 1976.
7. Sarkar, N. K.; Leonard, R.; Fuys, R. A., Jr.; and Stanford, J. W. Surface and interface corrosion of dental amalgams. *J Dent Res* 55:B285 Abstract 892 February 1976.
8. Sarkar, N. K.; Fuys, R. A., Jr.; and Stanford, J. W. The effect of copper on the sulfide tarnish resistance of dental amalgams. *J Dent Res* 55:B285 February 1976.
9. Status report on precision attachments (a Council report prepared by Drs. R. J. Goodkind and J. L. Baker). *JADA* 92:602 March 1976.
10. Composite restorative materials: some clinical suggestions for their use (a Council report prepared by Dr. G. T. Charbeneau). *JADA* 92:606 March 1976.
11. Guidelines on the use of ultraviolet radiation in dentistry. *JADA* 92:775 April 1976.
12. Hazards of asbestos in dentistry. *JADA* 92:777 April 1976.
13. Stanford, J. W. Consumer protection role of the Council on Dental Materials and Devices and its relationship to the FDA. *I.U.S.D. Alumni Bulletin,* Fall 1975 p 4, and *Conn Dent J* 50:63 April 1976.

RESOLUTIONS

This report is informational in nature and no resolutions are presented.

Council on Dental Research

Meetings: The Council met in the Headquarters Building, Chicago, on January 15-16, 1976. Dates for future Council meetings were selected as follows: February 17-18 and July 7-8, 1977.

Grants and Contracts: One of the Council's most successful programs, "Traineeships in Dental Research for Prebaccalaureate College Students," was inactivated in its twelfth year on December 31, 1975. Major support for the program stemmed primarily in the form of a training grant (DE 00162) from the National Institute of Dental Research. During the 12-year period, a total of 375 students were trained in 50 different institutions under the tutelage of 65 host scientists at a total cost of $665,145. The training grant was terminated as a result of enactment of the National Research Act which prohibits the National Institutes of Health from funding research training at the prebaccalaureate level. The last survey of the trainees showed that about 30 percent had either enrolled or graduated from dental school, 33 percent medical school and 37 percent were either seeking or had obtained a doctorate in the basic sciences.

Comment: The Council has been unable to find an alternative funding agency for support of the program in 1976. The inflation has had a detrimental effect on obtaining new funds for the program because of spiraling costs. For instance, the average cost per trainee during the period 1964-1967 was approximately $1,450. For the years 1972-1975 the average cost per trainee had risen to $2,125. It is estimated that the average costs per student for the period 1976-1979 would be well over $2,800 per year. The Council will appraise the situation during its July 1976 meeting.

The Council wishes to sincerely thank the host scientists who contributed so much of their valuable time and effort in making the program a success. The Council also wishes to acknowledge the wisdom of the National Institute of Dental Research for its interest and wholehearted support.

Liaison Activities with the Components of the ADA Health Foundation: In accordance with the *Bylaws,* the Council was most pleased to receive and evaluate status reports from the component directors of the Foundation, namely, the Research Unit, Na-

tional Bureau of Standards and the ADA Research Institute, Chicago. Council members were most appreciative and impressed with the breadth and scope of their diversified programs, the unique talents and professional reputation of the respective staffs, the number of scientific papers and presentations delivered, the sophisticated equipment available for use by the staff in conducting this research, and especially, the total amount of extramural, non-hard money funds obtained from competitive sources by the scientific staff for support of their respective programs ($625,000). Council members recommended that because of the spiraling costs for support of research it would be most prudent and highly appropriate for the two components of the Foundation to merge their talents and initiate several collaborative studies wherein one facility could complement the other in terms of scientific expertise and mutual use of sophisticated instruments. Such collaborative efforts might prove to be highly effective, especially in the area of clinical trials of materials and techniques now being developed or evaluated by the Foundation. Additional discussions and further planning will take place in July of 1976.

The Council served in other capacities with the Foundation. The Council Chairman and Secretary served as members of the ADAHF Research Institute search committee to obtain a new director for the Institute. During this interim period, the Council Secretary served as Acting Director for the Institute. The Council Secretary also serves as director of the Biomedical Research Support Grants program of the Health Foundation.

Activities with National Research Organizations: The Council maintains close rapport with various agencies concerned with the conduct, promotion and support of Dental Research.

ACTIVITIES WITH THE FEDERAL GOVERNMENT

New Construction for the National Institute of Dental Research (NIDR): Dr. Wallace Armstrong, Acting Director of the NIDR intramural research programs, presented the NIDR plans for expansion of the present clinical and laboratory facilities. Council members agreed that the need for additional space was acute because the current shortage has caused a detrimental effect on the total research program. Council members recommended that the Association vigorously support the NIDR in its forthcoming request to the National Institutes of Health for funds covering the costs of new construction. This recommendation has been forwarded to both the Council on Legislation and the Washington Office for their information and subsequent evaluation.

Impact of New Regulations Concerning Dental Schools—Eligibility for Biomedical Research Support Grants Support: The Council was informed that 12 of the 34 dental schools receiving such support have become ineligible for these funds in 1976 because of the recent increase in eligibility requirements. The amount in research grants that a school must be receiving from the NIH to qualify for the program has been raised from $100,000 in 1975 to $200,000 in 1976. Council members stated that such action defeats the total purpose of the program, namely, to provide a mechanism for expansion of the school's research capabilities. Council members urged that the Association recommend to appropriate authorities that the previous eligibility level of $100,000 be restored, and at the same time, maintain support for the total viability of the program. Following this recommendation, the Council secretary wrote to the deans of all dental schools, requesting that they support this recommendation through correspondence with the Division of Research Resources, National Institutes of Health. At the time of this report, 23 schools have responded to this recommendation.

Council Participation with NIH Grants Peer Review Study Team: The Council was invited by the NIH Study Team to present advisory comments concerning the current system used by the NIH for review of research grant applications. The Council Secretary was directed to pre-

pare written testimony for presentation during an open hearing in Bethesda on February 26, 1976. The statement supported the present concept that review by one's peers of a research grant application was a highly adequate and effective mechanism. Several additional constructive suggestions were offered to the team.

Protection of Human Subjects as Related to the National Research Act: Mr. Rodney J. Schaid and the Council Secretary informed the Council of new and proposed regulations concerning the use of human subjects in clinical investigations. Of particular interest for all clinical studies, the informed consent of each patient, regardless of the degree of risk involved, must be obtained before the subject participates in the study. It was also recomemnded that Study Clubs appoint a "Protection of Human Subjects Review Committee" for evaluation of any proposed research. The Council will issue an advisory report to the profession when all information has been properly collated.

The Council maintained active liaison with the research components of other federal agencies, namely the Department of Defense, the Department of Commerce, and the Veterans Administration.

ACTIVITIES WITH NONFEDERAL RESEARCH ORGANIZATIONS

The Council continues to maintain close liaison with the National Research Council, the American Association for Dental Research, the American College of Dentists, and the American Association for the Advancement of Science.

The Council follows the progress of dental research on an international basis by participating directly in the activities of the *Fédération Dentaire Internationale,* the European Organization for Caries Research (ORCA), and the International Association for Dental Research.

The Council also maintains close liaison with either the deans or directors of research in all dental schools in matters relating to research policy, legislation, training and program priorities.

New Council Responsibilities: As the responsive agent to the Association for the evaluation of new concepts, procedures, and techniques whenever they are being promoted by others for use by the membership, the Council updated its current advisory position statements and is preparing three additional reports concerning Genetic Counseling Procedures, Psychoneurosis and Suicide Rates in Dentists, and Long-Term Effects of Municipal Fluoridated Water Supplies.

This newly assigned responsibility permits the Council to collaborate and support various related programs of the Council on Dental Materials and Devices, the Council on Dental Therapeutics, the Bureau of Economic Research and Statistics, as well as the Bureau of Public Information.

American Association for the Accreditation of Laboratory Animal Care (AAALAC): The Association has supported the AAALAC Accreditation Program since its inception 11 years ago by encouraging all dental institutions to obtain certification of their respective animal facilities. Basically, the program of accreditation consists of a self-improvement effort employing the accepted peer review method of evaluation. This effort has significantly raised the level of laboratory animal care in medical, dental, and private facilities and thereby has contributed to improved quality of research conducted in these accredited facilities. The program, in addition, has been an important factor in deterring restrictive legislation aimed at biomedical and dental research by informing a concerned public that accredited animals used in research are receiving optimal care. Institutions accrediated by AAALAC represent over half of the entire animal population in the United States that are used for research purposes.

Research Priorities as Determined from Membership Survey: In the Fall of 1976, a survey will be conducted of 1,400 clinicians who limit their practice to a recognized specialty. The questionnaire will ask only one question:

> In your day-to-day treatment of patients, what techniques, concepts, procedures, and materials should be improved by research in order to provide better standards of dental care?

The results will then be subjected to statistical analysis and compared with the 1975 survey for the establishment of priority research programs of high clinical relevance.

50th Anniversary of the ADAHF Research Unit, National Bureau of Standards: Dr. Walter Brown, director of the Research Unit, informed the Council that the 50th anniversary of the ADAHF Research Unit at the National Bureau of Standards would be celebrated in 1978. Council members recommended that initial plans for celebrating this important event should be formulated during the July 1976 meeting of the Council.

RESOLUTIONS

This report is informational in nature and no resolutions are presented.

Council on Dental Therapeutics

Meetings: A meeting of the Council was held in the Headquarters Building, Chicago, on February 5-7, 1976. In attendance in addition to the Council members and staff was Dr. Eugene A. Savoie, trustee of the 14th District, and Dr. George Wade, Division of Dental and Surgical Adjuncts, Bureau of Drugs, the Food and Drug Administration. Dr. David S. Topazian served as vice-chairman of the Council for 1976.

At the February meeting, the Council was primarily concerned with revisions to be included in the 1977-78 edition of *Accepted Dental Therapeutics*. The Council also took the necessary action to implement Resolution 808 of the 1975 House of Delegates (*Trans.* 1975:744) regarding a change in Provision IX, Chemicals Proposed for Disinfection of Instruments, of the *Provisions for Acceptance of Products*. Other topics for discussion included agents used in endodontic techniques, local and topical anesthetic preparations, and methods to assure safe dispensing of fluoride products in the home environment.

A second meeting of the Council was held on June 10-11, 1976. The Council reviewed the proposed revision of the pamphlet, *Management of Dental Problems in Patients with Cardiovascular Disease*, which is sponsored by both the American Dental Association and the American Heart Association. The Council's discussion also included the topics of non-cariogenic sweetening agents and agents used in gingival retraction. A number of new dental product submissions to the Council were reviewed.

"Accepted Dental Therapeutics": The 37th edition of *Accepted Dental Therapeutics* is scheduled to become available in February 1977. The revision will incorporate those changes the Council believes indicated following its thorough and critical examination of the objectives and organization of the book. Drug monographs will be presented in the light of current scientific information and the section on local anesthetics will be updated, expanded, and reorganized. The latest information on prevention of oral disease and on nutritional factors in dental health will be included. Continued emphasis will be placed on the desirability of recognizing the total health status of the patient and the need for anticipating and preventing the development of emergency situations will be stressed.

Acceptance Program: The Council directed much of its activity toward the evaluation of therapeutic agents of interest to the dental profession. During the past year, the Council accepted approximately 35 new therapeutic agents or brands of these agents. During the same period, approximately 130 previously accepted products were reconsidered and reclassified.

Liaison with the American Heart Association: The Council continued to cooperate with the American Heart Association in a number of areas of mutual interest. The Council has dental representation on the Committee on Rheumatic Fever of the American Heart Association. This Committee is responsible for the preparation and publication of *Prevention of Bacterial Endocarditis.* Although this was recently revised, meetings are held periodically to consider interim need for revision.

Council representatives and the Committee on Medical Education of the American Heart Association are completing the revision of the pamphlet, *Management of Dental Problems in Patients with Cardiovascular Disease.* The revised pamphlet, originally published in 1964 as a report of a working conference jointly sponsored by the American Dental Association and the American Heart Association, will likely become available late in 1976.

Liaison with American Pharmaceutical Association: The American Dental Association continued its biannual meetings with representatives of the American Pharmaceutical Association. Agencies of the Association cooperating in this liaison are the Council on Dental Therapeutics, Council on Dental Materials and Devices, and Council on Dental Health as well as the Bureau of Public Information. The purpose of these meetings is to explore areas of mutual interest to the two Associations.

The liaison meetings have served to develop procedures to inform the pharmacist on matters relating to oral health. These procedures have involved the promotion of oral health centers in pharmacies, as well as the development of a series of lectures and slide sets related to oral health and disease for use both in the curriculum of schools of pharmacy and continuing education courses for the pharmacist.

Activities with Governmental Agencies: The Council on Dental Therapeutics continues to maintain close contact with the Food and Drug Administration in areas of mutual interest. A member of the staff of the federal agency serves as an official liaison representative to the Council and regularly attends its meetings. Members and staff of the Council also serve on dental advisory committees to the Food and Drug Administration.

Staff members also serve in an advisory capacity to the Caries Task Force established by the National Institute of Dental Research.

Contact is also maintained with the Federal Trade Commission on matters relating to the advertising of products which may affect oral health. This includes foods as well as over-the-counter drugs which may play a role in causing or preventing oral disease.

Council representatives meet biannually with representatives of other prescribing professions and representation of the Drug Enforcement Agency to discuss matters pertaining to the control of drugs subject to abuse. The federal agency provides information concerning special problems of drug abuse as well as special situations of drug control which relates to the prescribing profession. The agency also seeks information,

insight, and guidance in dealing with problems and drug use which may be peculiar to the prescribing professions.

Staff Activities: The routine activities of Council staff include participation in the review of all advertising related to products accepted by the Council as well as advertisements for numerous other related items not specifically included within the scope of the Council's program. Although this overall responsibility for review of advertising resides in the Office of Advertising Review, the claims for products made must be limited to those acceptable to the Council. Staff also frequently reviews and comments on copy for brochures, articles, and films on oral health produced by commercial organizations as well as by the Association. Members of the staff have been participating in conferences and other areas related to preventive dentistry, fluoridation, and drugs of dental interest. They also serve on the committees of the Food and Drug Administration, American Heart Association, American Cancer Society, American Society of Hospital Pharmacists, and American Pharmaceutical Association.

Inhalation Anesthetics: The Councils on Dental Research, Dental Therapeutics, and Dental Materials and Devices are concerned with various aspects dealing with potential hazards from prolonged exposure of dental professional personnel to high concentrations of inhalation anesthetics. The Association has established an ad hoc Committee on Trace Anesthetic Gases to determine whether there is a potential health hazard to the dentist, his wife, and auxiliaries who are exposed to anesthetic gases such as nitrous oxide and to make appropriate recommendations to the Board of Trustees. Subcommittees on Information, Devices and Control, Survey, and Criteria Document have been established. The Subcommittee on Information will serve to provide the public and profession with information on the problem; that on Devices and Control will concern itself with reports of monitoring and scavenging devices used to keep gases on acceptable level; the Committee on Survey will consider the need for and the conduct of a survey of the dental profession to investigate a relationship of diseases to anesthetic gas inhalation; and the Committee on the Criteria Document will maintain communications with various governmental regulatory agencies to provide dental "input" into any criteria documents and standards that may be established.

Hepatitis Workshop: On June 5, 1975, the Council conducted a workshop on viral hepatitis as related to dental practice. Outstanding authorities in the field were invited to help delineate the role of the dentist and other dental personnel in the prevention of the transmission of viral hepatitis infections. The information gathered at this workshop was published as a Council report in the January 1976 issue of *The Journal* (*JADA* 92:153 January 1976). The carrier state, the prevalence of the disease in dentists, and its transmission and possible prevention are discussed in this paper in a question-and-answer format.

Simplified Endodontics: Representatives from the Councils on Dental Therapeutics and Dental Research met with representatives of agencies having an interest in the endodontic treatment of teeth to identify problem areas and explore approaches to resolve them. The meeting resulted in agreement that a protocol for an animal toxicity study would be developed with the help of qualified experts so the results of of these studies can be considered valid.

Health Screening Program: A total of 1,390 dentists participated in the Health Screening Program. It was the ninth such program conducted in the past 11 years.
Tests and examinations provided were:

1. Clinical pathology: (a) calcium; (b) inorganic phosphorus; (c) total protein; (d) albumin; (e) total bilirubin; (f) alkaline phosphatase; (g) lactic dehydrogenase; (h) transaminase; (i) blood urea nitrogen; (j) serum cholesterol; (k) blood sugar; (l) uric acid
2. Computerized electrocardiogram
3. Digital and visual examination of oral cavity, head, and neck
4. Panorex radiographs of the head and jaws
5. Tonometry and visual acuity
6. Podiatric examination

The Health Screening Program will again be available at the 1976 annual session in Las Vegas.

Periodontal Pathology Research Center: The Periodontal Pathology Research Center, a joint effort of the American Dental Association and the American Academy of Periodontology, has completed its eighth year of activities. The Center has processed all of the materials available to it into teaching aids which can be obtained on loan by individuals or teaching institutions.

In the earlier phase of its existence, materials were requested for the purpose of creating teaching aids related to the histopathology of periodontal tissues. The processing of materials donated by various individuals was facilitated by funds from Philip Morris, Richmond, Virginia.

New loan sets are being prepared on oral histopathology and will be completed by the end of 1976. Existing materials will be revised and updated whenever possible. If certain sets become outdated without the possibility of proper revision, it may be necessary to withdraw them from circulation. More than 1,200 loan requests have been filled to date and most sets are in continuous use.

Division of Chemistry: The Division of Chemistry reviews products submitted to the Council as part of the Acceptance Program. This includes a technical review of the product and its ingredients, and the tests and standards proposed for them. Laboratory analyses are periodically done of products accepted by the Council and purchased from the open market as well as in some products that have not been submitted to the Council but are of interest. The extent of the latter two types of analysis has been restricted because of limited staff.

The Dentifrice Program has continued with considerable activity. The report of the Laboratory Abrasion Committee on procedures for the laboratory evaluation of dentifrices will appear in *The Journal of Dental Research*. This report will include an evaluation of the methodology by two collaborative studies with six participating laboratories. The complete Statistical Committee report on these studies will be available on direct request.

The Clinical Cleaning Committee has conducted a dentifrice cleaning study in Bloomington, Indiana with 350 subjects. Three dentifrices were manufactured in the laboratory so that the dentifrice characteristics such as flavor, consistency, and mouth

feel were identical but the abrasivity label was set at low, moderate, and higher levels. Three clinical methods were employed by three separate dental clinicians to grade the stain levels at 0, 2, 4, and 8 weeks of brushing with the test dentifrices. Before the study started, each subject brushed with a very low abrasivity dentifrice to help build up a level of tooth stain. The data is now being analyzed.

Acknowledgements: The Council wishes to express its sincere appreciation to Dr. N. Wayne Hiatt for his service on the Council.

RESOLUTIONS

This report is informational in nature and no resolutions are presented.

Council on Federal Dental Services

Meeting: The Council met in Washington, D.C. on May 17-18, 1976 with all members present. Other Association officials attending the meeting were Dr. Joseph P. Cappuccio, Fourth District Trustee, and Dr. C. Gordon Watson, ADA Executive Director. The federal dental services and government officials were represented at portions of the meeting by Major General S. N. Bhaskar, United States Army Dental Corps; Brigadier General Robert L. Thompson, Jr., United States Air Force Dental Service; Rear Admiral Robert W. Elliott, Jr., United States Navy Dental Corps; Dr. John C. Greene and Dr. Jack Robertson of the Public Health Service, Department of Health, Education, and Welfare; Dr. Dan Floyd, Veterans Administration; Dr. Robert Mecklenburg, Indian Health Service; Captain Henry J. Sazima, Department of Defense. Gordon Jones, dental student from the University of North Carolina and representing the American Student Dental Association, also attended the meeting as an observer.

Personnel: The Council unanimously elected Dr. Thomas P. Fox as vice-chairman. In addition, the Council acknowledges with appreciation the dedicated leadership and numerous contributions of its retiring chairman, Dr. Joseph R. Salcetti.

Federal Dental Services: Representatives of the federal dental services briefed the Council on developments within their respective departments. In addition, the Army, Air Force, and Navy Dental Corps provided a summary outline of their dental resources and patient care activities for the most recent 12-month reporting period. This information is displayed below.

	Army	Air Force	Navy
1. Active duty dental officers (12-month average)	1,930	1,554	1,755
2. Active duty dental officers in clinical assignments	1,619	1,535	1,725
3. Dental Auxiliaries			
Enlisted	1,240	1,801	2,198
Civilian	1,351	134	196

4. Dental Operatories	3,306	2,219	2,206
5. Patients	3,393,900	N.A.	1,930,618
6. Patient Visits	4,480,712	4,157,999	3,768,783

The Council was encouraged by the efforts of the Assistant Surgeon General for Dental Services to further increase the productivity and improve the management of the Army Dental Corps. Of particular significance was the issuance in April 1976 of new Army regulations which insure that dental officers will be rated by the line officer commander of the Army installation and not, as was previously the practice, by the hospital commander or other medical officers. This change also provides for direct dental representation at all post-staff meetings. Two additional and important new regulations place control over dental corps operating funds, equipment, supplies, and personnel in the Office of the Chief, Army Dental Corps. It is the opinion of the Army Dental Corps that these latter improvements will prevent the diverting of dental resources to nonpatient care activities as has occurred in the past. The Council remains concerned, however, over the extremely low retention rate within the Army Dental Corps. Data provided to the Council indicates that only 6 percent of the dental officers agreed to extend their service beyond the initial two-year obligation period. Overall turnover in the Army Dental Corps now approaches one-third of the active duty officers. The fiscal year 1975 acceptance rate of 86 percent for continuation pay in the Army Dental Corps is also the least favorable among the uniformed services. This compares to the more competitive rates of 99 percent and 98 percent, respectively, for the Navy and Air Force. Despite the low participation rate, the Army Dental Corps has been able to maintain assigned strengths at current authorization levels. The Council expressed a cautious optimism that implementation of the above noted Army regulations would have a positive impact on the recruitment and retention of dental corps officers.

The Air Force reported that continuation pay and accelerated promotions have definitely played an important role in reversing earlier attrition trends in the Dental Corps. Current accessions in the Air Force have, to date, offset the approximate annual turnover rate of 25 percent to 30 percent in the dental corps. Air Force spokesmen indicated that their professional recruitment program has been generally successful in attracting general practitioners to the dental corps. However, the Air Force has not been able to recruit an adequate number of dental specialty personnel. The Air Force Military Construction Program included 26 new dental facilities during the period from 1970 through 1975. Programming since 1973 has been based on new design criteria that includes an expanded ratio of dental treatment rooms per dentist.

The Navy Dental Corps reported no serious problems with respect to recruitment and retention. This is attributed to the following factors: remuneration (special and continuation pay), autonomy of the Navy Dental Corps, and modernization of equipment and facilities. Navy spokesmen have indicated that 82 percent of the Navy Dental Corps effort, as measured in dental procedures, is devoted to active duty personnel. The Council was also informed that the amount of support for Navy Dental Corps facilities is quite satisfactory. In this connection, five dental installations are slated for renovation or replacement in fiscal 1977, four in fiscal 1978, and in fiscal 1980 the remodeling and expansion of the National Naval Dental Center at Bethesda, Maryland. The Navy Dental Corps has begun the development of a new in-house peer review mechanism based largely upon the quality standards utilized by the Cali-

fornia Dental Association. Information on this system will be provided to the Council as it is implemented.

The Veterans Administration currently employs 850 dentists of which all but 17 occupy full-time positions. As a result of the Veterans Administration Physicians and Dentists Comparability Pay Act of 1975 (P.L. 94-123), 94 percent of the Veterans Administration dentists have signed an agreement to extend their service an additional four years. The law authorizes bonus pay of up to $6,750 annually for participating dentists and $13,500 for participating Veterans Administration physicians. Under current Veterans Administration policy, dentists are receiving an average yearly bonus of $3,000 with physicians receiving an average of $7,000 annually. The Veterans Administration was urged to monitor its recruitment and retention patterns in order to ascertain the need for increasing the bonus pay up to the statutory level of $6,750 for dentists as a recruitment incentive. In a separate matter, the Council expressed concern regarding the extent to which reimbursement arrangements between the Veterans Administration and participating dental practitioners accurately reflect the usual and customary fees for dental services in certain states. The Council recommends, therefore, that the Veterans Administration increase its efforts to obtain timely and accurate data on the cost of dental services.

The Public Health Service (PHS) Dental Commissioned Corps strength is currently 635 officers who are serving on active duty in five clinical programs, the Division of Dentistry, the National Institute of Dental Research, and various other programs of the six health agencies which comprise the Public Health Service. Although the total number of applications for commissioned corps positions has continued to exceed the available number of assignments, Public Health Service officials are concerned that applicants have become progressively more selective in the assignments they will accept since the end of the draft. This trend toward increasing selectivity on the part of dental applicants is occurring at the same time as the Public Health Service dental personnel needs have broadened as a result of resignations after one to three years of service, and, program expansions in the National Health Service Corps and Indian Health Service. The attrition rate among junior Public Health Service dental officers has increased significantly in recent years. Several factors, including the proposed closing of Public Health Service hospitals, efforts to abolish the Commissioned Corps, decreased training opportunities, and reorganizations have contributed to this problem. Continuation pay has, however, had a dramatic effect on the retention rate of dental officers who have completed four or more years of service. This is underscored by the fact that 99 percent of Public Health Service dental officers who are offered a contract accept continuation pay.

The Indian Health Service (Public Health Service) budget for dental activities includes 517 positions (198 dental offices), $9.9 million for direct services and $3.2 million for contract services. According to Indian Health Service officials this represents approximately 60 percent of program need. Attrition among dental officers in the Indian Health Service, formerly as high as 38 percent, has decreased sharply. In the opinion of the Council this will ensure a future cadre of experienced mid-career officers for the dental program if this trend continues.

Federal Dental Service Pay: The Council reviewed a number of legislative proposals, administrative actions and regulations affecting the pay of dentists in the uniformed services and the Veterans Administration. One of the most important of these concerns a provision in the Veterans Administration Physicians and Dentists Compara-

bility Pay Act of 1975 which directs the Office of Management and Budget, and the General Accounting Office, to conduct independent studies on the feasibility of instituting a uniform pay system for all dentists and physicians employed in the federal services. The Council complimented the ADA Washington Office for its efforts in alerting the federal dental services to the necessity of developing a coordinated response to these investigative studies. As a result of conferences held at the ADA Washington Office, the federal dental services are developing position papers emphasizing the importance of continuation pay, promotion opportunities, and other incentives in maintaining a viable productive dental service in the climate on an all volunteer service.

In a related action, the Council recommended that the Association formally request the Department of Defense to lower the required years of active service for continuation pay eligibility. A proposed resolution to this effect is appended to the Council report. Under current Department of Defense policy, dental officers must wait five years before they are eligible for continuation pay. It is the opinion of the Council that this delay presents a distinct negative influence on the ability of the services to motivate the young dental officer toward a career in the uniformed services. There is ample evidence of the need for such a change, the Council believes, in the increasing attrition rate which is occurring at the end of the initial period of obligation and, the accompanying effect of the resignations on productivity and procurement costs.

One of the potentially most significant legislative proposals affecting pay reviewed by by the Council is the Defense Official Personnel Management Act (H.R. 7486). For dentistry, the most important provisions in the bill are those which would modify the awarding of "constructive credit." At present, dental and medical officers in the uniformed services receive constructive credit for their years of professional education. These years of credit, generally amounting to four, are added to the number of actual active duty years for purposes of (1) determining entry grade, time in grade, and eligibility for promotion, as well as (2) for computing basic pay and retired pay. As originally introduced, the measure would have reduced from four years to three the number of constructive credit years to which entering medical and dental officers would be entitled and eliminate constructive credit from the formula that is used to determine retired pay. In both instances, however, dental and medical officers who were commissioned prior to the enactment of the legislation would be exempt from the proposed changes. In its review and discussion of the House bill with representatives of the military dental services, the Council received conflicting views on the probable effect on recruitment and retention if constructive credit is not used in computing retired pay. However, it was the unanimous opinion of the federal dental service representatives that any attempt to further reduce or eliminate constructive credit from the base pay formula would have a serious impact upon the ability of the services to attract quality dental officers.

Expanded Duty Dental Auxiliaries: The Council noted that the federal dental services had submitted, in accordance with a House of Delegates resolution (*Trans.* 1973: 726), their annual reports on newly initiated or completed experimental research training programs for expanded duty dental auxiliaries. Although the House of Delegates resolution does not obligate the federal dental services to report ongoing training programs, the Chairman of the Council on Federal Dental Services requested that the Department of the Army submit, for review by the Council on Dental Education, a report on their Dental Therapy Assistant Training Program. In its review

of the program protocol, the Council on Dental Education noted that the scope of functions identified for dental therapy assistants exceeds Association policy. The Council on Federal Dental Services has been advised by the Assistant Surgeon General for Dental Services (Army) that the training of civilian personnel as dental therapy assistants has been suspended. In addition, the Council is informed that civilian dental therapy assistants who resign from the Army will be replaced with dental assistants.

Information provided to the Council indicates, however, that the training and utilization of enlisted personnel as dental therapy assistants will continue under current Army/DOD policy. Because of this the Assistant Surgeon General for Dental Services has been requested to clarify the Army's position on expanded functions and provide this information to the Council on Federal Dental Services.

The Air Force presently trains and utilizes approximately 100 enlisted personnel as expanded duty dental auxiliaries. These auxiliaries function, according to Air Force officials, under the direct supervision of dental corps officers. However the Council is informed that the "placing, carving, and finishing" of restorative materials are included among the procedures delegated to these personnel. The Assistant Surgeon General for Dental Services has indicated to the Council that it is not the intent of the Air Force dental corps to train expanded duty dental auxiliaries for later use in the civilian sector. Rather, these personnel are trained to meet service needs only. The Council understands that the Navy Dental Corps and the Veterans Administration do not, at present, have programs for the training or utilization of expanded duty dental auxiliaries. The Indian Health Service conducts an experimental program to determine the practicality and feasibility of training expanded duty dental auxiliaries. According to information provided by the Council on Dental Education, certain procedures formerly included within the current program have been modified or discontinued to comply with ADA policy.

The Council continues to be concerned over those federal dental service programs for the training and utilization of expanded duty dental auxiliaries which are incompatible with resolutions of the ADA House of Delegates. It is the opinion of the Council that such activities, if allowed to proceed, could result in a dual standard in the quality of dental care rendered; in effect a situation where active duty military personnel and their dependents may receive "second-level dentistry." The Council also believes that the federal dental services concerned should be cognizant of the possibility that continued use of expanded function auxiliaries in the manner now permitted may well prompt federal agency proposals to substitute these personnel for dental officers in future authorizations of strength levels within the military. In summary, the Council wishes to emphasize its view that the federal dental services can, by a more effective use of its present work force of dental officers and through adoption of the more modern productive practices used in the civilian sector, meet the dental needs of its eligible beneficiaries without resorting to expanded duty dental auxiliary programs which exceed ADA policy. A proposed resolution urging the federal dental services to pursue this course is appended.

In a related matter the Council reviewed newly developed "Draft Standards for Dental Therapy Technician Services" now being proposed by the Civil Service Commission. If adopted in their present form, the standards would establish a new category of dental auxiliary for federal employment with duties that exceed allowable functions under ADA policy. It is the Council's understanding that the ADA has been formally requested to comment on the draft standards. The Council wishes to state

its concern over and opposition to the proposed standards. Furthermore, the Council urges the appropriate council/bureau of the Association to place a high priority on developing effective recommendations on this issue for prompt transmittal to the Civil Service Commission.

Dependent Dental Care: Expenditures for dental benefits under the CHAMPUS program have been reduced from a 1975 level of $7 million to the present sum of less than $2 million. The Council is advised that the Department of Defense is developing for a Summer 1976 release, new guidelines for future dental services under CHAMPUS. According to Department of Defense officials, these guidelines would not permit civilian practitioners to render adjunctive dental care, or treat handicapping malocclusions, for dependents who live within a 40-mile radius of a military installation that has the capability for providing such services. In addition, the Department of Defense plans to continue its restrictive definition of eligible adjunctive care as well as impose deductible and coinsurance requirements under CHAMPUS.

The Council recommends that the Association communicate to appropriate Department of Defense officials its concern over the sharp curtailment of CHAMPUS dental benefits. Additionally, the Council suggested that the Department of Defense be encouraged to explore the possibility of a comprehensive program of dental services for dependents utilizing civilian dental practitioners. Recent estimates developed within the Defense Department project the annual federal cost of such a program to be in excess of $120 million. The Council also noted that the ADA-endorsed dependent dental care legislation continues to be opposed by the Office of Management and Budget because of fiscal constraints.

The Department of Defense is also developing new criteria for designating those installations that are authorized to provide routine dependent dental care. At present, 75 of the approximately 440 major continental US military facilities are so designated. Effective in fiscal 1977, the Defense Department will increase from 30 to 40 miles the radius used to determine the availability of civilian dental resources.

Army-Air Force Dental Corps Bill: The Council believes that the Council on Legislation should continue to actively pursue Congressional action on the ADA-developed Army-Air Force Dental Corps Bill (H.R. 3042). In its consideration of Association objectives in this matter, the Council received the views of Major General S. N. Bhaskar who indicated that the recently promulgated Army regulations (noted earlier in this Report) will permit significant improvements in the Army Dental Corps' command authority over its own professional operation, personnel, and material. General Bhaskar pointed out, however, that the Defense Department could at some future date rescind the new regulations. For that reason, General Bhaskar recommended that the essential elements contained in the new Army directives be enacted into federal statute.

Veterans Omnibus Health Care Act of 1976: On February 2, Senator Alan Cranston, Chairman of the Veterans' Affairs Subcommittee on Health and Hospitals, introduced the Veterans Omnibus Health Care Act (S. 2098). The bill is intended, according to its sponsors, to establish statutory priorities for out-patient care eligibility. Veterans seeking treatment for a service-connected disability would, under the legislation, be accorded the highest priority while veterans with nonservice-connected conditions would be eligible on a space available basis.

In remarks accompanying the introduction of the bill, Senator Cranston contended that the rapid expansion of outpatient and ambulatory care provided by the Veterans Administration in recent years has primarily benefited veterans with nonservice-connected disabilities. This has occurred because of the liberalized eligibility requirements provided by the 1973 Veterans Health Care Expansion Act which authorized, for the first time, outpatient care for any veteran "suffering from a nonservice-connected disability for whom outpatient treatment would obviate the need for hospitalization." In turn this has produced an overcrowding of existing outpatient clinics and threatens to lower the quality of health care for the systems "primary beneficiaries"—veterans suffering from service-connected disabilities.

Notwithstanding the stated purpose of the measure, S. 2908 would for dentistry actually broaden the present authority for outpatient services in the following manner:

1. The existing law limits outpatient dental care to the treatment of conditions that are associated with a *service-connected* disease or injury. Under S. 2908, the Veterans Administration would be authorized to provide dental services, *regardless of service connection,* so long as the dental condition is associated with or aggravating a medical or dental disability for which the veteran is receiving treatment at a Veterans Administration facility,
2. The Veterans Administration currently allows treatment for nonservice-connected dental conditions during the period in which a veteran is hospitalized for a *service-connected medical disability.* Section 105 of the bill would authorize outpatient dental services necessary to complete a dental treatment plan initiated during hospitalization.
3. The Veterans Administration would be authorized to provide "emergency" outpatient dental care for a nonservice-connected dental condition, but only to the extent required to relieve pain and/or control infection. Major restorations, therapy, or prostheses would not be allowed under this change.

The Council reviewed this legislation in the content of ADA policy on dental benefits for veterans. That policy (*Trans.* 1953:232) states in part:

> Resolved, that nothing in this statement of policy should be construed to apply to the present system for providing dental services in Veterans Administration hospitals and domiciliary institutions or to the present system for providing outpatient dental care (1) to veterans whose dental conditions have been professionally determined to be aggravating a service-connected medical condition; and (2) to veterans whose service-connected dental conditions have been determined to be disabling and compensable.

It is the opinion of the Council that the above noted proposal No. 1 (concerning outpatient dental care adjunctive to nonservice-connected medical disabilities) is in conflict with Association policy. The Council believes that ADA policy is supportive of proposal No. 2 because the dental care is contributing to or otherwise aggravating a service-connected medical disability. These recommendations have been communicated to the Council on Legislation. With respect to those provisions of the bill concerning emergency dental care (No. 3), the Council while supportive of the concept in principle does not believe the Association has definitive policy on the question. It is recommended therefore that this issue be reviewed by the Board of Trustees for their determination.

Armed Forces Health Professions Scholarships: On December 31, 1975, a previously enacted statutory tax exemption for Armed Forces Health Professions Scholarships expired. This was followed in April 1976, by a ruling from the Internal Revenue Service that all amounts received under such scholarships (tuition, fees, books, monthly stipends, etc.) must now be included by the recipients under gross income and this subject to federal withholding taxes. At the present time, approximately 1,100 dental students are receiving Armed Forces Health Professions Scholarship. A number of bills are pending in Congress that will rectify this problem. The Council complimented the ADA Washington Office and the Council on Legislation for its efforts in seeking legislative relief for the problem.

Dental Advisory Committee to the Department of Defense: The Council is pleased to note that, in keeping with the resolution of the House of Delegates (*Trans.* 1974: 681), all appointments to the newly established "liaison committee" will be complete by July 1, 1976. The liaison committee will be composed of three representatives of the ADA, the Assistant Secretary of Defense for Health, and the three dental corps chiefs. It is anticipated that the committee will hold its initial meeting in the Fall of 1976.

Supplemental Report: Subsequent actions and information pertinent to Council activities and responsibilities will be reported in a supplemental report.

RESOLUTIONS

7. Resolved, that the American Dental Association urge appropriate agencies of the federal government to lower the required years of creditable service for continuation pay eligibility for dental officers in the uniformed services.

8. Resolved, that the American Dental Association strongly urge the federal dental services to improve the productivity of its present workforce of dentists rather than utilize dental auxiliary personnel in the performance of duties which are in conflict with ADA policy.

Council on Hospital Dental Service

Meetings: The Council met in the Headquarters Building, Chicago, on April 9-10, 1976, with all members present. Review committees, which provide the Council with recommendations on policy and dental service accreditation matters, met immediately preceding the Council meeting.

The Council was privileged to have the advice and counsel of Dr. Irving E. Gruber, first vice-president; Dr. George P. Boucek, Third District trustee; Dr. A. J. Aaronian, representing the Veterans Administration; Dr. Howard S. Glazer, representing the American Student Dental Association; Dr. Fred A. Henny, representing the Advisory Committee on Dentistry to the Joint Commission on Accreditation of Hospitals; John D. Porterfield, M.D., representing the JCAH; and C. Y. Shu, M.D., representing the American Hospital Association.

Personnel: The Council acknowledges the contributions made by Dr. Robert E. Glenn who resigned his Council membership prior to expiration of his term of appointment. The Council acknowledges with appreciation the six years of service of Dr. Syrus E. Tande who resigned his position of Council Secretary to enter a dental education career. In addition, the Council wishes to report the appointment of Ms. Carolynn S. Steinwald as coordinator, Hospital Dental Service and Advanced Dental Education.

Review Committee Meetings: The Council agreed at its April 1975 meeting that its existing procedure for mail ballot review of dental service approval actions needed significant improvement. With support and approval of the ADA Board of Trustees, the Council established two review committees. The Board of Trustees also approved the Council request for biannual Council meetings.

The initial meetings of the two, five-member Council review committees were held on April 7-8, 1976, immediately preceding the Council meeting. Each committee is composed of two Council members and three consultants with particular expertise in hospital dental practice. Full discussion of applications, consultant and progress report, and other information related to hospital dental service is provided. Specific recommendations on each program were transmitted to the Council for final approval action.

The Council was extremely gratified to note the significantly enhanced adjudication mechanism provided by the review committees, and believes that this revised process will enable it to meet its commitment to increased quality in the Council on Hospital Dental Service approval program.

Hospital Dental Service Approval Program: Approval actions of the Council from May 1975 through April 1976 are summarized in Table 1. The actions were taken on the basis of site evaluation reports, progress reports specifying the degree to which the institution was able to implement recommendations included in previous evaluation reports and review of applications. The total number of actions taken during the reporting period was 293. As indicated in Table 2, the total number of approved hospital dental services and patient care units is 1,316.

Table 1

Council Actions on Programs, Including Hospitals and Patient Care Units April 1975-April 1976

Type of Action	Hospital Dental Services	Patient Care Units	Total
Approval	139	24	163*
Provisional approval	81	2	83
Preliminary provisional approval	7	2	9
Accreditation denied or withdrawn	18	1	19
Discontinued programs	14	5	19
Total number of actions	259	34	293

*This includes approval of 34 new hospital dental services and 11 new patient care units, totaling 45.

Table 2

Overall Statistical Report on Hospitals, Including Those Providing Dental Services

Hospitals listed in Hospital Statistics, 1975	6,604
Hospitals reporting dental facilities	2,630
Percentage of hospitals reporting dental services	39.8
Hospitals with approved dental services	1,081
Patient care units with approval dental services	145
Provisionally approved programs	83
Preliminary provisional approved programs	7

Patient Care Units Other Than Hospitals: The Council reviewed the report of its ad hoc committee which was established in 1975 to study the Council's patient care unit program. The Committee report reflected input from federal dental services which conduct 138 of the 145 programs.

The patient care unit program was initiated by *Bylaw* authority in 1959 (*Trans.* 1959:215) and has been redefined several times subsequently. Patient care units other than hospitals are currently defined as: (1) approved nursing homes or other post-acute facilities, and (2) federal service facilities with medical and/or dental services which are hospital affiliated. These classifications include convalescent hospitals, skilled nursing facilities, residential care facilities and specifically excludes group health centers and group practices.

Although there exists a drastic need for oral health care for patients in the approximately 23,000 long-term care facilities, few have applied for accreditation in the

Council's PCU program. The Council recognizes that oral health care for patients in these institutions is grossly inadequate. Also, the Council recognizes its obligation to promulgate standards for oral health care in the nation's long-term care facilities and, in addition, is cognizant of the inadequacy of its current *Standards* and involvement in this area.

Currently, the PCU approval program primarily encompasses federal institutions and is inadequate in comparison to the various federal service evaluation mechanisms already in effect. The Council also considered the potential number of institutions and the confluent fiscal and manpower expenditures which would be necessary to initiate an effective program of long-term care evaluation.

In view of the above and an ongoing revision of *Standards* and *Guidelines,* the Council adopted a resolution to continue the study of PCU's in cooperation with the Council on Dental Health and imposed a moratorium on further PCU evaluation activities pending completion of the study.

Coordination of Approval Activities: The Council has for several years sought to coordinate evaluation procedures of hospital dental services and advanced dental education programs within teaching hospitals. Since January 1975, all Association accreditation activities in teaching hospitals have been coordinated. The Council in cooperation with the Commission on Accreditation evaluates the service and education programs within a hospital during a single site visit. Additionally, the coordinated program has been expanded so that a single letter is sent to the institution transmitting the accreditation actions taken by both the Council and Commission. Continued refinements in the program will provide additional benefits to the institution and Association.

Standards for Hospital Dental Services: At the 1975 annual session, the House of Delegates adopted a resolution rescinding *Guidelines for Hospital Dental Services* and mandating continued revision of *Standards for Hospital Dental Services* (*Trans.* 1975:711). The Council at its April 1976 meeting adopted as its highest priority the revision of *Standards* and development of new *Guidelines.* The revised *Standards* will include all pertinent portions of the *Accreditation Manual for Hospitals* and *Guidelines for the Formulation of Medical Staff Bylaws, Rules and Regulations,* published by the Joint Commission on Accreditation of Hospitals. The Council established an ad hoc committee to develop an initial draft of revised *Standards* and new *Guidelines* for consideration by the Council at its September 1976 meeting.

Review of Status of Programs Not Meeting Revised Eligibility Requirements: The 1975 House of Delegates adopted a resolution which authorizes only those hospitals accredited by the JCAH and/or listed in the *American Hospital Association Guide to the Health Care Field* to be included in the hospital dental service approval program (*Trans.* 1975:711). All ineligible programs have been notified of the Council's intent to withdraw dental service approval at the Council's September 1976 meeting. The Council stipulated that those institutions not able to meet the revised eligibility requirement may request on-site Council consultation on a direct cost reimbursement basis.

Foreign-Based Dental Service Approval: The Council reconsidered its position on the foreign-based hospital dental service approval program. All foreign-based hospitals

and patient care units have been notified of the Council's intent to withdraw dental service approval at the Council's September 1976 meeting, with provision, however, that those institutions willing to reimburse evaluation site visit travel expenses on a direct cost basis may be maintained in the Council's accreditation program.

Liaison With The Joint Commission on Accreditation of Hospitals: The Association's request for corporate membership in the JCAH was initiated in 1957 and in recent years JCAH membership has been a high Association priority. At its April 1975 meeting, the Council recommended that a direct approach to the four JCAH member organizations from the Association's Board of Trustees and Council on Hospital Dental Service be utilized in seeking corporate membership and that consideration be given to a more forceful position in efforts to achieve such membership. In implementing the above recommendations the President of the Association wrote to the Presidents of each of the four JCAH member organizations requesting an opportunity for Association representatives to meet with their respective Boards of Trustees or Regents. To date, meetings have been held with key JCAH Commissioners, American Medical Association Trustees, American Hospital Association Trustees, and American College of Surgeons Regents. Association representatives at those meetings have included, among others, the President, members of the Board of Trustees, and the Executive Director. In addition, a nationwide person-to-person campaign has been initiated to make personal contact with individuals closely related to the Joint Commission and its parent organizations. To date, contacts have been established with many AMA and ACS officers, trustees and regents.

For some time, discussion has taken place regarding Association membership on various JCAH accreditation councils in lieu of corporate membership. These discussions have included the possibility of establishing a Hospital Accreditation Council with Association membership, to administer the hospital accreditation program currently managed solely by the Board of Commissioners. The Council reiterated its full concurrence with the House of Delegates position to vigorously pursue Association corporate membership on the Joint Commission and to accept no lesser membership level prior to achieving such membership. In addition, the Council requested the Association's House Counsel to draft a document for transmittal to the Joint Commission setting forth the legal reasons why the Association should be granted a seat on the JCAH.

Liaison Activity With Other Health Organizations: The broad range of Council responsibility requires liaison with many health-related organizations including the American Academy of Dental Group Practice, American Association of Dental Schools, American Association of Hospital Dentists, American Society for Geriatric Dentistry, American Society of Oral Surgeons, the Department of Health, Education, and Welfare and the Joint Commission on Accreditation of Hospitals and its member organizations.

During its April 1976 meeting, the Council convened a special meeting with the ASOS Committee on Hospital Affairs to discuss items of mutual concern to both organizations, relating in particular to formalized liaison between the Council and the ASOS Committee. The Council believes that the common goals of both organizations, and others, could be best achieved by working together whenever appropriate. The Council, therefore, adopted a resolution inviting one observer each from the ASOS, AAHD, and AADS to participate during portions of regularly scheduled

Council meetings. The Council also requested that staff prepare a list of additional organizations, the areas of interest of which might indicate the need for similar participation.

Also during the April 1976 Council meeting, a special meeting with representatives of the American Academy of Dental Group Practice Accreditation Committee was held to discuss possible Council liaison with that organization. Specifically, the AADGP advocated Association support of the Academy's accreditation program for dental group practices and clinics. Discussion was also held concerning incorporation of the AADGP accreditation program within the Council's patient care unit program or the sponsoring of the Academy's program within the JCAH Accreditation Council on Ambulatory Health Care. The Council indicated its desire to be the sole agent of the dental profession to seek involvement with the JCAH and reiterated its position of accepting no less than corporate membership. Further consideration will be given to the AADGP program at the Council's September 1976 meeting.

The Advisory Committee on Dentistry to the JCAH met in June 1975 to review suggested revisions in JCAH Hospital Standards, the Surveyor's Report Form (Medical Staff) and Hospital Survey Questionnaire. The Committee met again in August 1975 to review revisions of Subpart J, Conditions of Participation, Hospitals, Hospital Survey Report SSA-1537, and *Guidelines for Medical Staff Bylaws*.

In May 1976, a meeting of the Dental Liaison Committee to the American College of Surgeons was held to discuss the revised definition of the specialty of oral surgery. The Committee agreed that the revised definition does not promulgate nor reflect a change in the traditional practice of oral surgery but rather is an attempt to more adequately clarify the legitimate, current scope of the oral surgeon's clinical activity. The Committee noted that historically the Dental Liaison Committee has been convened on call of either organization in a crisis-oriented response to problems real or perceived. It was the unanimous opinion of the Committee that regularly scheduled meetings to discuss items of mutual interest would be desirable and advantageous.

Recently, liaison activities with the American Hospital Association have been significantly enhanced. Plans are currently underway for an ADA-AHA sponsored Institute on Hospital Dentistry scheduled for October 19-20, 1976 at AHA Headquarters in Chicago. This will represent the first institute to be held since 1972. In addition, there is now dental representation on the AHA Council on Professional Services and discussion of such representation on the AHA Committee on Physicians.

Preliminary staff discussions have been held with representatives of the AMA relative to a series of meetings between dental and medical specialties relative to oral and maxillofacial surgery practice in the hospital environment. It has tentatively been agreed that a series of conferences with appropriate representatives of both Associations should be scheduled to address the several problems existing between medical and dental specialties. It was suggested that the Association and the AMA alternate sponsorship of these meetings.

Publication of Listing of Approved Hospital Dental Services: The Council plans the biannual publication of a *Listing of Approved Hospital Dental Services*. The publication, similar in format to other Association lists of accredited programs, will respond to numerous requests from the membership and additionally provide enhanced visibility to hospital dental practice and the Council's approved program.

Survey of Hospital Dental Services: The Council recognizes an urgent need for information and statistics on dental practice in the hospital setting. Current data is not available, as the last Association survey of hospital dental practice was conducted by the Council and Bureau of Economic Research and Statistics in 1969. For this reason, the Council recommends the establishment of a semiannual survey of hospital dental practice by the Bureau in cooperation with the Council.

American Dental Association—New York City Health and Hospitals Corporation Task Force on Dentistry: The New York City Health and Hospitals Corporation on November 5, 1975, mandated the closing of dental clinics throughout the municipal hospital system no later than December 30, 1975. An Advisory Task Force on Dentistry was established in response to the Association's concern about the arbitrary and capricious decision of the HHC in recommending the drastic and almost total reduction of oral health care provided in 11 of New York City's municipal hospitals. As a result of the proposal submitted by the Task Force on Dentistry, action was taken to rescind the decision to terminate dental services in favor of the less extreme Task Force plan to achieve a cash savings in fiscal 1976 of about $815,000 while continuing to provide essential oral health care in municipal hospital facilities.

Special recognition was given the role which representatives of organized dentistry played in presenting a unified voice by presenting viable alternatives to the closure. The HHC publicly acknowledged its appreciation of the manner in which the dental profession presented its position and commented further that dentistry presented a model for other professions to follow. Indeed, the HHC set up additional Task Forces to deal with other disciplines of medicine in the same manner.

RESOLUTIONS

This report is informational in nature and no resolutions are presented.

Council on Insurance

English, Leon J., Wisconsin, 1977, chairman
Inman, Conrad L., Jr., Maryland, 1978, vice-chairman
Casey, William L., Arkansas, 1976
Tapper, Irving B., Ohio, 1978
Zeali, Robert J., Connecticut, 1977
Wisniewski, Walter E., secretary

Meeting: The annual meeting of the Council was held in the Headquarters Building on April 8-9, 1976 with all members present. Dr. Conrad L. Inman, Jr. of Maryland was elected vice-chairman.

Group Life Insurance Program: During 1975, members insured under the Group Term Life Program increased by 2,637 or by 5 percent as compared to the 2,535 or 4.9 percent participation growth rate experienced in 1974. The total number of members insured as of December 31, 1975 was 56,564 as against the 53,927 members covered at the end of 1974. Currently, some 46 percent of the total membership is insured under the program, 1 percent above 1974's percentage of total insured membership. This growth rate over 1974 indicates a gradual maturing of the program with well in excess of 50 percent of the eligible membership currently insured. The volume of insurance again increased, in 1975 by 10.4 percent, to a nearly $3 billion level as members continue to take advantage of higher limits of protection. In 1968, a plan of surplus distribution was inaugurated. The favorable experience of the life program has resulted in the allocation of more than $20 million in unused premium income to participating members from 1968 to 1975. An additional $3.6 million (32.3 percent) has been distributed during 1976. Distributions are made in the form of credits against the participating member's premium for the subsequent year.

Upon obtaining approval from the Council at its April 1975 meeting, the Great-West Life Assurance Company announced to the membership late in the summer the availability of a Term Deposit Settlement Option. Under this new feature of the Group Term Life Program, beneficiaries of all deceased participants are given the opportunity to leave with the Great-West insurance proceeds at a highly competitive interest rate over a five-year period. A favorable response to this new measure of flexibility offered through the life program has been received. As a result of a ruling by the Attorney General of the State of Ohio, the $100,000 maximum level of protection available under the program is now available in that State which previously was limited to a maximum of $75,000.

During the month of April, a no-medical enrollment period for members of the American Student Dental Association was again conducted. A total of 4,426 students

were insured at the end of 1975 out of a total of 15,007 or 29 percent of those eligible to participate. This represents a decline from the 33 percent of eligible students recorded for 1974 and the 37 percent of total eligibles participating at the end of 1973. In terms of numbers, there were 471 fewer students participating in the program in 1975 than in the previous year.

Group Disability Income Protection Plan: As of December 31, 1975, the Income Protection Plan registered a total participation of 28,738 insured members as against the 28,132 insureds at year end 1974. This represents the ninth consecutive year of increased participation in the program.

On November 1, 1975, all of the program improvements negotiated by the Council with the Insurance Company of North America went into effect. Foremost among the improvements was a liberalized definition of disability which eliminated the former requirement under the Extended Plans that the insured be totally prevented from performing the duties of any substantially gainful occupation for which he might be suited by reason of education, training, and experience in order that benefits might continue. In addition to the new definition of disability, which applies to the dentist's specialty, a higher benefit level of $2,000 and various waiting period options, to reduce the cost of coverage, were introduced. A return to work provision, whereby the insured who is prevented from returning to dentistry may elect to pursue another occupation and can continue to receive monthly benefits until income from the new occupation reaches 80 percent of the benefits, was also introduced. This return to work provision also applies to a return to the dental practice. Additionally, under the improved Group Plan, dismemberment benefits are paid *in addition to* monthly benefits as opposed to *in lieu of* monthly benefits. A 20 percent premium increase for the 60-69 age groups was also required as a result of adverse claims experience of participants in this category. While it is still too early to determine the total effect of the program improvements on participation, the Council in confident that the competitiveness of the Plan has been greatly enhanced.

In September 1972, a special disability insurance program was made available to members of the American Student Dental Association. The program was designed to represent early tangible evidence of Association membership benefits to prospective active members. The ASDA member who is in the last two years of dental school can purchase $200 or $400 monthly benefits for a nominal cost of $10 or $20. A unique feature of this program is that 100 percent of the premium paid will be applied against the initial premium due upon conversion to the Association's Income Protection Plan, provided the student has had no claims. As of December 31, 1975, there were 1,298 student participants in the program. Of greater significance is the fact that 335 participants in the ASDA/ADA plan converted to the Income Protection Plan at time of eligibility. This represents 14 percent of the total number of new insureds under the program. Since the continued success of the Income Protection Plan is dependent upon the entry of young lives, this sound level of conversion is of great encouragement for the continued success of the program.

Group Retirement Programs: At year end 1975, there were 9,236 dentists and their employees participating in the ADA Members Retirement Program as opposed to the 7,652 participating at the end of the previous year. As of December 31, 1975, 196 Corporate Plans were in effect under the ADA Corporate Members Pension and Profit Sharing Plan. There are plan participants in every state. Total contributions

for 1975 were approximately $22.5 million reflecting an increase of 42 percent over 1974. The value of participants' accounts at the end of 1975 was in excess of $82.1 million, an increase of more than $32 million over 1974. During 1975, participants contributed predominately to the fixed income account which accounted for 64 percent of the contributions made. Thirty-six percent of the 1975 contributions were allocated to the equity account. In 1974, participants' contributions were almost equally divided between the two accounts. The percentage change in the unit value of the ADA Plan for 1975 was 28 percent as compared to 44.8 percent for the Dow Jones "30" and 37.2 percent for Standard and Poor's "500." The percentage change in the unit value since 1968 was 34.3 percent as compared to 29.6 percent for the Dow Jones and 23.6 percent for Standard and Poor's. In 1975, 221 Plans covering 303 participants with a value of approximately $1.4 million transferred to the ADA Plan from other funding agencies. The ADA Keogh Plan was amended in September 1974 to provide for the new contribution limits permitted under the Employee Retirement Income Security Act (ERISA) of 1974. In 1975, further amendments, including those for the Corporate Plans, were made in accordance with interpretations of proposed rulings on the Act and filed with the IRS. Foremost among these required amendments was a change in the retirement age requirement. Formerly, participants could begin to withdraw funds at age 59½ while still in active practice. As a result of ERISA, participants must now be retired at age 59½ or wait until age 65 to withdraw funds. Subsequent to filing the Plans with the IRS, the IRS announced a Special Reliance Procedure and with it published *ERISA Guidelines*. The *Guidelines* are a listing of all important regulations promulgated since enactment of ERISA, many of which were promulgated after the Plans had been filed with the IRS. As a consequence, further amendments to the Plans will be required. Discussions with the IRS over these and other required amendments have been conducted during 1975 and will continue into 1976.

Excess Major Medical Program: The Association's new Excess Major Medical Program became effective January 1, 1975. Open enrollment periods were held in January and February and again in October and November. At the end of the introductory year, 11,775 members or 9.8 percent of the total membership were insured under the program. The vast majority of members chose the $15,000 deductible plan.

The Excess Major Medical Program is a health insurance plan designed to protect insureds against catastrophic losses. There is no maximum limit on the amounts payable under the program which makes available three deductible plans, $15,000, $20,000, and $25,000. The program includes a three-year, family-contributed deductible accumulation period, and up to a ten-year benefit payment period. The level of acceptance by the membership during this initial year has been gratifying.

Professional Protector Plan: The Professional Protector Plan is a package program combining professional and office liability coverage in addition to casualty protection. The plan is uniquely suited to the dental practice and was specifically designed to answer the dentist's insurance needs. Despite the disastrous experience of the fire and casualty insurance industry in general, and specifically in the malpractice field, the program has continued to follow a pattern of solid growth. Forty-seven constituent dental societies, in addition to the District of Columbia, Puerto Rico, and the Virgin Islands, now co-endorse the plan. Participation during 1975 increased to 22,388 which represents 32.9 percent of the eligible dentists in the co-endorsing states. Total written premium in 1975 was in excess of $6 million, representing a 46.1 percent

increase over the previous year. In addition to the increased new business volume, written premium increased as a result of increasing property values and implementation of rate increases authorized by the Council for the first time since the program's inception some six years ago. The premium increase was authorized for the coverages under the program as well as for those dentists who render their patients unconscious by general anesthesia or other technique. In spite of this increase, the Professional Protector Plan continues to exhibit a cost below comparable coverages.

In October 1972, the American Student Dental Association Professional Protector Plan went into effect. Under this program, the student member may purchase instrument coverage, professional liability protection, or both. A special offering is made to senior dental students providing them with professional liability coverage for state and regional boards of dentistry examinations. Should the student elect to continue coverage under the ADA Professional Protector Plan, he will receive credit for the unearned portion of the premium.

Great-West Teacher Training Fellowship: Great-West Life Assurance Company for many years has continued to contribute annually to the American Fund for Dental Health for sponsorship of a training fellowship. The Council gratefully acknowledges this worthwhile contribution.

American Fund for Dental Health Support: The Council also wishes to acknowledge with gratitude the continuing support of the American Fund for Dental Health by the Equitable Life Assurance Society of the United States, W. F. Poe Associates, Inc., and M. A. Gesner, Inc.

RESOLUTIONS

This report is informational in nature and no resolutions are presented.

Council on International Relations

Meeting: The Council met in the Headquarters Building March 22-23, 1976, with all members present. The following consultants attended part of the meeting: Dr. Herbert J. Bloom, Detroit; Dr. B. F. Dewel, Evanston, Illinois, and Mr. Edward T. Lawler, Minneapolis, American Student Dental Association. Dr. Charles D. Carter, Bowling Green, Kentucky, trustee of the Sixth District, was present on the second day as the representative of the Board of Trustees.

Dr. Claus was unanimously reelected to his fourth term as vice-chairman.

In tribute to the memory of John Cedrins, Ph.D., assistant director of the Bureau of Library Services, who worked closely with the Council for many years prior to his sudden death on March 8, an appropriate resolution was adopted.

Association Membership for US Dentists Overseas: United States dentists practicing overseas who wish to retain active membership in the Association may not do so under the present wording of the *Bylaws*. The Council recommends an appropriate amendment of the *Bylaws* to make such dentists eligible for direct membership. The proposed amendment is the addition of the following phrase to Chapter I, Membership, Section 20, Qualifications, Subsection A, Active Member, of the *Bylaws* at the end of the first paragraph:

> or is a member in good standing of this Association and licensed to practice in a state, the District of Columbia, the Commonwealth of Puerto Rico, or a dependency of the United States and is practicing in a country other than the United States and is consequently not eligible for membership in a constituent and component society, if such exist.

Dentists who would not qualify for active membership under the foregoing amended bylaw, could qualify for affiliate membership. The *Bylaws* state that "A dentist practicing in a country other than the United States who is a member of a national dental organization in such country may be classified as an affiliate member upon application to the Executive Director and upon proof of qualification." The dues of $20 per year include a subscription to *The Journal of the American Dental Association* and entitlement to attend any scientific session of the Association and to such other services as are authorized by the Board of Trustees. However, dentists may be living

in a lesser developed country where a national dental association does not exist. The Council believes that in such instance it would seem appropriate to accept some other credential, such as verification of their position and work by an official of the sponsor of the program with which they are associated. This provision could be accomplished by addition of the phrase "if such exists" following the words "national dental organization" in Chapter I, Membership, Section 20, Qualifications, Subsection E, Affiliate Member, of the *Bylaws*.

An appropriate resolution appears at the end of this report.

Certificate of Recognition for Volunteer Service in a Foreign Country: The Certificate of Recognition for Volunteer Service in a Foreign Country was issued this year to 128 dentists in 26 states. An additional 42 applications did not meet the criteria and will be considered at the 1977 Council meeting if properly completed.

The program is being well received throughout the profession as evidenced by the number of nominations, publicity in dental journals and lay press, presentations of the certificates at dental society meetings and letters of appreciation from recipients. To offset some lack of understanding about the objectives of the program and the significance of the award, the Council adopted the following resolution:

> **Resolved,** that to qualify for the Certificate of Recognition for Volunteer Service in a Foreign Country, the individual must serve for a minimum of 14 days, either in one period or in several visits, in any given year.

The criteria also specify that the recipient must "be nominated by his component or constituent society." The Council recommends the addition of the phrase "federal dental service or dental school" to the criteria for clarification.

The Council requests authorization to add the minimum length of service requirement and the clarifying phrase to the criteria approved by the House of Delegates (*Trans.* 1974:699), and an appropriate resolution appears at the end of this report.

Dental Effort in Guatemala Emergency: Information on the dental needs resulting from the earthquake which struck Guatemala February 4 was relayed to the Council via the US Department of State during the Midwinter Meeting of the Chicago Dental Society. Thus, it was possible to bring the plea for help to the attention of the Chicago Dental Society and various other groups and individuals immediately, and the response was impressive. Space limitations do not permit detailing the many contributions which ranged from $1,000 donated by the American Academy of Restorative Dentistry to $204 by American Dental Association employees, plus equipment and supplies provided by members of the American Dental Trade Association. The Council cooperated with the Christian Dental Society in receiving and administering the contributions since donations to CDS are tax deductible and since it is a dental organization experienced in handling such situations.

The Council adopted the following resolution:

> **Resolved,** that the Council on International Relations express profound appreciation to the many individuals and groups throughout the dental profession and the dental trade whose generous response to the plea for help for their Guatemalan colleagues and other surviving victims of the most tragic disaster to strike a Central American country demonstrated the finest example of the profession's ideals of humanitarian service, and be it further

Resolved, that special commendation be extended to Dr. Charles H. Shaner and Dr. Steve Lynch, past presidents of the Chicago Dental Society, for their personal efforts which contributed immeasurably to the remarkable success of the dental effort in behalf of Guatemala.

Vietnamese Refugee Dentists: With the arrival in the United States last year of thousands of Vietnamese refugees, including hundreds of health professionals, the Council began receiving requests to help the refugee dentists become licensed in order to practice their profession and become self-supporting. Since the basic requirement for licensure in nearly all states is a dental degree from an accredited US dental school, the most practical approach for the Vietnamese refugee dentists is to complete the additional training required for the US degree, a goal that will require supporting funds as are being provided for the training of Vietnamese refugee physicians through the Indochina Refugee and Migrant Assistance Act of 1975. In September, Dr. L. M. Kennedy, then president of the Association, sent an appropriate letter to the Secretary of the Department of Health, Education, and Welfare as did the Executive Director of the American Association of Dental Schools and other leading educators. In March 1976, the Educational Development Branch of the Public Health Service Division of Dentistry advised that $312,000 for training programs for the 80 Vietnamese refugee dentists of record had been approved by HEW, that contracts were being sent out to dental schools for bids and that several training sites would be set up.

The Council acknowledged the foregoing development with appreciation but expressed disappointment that the programs will be short-term, 2-3 months, rather than 2-3 years as originally envisioned and do not assure successful completion of the National Board Examinations. A letter expressing the Council's concerns has been sent to the PHS Division of Dentistry.

Foreign Dental Personnel Coming to the United States: Nearly 800 requests were received in 1975 from or in behalf of foreign-trained dental personnel who wished to study, practice, or find employment in the United States or from US citizens wishing to obtain dental degrees in another country and return to the United States to practice or wishing to study abroad for a year or more and then enter a US dental school on an advanced-standing basis and obtain a US degree. Seventy-four countries were represented in the requests.

Future Conference With Counterpart Agencies at National and State Levels: Previous conferences at the national level with representatives of dental, allied and specialty groups, organizations sponsoring voluntary programs overseas, and government agencies in the international area have led to improved communication and increased recognition of the Council as the central source of information on matters pertaining to international dentistry. In view of the demonstrated need for better two-way communication between the Council and its counterpart agencies of constituent dental societies to overcome some lack of understanding about the role of the Council and the assistance it can provide to individuals and organizations as well as the information it needs from them, the Council hopes to hold a one-day conference in conjunction with its 1977 meeting, contingent on the availability of funds. Participation of organizations represented at previous conferences will also be invited in the interest of a more well-rounded educational experience as well as for sustaining the interest already stimulated among these groups.

National Council for International Health: The National Council for International Health, of which the Association is a sponsoring organization, forms a direct line of communication between dentistry and other US health professions involved in international health. The Council believes that the importance of Association membership cannot be overemphasized.

A panel on dentistry, organized by the Council and the Pan American Health Organization, was a highlight of the successful 1975 International Health Conference sponsored by the NCIH in Washington, D.C., last October. Similar participation is anticipated for the 1977 conference.

The Council appreciates the Board of Trustees' previous support of NCIH and requests its continuation.

MEDICO Request: In response to a request from MEDICO, the medical arm of CARE, the Council is cooperating in the design and development of a dental program in a country to be selected by CARE for the purpose of demonstrating how dental programs fit in with other MEDICO programs and attract greater participation from the dental profession. The project should open up additional opportunities for the many Association members who seek positions for humanitarian service. The Council appreciates the Board of Trustees' previous support of MEDICO and recommends that it be continued.

Project HOPE Extension of Dental Programs: Retirement of the *SS HOPE* has freed funds to expand HOPE's world-acclaimed programs and develop specialty projects, including dental, at sites where they are required and without regard to being part of a total health program as was the policy in the ship operation. Current and future sites include Egypt, Eastern Caribbean, Central and South America, and Tunisia.

The remarkable achievement of Project HOPE is a credit to the Association and its members who have admirably represented their country and their profession through their service as HOPE volunteers. The Council thanks the Board of Trustees for its previous support of Project HOPE and requests that it be continued.

Conference of Professional Associations: The Association served as one of the ten cooperating agencies for a Conference of US Professional Associations cosponsored by the United States Department of State and Meridian House International, a private, nonprofit organization, June 24, 1975, at the National Academy of Sciences, Washington, D.C. Objective was to encourage the initiation or further development of international nongovernmental programs of such associations and to find out how the Department can assist.

The Council Secretary represented the Association at the planning conference in April, served as co-chairman of a principal workshop at the June Conference and presented its report to the plenary session. The attendance of 120 from 60 professional organizations represented the fields of banking, communications, economics, engineering, health, law, public administration, science, social sciences, and urban affairs. The conference clearly indicated positive interest in and need for a central point for follow-through actions and for strengthening constructive international programs of professional associations and their members. The international activity of the Association was cited as a "model" for professional associations.

Assistance to Dr. Francisco W. Pucci, Uruguay: Dr. Francisco W. Pucci, Uruguay, in-

ternationally known dental leader who was imprisoned by his government for political reasons, has been acquitted by a military tribunal. He expressed his gratitude for the efforts made in his behalf by the dental profession throughout the world, including those of the Association (*Trans.* 1974:303).

Annual Session Activities: The Council will maintain an International Hospitality Center at the Las Vegas Convention Center during the 1976 annual session and will sponsor its customary Reception in Honor of International Guests in cooperation with the USA Section of the *Fédération Dentaire Internationale*.

The international registration at the 1975 annual session in Chicago with the FDI world dental congress totaled 2,704 individuals from 61 countries, including 1,903 dentists and 901 nondentist guests. The Council expresses deep appreciation to the chairman and vice-chairman of the local reception committee, Dr. Charles H. Shaner and Dr. Rudolph A. Seidel, and their committee members for their outstanding cooperation and thoughtful hospitality and to the International Visitors Center of Chicago for the assistance of IVC volunteers who served as interpreters. The Council also offers special thanks to Dr. Hannelore Loevy and Dr. Darío Cardenas, of the faculty of the University of Illinois College of Dentistry, for providing simultaneous interpretation for the international dental health conference sponsored by the Council, the Council on Dental Health, and the Pan American Health Organization.

Acknowledgment: The Council regrets that the 1976 annual session will mark completion of the six-year term of Dr. Everett C. Claus. The Council believes that no member has contributed as much to resolving its humanitarian concerns as well as broadened the personal views of its members and expresses appreciation for his magnificent example of selfless, dedicated service.

RESOLUTIONS

9. Resolved, that Chapter I, Membership, Section 20, Qualifications, Subsection A, Active Member, of the *Bylaws* be amended by the addition of the following phrase at the end of the first paragraph:

> or is a member in good standing of this Association and licensed to practice in a state, the District of Columbia, the Commonwealth of Puerto Rico or a dependency of the United States, practicing in a country other than the United States and consequently not accepted for membership in a constituent and component society, if such exist

so that the first paragraph of Subsection A will read as follows:

> A. ACTIVE MEMBER. A dentist shall be classified as an active member of this Association who is licensed to practice in a state, the District of Columbia, the Commonwealth of Puerto Rico or a dependency of the United States, providing he is a member in good standing of this Association, its constituent and component societies, if such exist, or is a member in good standing of this Association and licensed to practice in a dependency of the United States wherein a constituent society does not exist, or is a member in good standing of this Association and licensed to practice in a state, the District of Columbia, the Commonwealth of Puerto Rico or a dependency of the United States, practicing in a country other than the United States and consequently not accepted for membership in a constituent and component society, if such exist.

and be it further

Resolved, that Chapter I, Membership, Section 20, Qualifications, Subsection E, Affiliate Member, of the *Bylaws* be amended by the addition of the words "if such exists" following the words "national dental organization" so that Subsection E will read as follows:

> E. AFFILIATE MEMBER. A dentist practicing in a country other than the United States who is a member of a national dental organization, if such exists, in such country may be classified as an affiliate member upon application to the Executive Director and upon proof of qualification.

10. **Resolved,** that criteria 2 of the criteria for awarding the Certificate of Recognition for Volunteer Service in a Foreign Country (*Trans.* 1974:699) be amended as follows:

(1) by adding at the end of paragraph 2 the words "for a minimum of 14 days, either in one period or in several visits, in any given year," the amended paragraph to read:

> have served in a foreign country in a program sponsored by a church or other recognized voluntary or nonprofit organization for a minimum of 14 days, either in one period or in several visits, in any given year

and (2) by adding at the end of paragraph 5 the words "federal dental service or dental school," the amended paragraph to read:

> be nominated by his component or constituent society, federal dental service or dental school.

Council on Journalism

Meeting: The Council met at ADA Headquarters in Chicago on March 7, 1976. All members were present except Dr. Roy S. Mar. The Council was pleased to welcome its two new members, Dr. Harold F. Klein and Dr. Bernard P. Tillis. Others present at the meeting were Dr. C. Gordon Watson, ADA executive director; Dr. Herbert C. Butts, ADA editor and ex-officio member of the Council; Mr. Peter C. Goulding, ADA assistant executive director for communications; Prof. Paul Barton, consultant; and Dr. William W. Howard, consultant and local arrangements chairman for the 1977 Journalism Conference in Portland, Oregon.

At the afternoon session, the Council met jointly with the Board of Directors of the American Association of Dental Editors.

Journalism Conference: The Council held its 25th Journalism Conference at ADA Headquarters on March 8-9, 1976. Attendance was 100, which was lower than attendance at the 1975 San Diego Conference and the one held in Memphis in 1974. Attendance has always been greater when the conference is held away from Chicago, and for this reason the Council decided to hold the conference in other sections of the country for two years and in Chicago on the third year. Special effort was made this year to encourage attendance of editors in the immediate area who had not attended before. Twenty-five of the 100 attended for the first time, seven of which were dental students. The Council encourages dental student attendance at both its conferences and seminars in order to develop student interest in the field of communication.

This year, the participants were welcomed by Dr. Robert B. Shira, president, American Dental Association. Other speakers and their topics were: "An ADA Trustee Looks at the Role of the Editor," Dr. Robert H. Griffiths, ADA trustee, Eighth District; "Professional Issues," Dr. Coleman Gertler, ADA trustee, Ninth District; "Personal Management Skills: The Key to Professional Growth," Mr. James Siress, senior consultant, Lawrence-Leiter and Company; "The Controversial Medical Story," Mr. James Pearee, science writer, Chicago Tribune, and Mr. Frank Chappell, science news director, American Medical Association; "Dental Health Education Seminars," Mr. Delmar J. Stauffer, director, ADA Bureau of Dental Health Education; "Services Available from National Institutes of Health," Mrs. Tula Brocard, NIH infor-

mation officer; "Telling Dentistry's Story in the Mass Media," Mr. Peter C. Goulding, ADA assistant executive director for communications; "Getting Your Message Across," Mr. Herbert Pinzke, president, Pinzke Design, Inc.; "IRS Requirements: Tax on Advertising Income," Mr. Bernard J. Conway, ADA assistant executive director for legislation and legal affairs; "Council Status Reports: How You Can Use Them Effectively," Dr. John W. Stanford, secretary, ADA Council on Dental Materials and Devices.

The 1977 Journalism Conference will be held at the Thunderbird Motor Inn, Portland, Oregon, March 28-29. The 1978 Conference will be held in Atlanta, Georgia. Dr. Rollin E. Mallernee is serving as local arrangements chairman for the 1978 Conference.

MSU Dental Editors Seminar: The dates for the 1976 Dental Editors Seminar are June 20-24. This will be the third year that the Seminar has been held at Michigan State University, East Lansing, Michigan. Attendance is limited to 25 and this year's participants include representatives from nine constituent dental associations, seven component societies, five dental specialty groups, one dental hygienists' association, and three dental students.

The cooperation of the Seminar director and his faculty continue to be excellent. The schedule of classes for this year include lectures on the editor's responsibility, public relations, organizing the publication, photography, workshops on design (a practical scissor and paste workshop on the basics of putting a journal together), editorial writing, feature writing, news writing, reporting, headline writing, layout, and production scheduling.

The Michigan Dental Association is again cooperating by holding the editors reception at MDA Headquarters. This helps establish a closer relationship between the dental profession and the MSU Seminar faculty.

Council Publications: The Council continues to expand the kit of material sent to newly appointed editors, in the hope that the work of the editor can be made easier and more effective. The material added this year included articles on "Developing the Feature Story," "Reporting a Meeting," "Principles of Good Writing," "The Editor and His Dental Society," "The Editor's Responsibility to His Members," "The Work of the Editor," "Production Planning," "Publication Budgeting," and "Business Management of Dental Journals."

Work on the 9th edition of *Rates & Data: Dental Publications* will begin later this year. *Rates & Data* provides the advertiser with the advertising rates and mechanical requirements of all dental publications which carry advertising.

One hundred and sixty copies of the *Handbook for Dental Editors and Authors* were distributed during the past year, making a total of 685 distributed since it was first published three years ago—a fair rate of distribution since there are less than 600 dental editors in the U.S.

ICD Journalism Award Program: The Council again wishes to express its appreciation to the International College of Dentists for its very successful Journalism Award Program. This was the fifth year for the program. Three awards, eleven honorable mentions, and one special citation were presented by Dr. John W. Hein, president of the USA section of ICD, at the editors dinner on March 8.

The Golden Pen Award was presented to *CDS Review* (Chicago Dental Society)

for the interview "Shira to fight fragmentation of the profession" which appeared in the October 1975 issue; the Golden Pencil Award was presented to the *Journal of the American Society for Preventive Dentistry* for dramatic cover and text graphics in "The sour side of sugar" in the January-February 1975 issue; the Golden Scroll Award was presented to *The Condenser* (Dental Student and Dental Alumni Associations, State University of New York at Buffalo) for combining alumni and student news in a handsome publication; the Special Citation was presented to the *Disclosing Tabloid* (the Ohio State University College of Dentistry student newspaper) for imagination in writing, art, design, and typography.

Standards and Guidelines: The Council continuously edits the publication guidelines which it recommends to dental editors to assure that the guidelines reflect changes in procedures and attitudes, particularly legislative or consumer attitudes.

The Council also has revised its *Standards for Dental Publications,* which was approved by the House of Delegates in 1969. The text of the proposed revision and a resolution requesting approval are presented with this report.

Acknowledgment: Dr. Charles J. Defever has completed his term on the Council, serving as its chairman during the past year. The Council wishes to express its sincere appreciation for his contributions to the improvement in dental journalism and particularly for the personal guidance he has given to the Dental Editors Seminar at Michigan State University.

RESOLUTION

11. **Resolved,** that the revised *Standards for Dental Publications* be approved.

APPENDIX:

Standards for Dental Publications

Standards for Dental Publications has been edited to incorporate attitudes and procedures developed since the document was revised by the Council on Journalism in 1969 and approved by the House of Delegates.

Objectives: The dental society publication is both an educational tool and a channel of communication between the dental society and its members. While emphasis in content may vary, the objectives of the publication should be (1) to broaden the dentist's professional knowledge and improve his competence so he can provide better health service, and (2) to keep him informed on professional affairs. To accomplish these objectives, an association's publication should:

1. Inform the dentist on issues of concern to the profession.
2. Reflect the dental society's attitudes and actions on professional issues.
3. Serve as a forum for debate.
4. Report the meetings, decisions, and activities of the dental society and its committees.
5. Maintain a balanced content.
6. Maintain an attractive and interesting format.

The objectives of other dental publications, such as school, alumni, dental student, fraternity, and commercial, should closely parallel those of dental society publications, namely, education and communication, and the same standards should apply to all dental publications.

Content: Each dental society should first determine the type or types of publications that will best serve the needs of its members—newsletter, tabloid, bulletin, journal, or a combination of newsletter and journal. The format of the publication will, to some extent, determine its content. However, the following essential items are suited to any format and should be included when possible: editorials, reports on current issues, national and local dental news, dental society actions and reports, information on dental programs, and a section where members can express their opinions. Most formats will accommodate an occasional feature or scientific article.

Administration: The major responsibilities of the dental society, as owner of the publication, are selecting the editor and business manager, either by election or appointment; determining the type, scope, and frequency of the publication; establishing written editorial and advertising policies for the guidance of the editor; and determining how the publication will be financed. The governing body of the society may appoint a committee to act in an advisory capacity to the editor, yet permitting him necessary editorial freedom.

The editor should be selected for his ability and appointed or elected for a term of from three to five years, with reappointments for as long as his services are satisfactory to the members.

The dental society that changes editors every year or two is doing itself an injustice as training and experience make the editor more valuable to his society.

The editor should be a member of the administrative body of his dental society. By having direct access to discussions and to all information pertaining to issues being considered by the society he will be better prepared to report on those issues to the members.

Editing a dental publication is not a one-man job to be undertaken after office hours. The editor should receive a salary and have adequate editorial and secretarial assistance. In addition, his expenses should be paid to journalism conferences where he can learn to produce a better journal and to other meetings which should be reported to the members.

The following resolutions on the dental society's responsibility for its publication have been approved by the ADA House of Delegates:

> **Resolved,** that the principle that dental societies must have complete control of the contents, both editorial and advertising, of their official publications be endorsed, and be it further
> **Resolved,** that disapproval be expressed of any arrangement between dental societies and the publishers of their official publications in which complete professional control does not rest with the dental societies concerned (*Trans.* 1960:224).

> **Resolved,** that the principle be endorsed that the dental society editor be a member of the society's administrative body—with or without a vote—in order that he may attend all official business sessions and thus have direct access to all information pertaining to the official actions, policies and activities of the society, which will enable him to discharge his duties and obligations to the membership in the most effective manner (*Trans.* 1962:273).

> **Whereas,** the editor should be an important link between the dental society and its members and to discharge this responsibility properly he must have experience as well as training, therefore be it
> **Resolved,** that the principle be endorsed that the dental society editor be chosen for his ability, trained, and then retained for as long as possible (*Trans.* 1965:335).

The type or types of publications selected by the dental society will depend on the purpose to be served, but whatever type or types are selected they should be well designed, attractive, and readable—the best the society can afford. When possible, a typographic designer should be employed to design a pleasing and practical format.

To communicate adequately with its members, the dental society should issue some form of publication, preferably monthly but no less than four times a year. A monthly newsletter or a combination of a quarterly journal and a monthly newsletter will, in most instances, provide the frequency needed to keep the members informed.

The dental society should subsidize the cost of its publication as it does other services to its members. The publication should not be required to be self-supporting. Additional revenue may be obtained from subscription fees and from the sale of ethical advertising.

Editorial Staff: The size of the editorial staff will depend on the size and frequency of the publication. The staff of the larger publication may include a business manager, advertising manager, art director, assistant editors, associate editors, manuscript editors, district editors or correspondents, and a secretary. The minimum staff should include district correspondents and a part-time secretary to prepare copy for the printer.

The staff should be well trained. This can be done by the editor, by distributing a manual of instruction, and by staff journalism conferences.

A manual for district editors or correspondents should contain the following information: the type of material to be submitted for publication (news—personal or dental society, editorials, reports, or features), guidelines on preferred style, instructions on how to prepare the copy, length of copy, and a schedule for submission of material. The manual may also contain aids to better writing.

Publication Policies: The following policies are recommended for maintaining the standards of professional journalism:

1. It is preferable that the dental society own its publication, but in any event it should, through its editor and business manager, control both the editorial and advertising content.
2. The content and format of the publication should be in keeping with professional ideals and be representative of the strength and vision of its sponsor.
3. Scientific articles should be supported by adequate scientific evidence.
4. If the publication carries advertising, the dental society should have, in writing, an advertising code to assist the editor or business manager in evaluating advertising—one that will serve not only as a guide for the acceptance of advertising, but provide a basis for nonacceptance as well.

   Ideally, advertising should be placed in the publication so that it does not interfere with the continuity of the scientific or editorial material.
5. The publication should be copyrighted to protect the rights of the publisher and authors and to prevent unethical and unauthorized use of the material.
6. A written policy should be established to serve as a guide in acting on requests for reprints and to guard against the unethical use of reprinted material.

Printer: Careful selection of a printer is essential to the successful publication of a dental journal. The printer must be a competent artisan and a good businessman with a sound financial rating. He must have adequate personnel and equipment. He must be able to give prompt and reliable service, a point especially to be considered if the printer is located out of the city.

To assure regularity and continuity of the publication and to provide protection for both publisher and printer, the dental society should have a written contract with the printer which covers the following:

1. Basic specifications of the publication—frequency, quantity, number of pages, page size, paper stock, composition, illustrations, presswork, binding, mailing.
2. Materials and services furnished by the dental society—copy, illustrations, layouts or dummies, inserts, mailing envelopes, wrappers or labels, print and kill orders.
3. Materials and services furnished by printer, with costs—messenger service, composition (including costs of color and inserts, and basis of charges for author's alterations), paper, ink, presswork, binding, mailing, and delivery.
4. Production schedule and overtime rates.
5. Terms and conditions—basis for payment, "escalator" clauses, length of contract.

Standards for Evaluation: Occasionally, the editor receives a request from another publication for an article or for permission to reprint articles from his publication. Evaluation of such a request

should be based on the standards, not the ownership, of the publication making the request. The following standards can be used for evaluating all dental publications, both professional and commercial:

1. The content of the publication, both editorial and advertising, should be in accord with the object of the American Dental Association—to encourage the improvement of the health of the public, to promote the art and science of dentistry and to represent the interests of the members of the dental profession and the public it serves.

2. The publication should have advertising standards which prohibit the acceptance of advertising of products affecting the health of the public, the safety and effectiveness of which have not been demonstrated. The claims for the products should be supported by scientific evidence.

3. Scientific articles appearing in the publication should be supported by adequate scientific evidence; nonscientific articles should be in keeping with the purposes of the profession.

Council on Judicial Procedures, Constitution and Bylaws

Meetings: The Council met on January 21-22 and May 20-21, 1976 in the Headquarters Building. In addition, the Council sponsored the Workshop Conference on Specialty Practice held in Milwaukee, Wisconsin, on January 19-20, 1976. Dr. Joe N. Price was elected vice-chairman of the Council.

JUDICIAL PROCEDURES

Appeals to the Council: The Council heard the appeals of Drs. Wallace Ayers, Charles Block, and Donald Jones. The Council heard the appeal of Dr. Ayers from the decision of the San Diego County Dental Society, affirmed by the California Dental Association, imposing the penalty of expulsion from membership for a violation of Section 12 of the American Dental Association *Principles of Ethics* and an equivalent provision of the California Dental Association's *Code of Ethics*. The hearing was held on January 21, 1976. The Council affirmed the decision of the San Diego County Dental Society finding Dr. Ayers guilty of violating the American Dental Association *Principles of Ethics* and the California Dental Association *Code of Ethics*. However, the Council noted a failure to inform Dr. Ayers of certain pretrial conclusions drawn by the component society's Ethics Committee and his subsequent reformation of conduct in accordance with the uncommunicated recommendations of the Ethics Committee. For those reasons, the Council suspended the penalty of expulsion and placed Dr. Ayers on probation for a period of two years on condition that the penalty imposed would revert to expulsion should a similar violation reoccur.

The Council heard the appeal of Dr. Charles Block from the decision of the California Dental Association imposing the penalty of expulsion from membership for eight separate violations of Sections 7, 12, 13, 17, and 18 of the American Dental Association *Principles of Ethics* and equivalent provisions of the California Dental Association's *Code of Ethics*. It may be of interest to note that this was the first appeal heard by the Council under the revised California Dental Association Bylaws which prescribe a system for initiating disciplinary proceedings against members, including

the initial hearing, by a constituent dental association trial panel. This procedure is consistent with Chapter XI, Section 20(A) of the Association's *Bylaws*. The Council's hearing was held on January 21, 1976. The Council affirmed the decision of the California Dental Association finding Dr. Block guilty of one charge relating to a violation of Section 18 of the American Dental Association *Principles of Ethics* and an equivalent provision of the California Dental Association *Code of Ethics*. The Council reversed the decision of the California Dental Association with respect to the remaining seven charges. The Council also reviewed the imposition of the penalty of expulsion. In addition to the matters discussed above, the Council noted Dr. Block's expressed willingness to conform to the applicable ethical provisions and reduced the penalty of expulsion to a penalty of suspension for a period of two years. The above decisions are fully in accord with Chapter XI, Section 20(D)(f) of the Association's *Bylaws* which provides, in part, "The appeal agency shall have the discretion . . . to reverse the decision of the society which preferred charges against the accused member . . . or to uphold the decision of the society which preferred charges and reduce the penalty imposed."

The Council heard the appeal of Dr. Donald Jones from the decision of the California Dental Association imposing the penalty of expulsion from membership for a violation of Section 18 of the American Dental Association *Principles of Ethics* and an equivalent provision of the California Dental Association's *Code of Ethics*. The hearing was held on May 20, 1976. The Council affirmed the decision of the California Dental Association finding Dr. Jones guilty of violating the American Dental Association *Principles of Ethics* and the California Dental Association *Code of Ethics*. The Council also affirmed the discipline imposed by the California Dental Association.

Workshop Conference on Specialty Practice: At the request of the Council, the Board of Trustees approved a Workshop Conference on Specialty Practice to be held in conjunction with the Councils on Dental Education, Dental Health, and Dental Care Programs. The Conference was held January 19-20, 1976 in Milwaukee, Wisconsin. The sponsoring specialty societies and the American Association of Dental Examiners together with the Councils involved sent representatives to the Conference.

The purpose of the Conference was to recommend solutions to jurisdictional problems among the specialties by defining the boundaries of the specialty practice areas and to suggest solutions to complications arising from the application of Section 18 of the *Principles of Ethics*.

Additional matters related to these subjects were referred to the Workshop Conference and the Council for consideration. Those matters calling for report to the 1976 House as well as those additional matters requiring the attention of the House are treated here.

MORATORIUM—ANNOUNCEMENT IN MORE THAN ONE SPECIALTY AREA

The 1974 House of Delegates amended Section 18 of the Association's *Principles of Ethics* to permit announcement of limitation of practice by those educationally qualified in more than one specialty area (*Trans.* 1974:693). Thereafter some difficulty with the administration of the educational criteria for announcement in an additional specialty area became apparent. At that time, the Council on Dental Education reviewed the matter and requested clarification from this Council.

Strict adherence to the language of Section 18 of the *Principles* required the interpretation that a dentist wishing to announce limitation of practice in an additional specialty area must meet the then existing educational requirements and standards for that additional specialty area. Consequently, certain dentists who were precluded from announcing in an additional specialty area under the pre-1974 provisions of Section 18 of the *Principles* and who fulfilled their educational

qualifications prior to 1967, for reasons described later in this report, were not now privileged to announce in the additional area. Prior to 1967, the Council on Dental Education accredited undergraduate programs and hospital internships and residencies only. In 1967, that Council expanded its accreditation program to include evaluation of specialty education programs. For that reason, unless certified by a specialty board, a dentist who graduated from a specialty training program prior to 1967 could not now begin to announce limitation of practice in that specialty. In other words, a dentist wishing to announce in an additional specialty area is governed by the same provisions as a dentist wishing to initially announce in one specialty area. However, this Council's review of the background of the 1974 resolution amending Section 18 of the *Principles* together with its review of the transcript of the House of Delegates debate leading to the adoption of the resolution suggested that this may not have been the result envisioned.

Three resolutions were considered by the 1975 House of Delegates as a consequence of this dilemma. The Council suggested alternative resolutions. One of these would have restricted announcement in an additional specialty area to dentists who in 1967 and thereafter have fulfilled currently existing educational requirements and standards, including the successful completion of an accredited education program. The other alternative resolution would have permitted announcement in an additional specialty area by dentists who before 1967 fulfilled advanced dental educational programs which extended for two or more years as specified by the Council on Dental Education. The 1975 House of Delegates referred these resolutions to the Council to be included on the agenda of the Workshop Conference and for report to the 1976 House of Delegates (*Trans.* 1975:726).

In addition, at the suggestion of the Board of Trustees, the 1975 House of Delegates adopted a moratorium upon implementation of the privilege of announcing in more than one specialty area pending action on this report by the 1976 House (*Trans.* 1975:726). The Board noted that the alternative resolutions suggested by the Council indicated a need for further evaluation of the consequences of extending the multiple announcement privilege. In addition, the Board noted that official definitions of the specialties had not been adopted, and that the Workshp Conference would address itself to these definitions. The Board believed that without such definitions, the combining of specialties might present serious problems. The Board also noted conflicts with certain state dental practice acts and with the policies of some certifying boards and their sponsoring associations. The moratorium adopted by the 1975 House of Delegates reads as follows:

> Resolved, that a moratorium be imposed upon implementation of the privilege of announcing in more than one specialty under Section 18 of the *Principles of Ethics* until the report of the January 1976 Workshop Conference on Specialty Practice is received and acted upon by the 1976 House of Delegates.

The Council carefully considered the recommendation of the Workshop Conference which favored restricting the privilege of announcement of limitation of practice to a single specialty area or, by a somewhat lesser margin, restricting the privilege to no more than two specialty areas. The Council also considered the existing accreditation of four combined or dual-specialty programs by the Council on Dental Education predicated on the 1974 action of the House of Delegates. In addition, the Council considered the legal implications of restricting announcement to one or two specialty areas when an individual is educationally qualified in additional areas, especially when combined or dual programs have been accredited by another agency of the Association.

While the Council considered the legal implications a matter of concern, it was persuaded by the need for an even-handed and well reasoned approach to the administration of Section 18 of the *Principles*. In this context, the Council considered the public benefit served by restricting announcement of limitation of practice to a single specialty area. However, the Council believes that this reasoning had its greatest impact at the time specific educational requirements for announcement of limitation of practice were in the early developmental stage. In contrast, it is the Council's opinion that the present educational requirements are relatively stringent and fully in accord with public benefit considerations. In addition, the Council notes that the exclusive practice requirement in the area of announced specialty practice remains an integral part of Section 18 of the *Principles*. While the Council recognizes that restricting announcement to two specialty areas would be a logical extension of the existing accreditation of four combined or dual-specialty education programs, the Council is persuaded that such a limitation is neither reasonable nor supported by public benefit considerations in view of the present stringent educational requirements and the exclusive practice provision. For these reasons, it is the recommendation of the Council

that a dentist educationally qualified or certified by the specialty board in two or more specialty areas be permitted to ethically announce in those areas.

Educational eligibility for announcement in an additional specialty area was also reviewed by the Workshop Conference and by the Council. In its consideration of this matter, the Council noted the action of the 1975 House of Delegates (*Trans.* 1975:690) concerning the educational eligibility for board certification. It is the recommendation of the Council that the criteria for announcement in an additional specialty area should be essentially the same as the criteria for eligibility for certification.

In accordance with this recommendation, the Council adopted an advisory opinion to Section 18 of the *Principles* to become effective upon the endorsement by the House of Delegates of the educational criteria, to read as follows:

> A dentist who is presently ethically announcing limitation of practice in a specialty area, and who wishes to announce in an additional specialty area and who is qualified educationally in more than one recognized dental specialty by virtue of three years of advanced training in oral surgery or two years of advanced training in one of the other recognized dental specialties prior to 1967, but who was not permitted to announce limitation to practice in more than one area prior to the 1974 revision of Section 18, must submit documentation to the appropriate constituent society of successful completion of the requisite education in programs listed by the Council on Dental Education in each area for which he wishes to announce.

An appropriate resolution concerning the moratorium and educational eligibility for announcement in an additional specialty area is presented at the end of this report.

SCOPE OF SPECIALTY PRACTICE AND REFERRAL PATTERNS

The 1975 House of Delegates referred the following resolution, originally proposed by the Council on Dental Health, to the Council on Judicial Procedures, Constitution and Bylaws (*Trans.* 1975: 680):

> Resolved, that in overlapping areas of clinical responsibility specialists should be permitted to perform those procedures which are related to their specialties, consistent with their education, competence, and the provision of good dental health care.

In turn, the Council placed this resolution on the agenda of the Workshop Conference. At the same time, the Conference also considered the question of overlapping areas of clinical responsibility from the perspective of the definitions of the specialties. In the latter instance, the Council on Dental Education has adopted a recommendation of the Conference as the preamble to the definitions of the recognized special areas which reads as follows:

> It is recognized there are overlapping responsibilities among the recognized areas of dental practice. However, as a matter of principle, a specialist shall not provide routinely procedures that are beyond the scope of his specialty.

Since the preamble language is inconsistent with the language of the resolution referred to the Council, it is recommended that no further action be taken at this time. The Conference also reviewed the related problem of appropriate referral patterns. The Conference recommended that some guidelines in this area would be helpful. For this reason the Council suggests that Section 7 of the *Principles of Ethics* be amended with minor modification to reflect the guidelines recommended by the Conference. An appropriate resolution is presented at the end of this report.

DEFINITIONS OF SPECIAL AREAS OF DENTAL PRACTICE

As previously indicated, the Council on Dental Education has acted to finalize current definitions of the eight specialty areas of dental practice. These definitions, as published, conform with the recommendations of the Conference. It should be noted that the Council's administration of the exclusive practice provision of Section 18 of the *Principles* is largely dependent upon these definitions.

Subsequent to the action of the Council on Dental Education, the American Association of Endodontists informed the Council that it had acted to revise its definition. The Council directed that this communication be referred to the Council on Dental Education. In addition, the Conference participants representing the American Association of Orthodontists and the American Academy of Pedodontics agreed to resolve their dispute concerning the scope of pedodontic practice. Following the Conference representatives of those organizations, the Council on Dental Education and this Council met and resolved that dispute. Specifically, it was agreed that Section 8 of the Scope of Pedodontics would read,

> Ability to diagnose and demonstrate knowledge and skill in dental procedures relating to the growth and development of the stomatognathic system.

Subsequently, the American Association of Orthodontists informed the Council that it had taken the following action:

> The American Association of Orthodontists urgently recommends that the scope of practice of the specialty of pedodontics in orthodontic problems be limited to the essence of the following:
>
> > Preventive measures including space maintenance intended to maintain the integrity of an otherwise normally developing occlusion.

The Council on Dental Education, however, has indicated no intention of changing the definition and scope of pedodontics as agreed upon by the American Association of Orthodontists and the American Academy of Pedodontics representatives at their meeting following the Milwaukee Conference. This section of the report on the Conference is informational only.

PEER REVIEW

The Conference reviewed a number of matters relating to third parties and specialty practice. With regard to peer review, the Conference endorsed the following:

> That the Specialty Representatives Group recommend that the American Dental Association Council on Dental Care Programs utilize the sponsoring organizations of the certifying board of special areas of dental practice as their resource for Peer Review Purposes on a State and National Level.

In addition, the Conference recommended the following:

> That in instances where a specialist Peer Review Panel Procedure is invoked, that the specialist panel act in an advisory capacity to the existing Peer Review Committee.

The Council has requested the Executive Director to refer these recommendations to the Council on Dental Care Programs. This section of the report on the Workshop Conference is informational only.

Specialty Nomenclature: In conjunction with its review of the recommendations of the Workshop Conference on Specialty Practice and other matters, the Council noted that it would be helpful to include as a portion of Section 18 specified specialty nomenclature to be used in announcement of limitation of practice. It is the Council's recommendation that the proposed amendment will serve as a useful guideline to the membership. An appropriate resolution is presented at the end of this report.

Moratorium on Disciplinary Actions Involving Advertising: The Council has considered the present legal climate in relation to the restrictions on various forms of advertising

contained in the Association's *Principles of Ethics*. Two fields of law are involved; namely, antitrust law and the First Amendment of the *Constitution*.

Historically, in the antitrust area, it had been thought that early decisions had resulted in at least a partial exemption of the learned professions. While it had been understood that internal professional regulation could not interfere with extraprofessional advantageous business relationships specifically, for example, third-party relationships, it had been believed that internal professional regulation concerning activities among colleagues and with patients and clients was cloaked with an antitrust exemption. The *Goldfarb* case, 421 US 773, decided by the US Supreme Court in 1975, laid that notion to rest. Specifically the Court held that a professional service rendered in exchange for a client's fee was commerce, that a lawyer's title search was in interstate commerce and that a minimum fee schedule and its ethical enforcement constituted price fixing. With respect to interstate commerce, it should be noted that the Court's definition has been expanded to include any substantial burden, direct or indirect, as a result of the conduct of the enterprise under scrutiny, including interstate financing, insurance payments, and purchases. See *Hospital Building Company vs Trustees of the Rex Hospital,* ____ US ____, (May 24, 1976) and *Goldfarb,* cited above. In this context, the Council also reviewed the Federal Trade Commission complaint against the American Medical Association concerning the enforcement of its ethical advertising restrictions. The Council also noted the Federal Trade Commission's initiation of a preliminary investigation of this Association's ethical advertising restrictions.

Concerning the recent action of the Federal Trade Commission against the American Medical Association, a recently issued statement of that Association's Judicial Council reaffirming its "long standing policy" is worthy of note. That statement is as follows:

STATEMENT OF THE JUDICIAL COUNCIL

Re: Advertising and Solicitation

This statement reaffirms the long standing policy of the Judicial Council on advertising and solicitation by physicians. The *Principles of Medical Ethics* are intended to discourage abusive practices which exploit patients and the public and interfere with freedom in making an informed choice of physicians and free competition among physicians.

Advertising

The *Principles* do not proscribe advertising; they proscribe the solicitation of patients. Advertising means the action of making information or intention known to the public. The public is entitled to know the names of physicians, the type of their practices, the location of the offices, their office hours, and other useful information that will enable people to make a more informed choice of physician.

The physician may furnish this information through the accepted local media of advertising or communication which are open to all physicians on like conditions. Office signs, professional cards, dignified announcements, telephone directory listings, and reputable directories are examples of acceptable media for making information available to the public.

A physician may give biographical and other relevant data for listing in a reputable direc-

tory. A directory is not reputable if its contents are false, misleading, or deceptive, or if it is promoted through fraud or misrepresentation. If the physician at his option chooses to supply fee information, the published data may include his charge for a standard office visit or his fee or range of fees for specific types of services, provided disclosure is made of the variable and other pertinent factors affecting the amount of the fee specified. The published data may include other relevant facts about the physician, but false, misleading, or deceptive statements or claims should be avoided.

Local, state or specialty medical associations, as autonomous organizations, may have ethical restrictions upon advertising, solicitation of patients, or other professional conduct of physicians which exceed the *Principles of Medical Ethics*. Furthermore, specific legal restrictions upon advertising or solicitation of patients exists in the medical licensure laws of at least thirty-four states. Other states provide regulation through statutory authority to impose penalties for unprofessional conduct.

Solicitation

The term "solicitation" in the *Principles* means the attempt to obtain patients by persuasion or influence using statements or claims which (1) contain testimonials; (2) are intended or likely to create inflated or unjustified expectations of favorable results; (3) are self-laudatory and imply that the physician has skills superior to other physicians engaged in his field or specialty of practice; or (4) contain incorrect or incomplete facts, or representations or implications that are likely to cause the average person to misunderstand or be deceived.

Competition

Some competitive practices accepted in ordinary commercial and industrial enterprises—where profit making is the primary objective—are inappropriate among physicians. Commercial enterprises, for example, are free to solicit business by paying commissions. They have no duty to lower prices to the poor. Commercial enterprises are generally free to engage in advertising "puffery," to be boldly self-laudatory in making claims of superiority, and to emphasize favorable features without disclosing unfavorable information.

Physicians, by contrast, have an ethical duty to subordinate financial reward to social responsibility. A physician should not engage in practices for pecuniary gain which interfere with his medical judgment and skill or cause a deterioration of the quality of medical care. Ability to pay should be considered in reducing fees and excessive fees are unethical.

Physicians should not pay commissions, rebates, or give "kickbacks" for the referral of patients. Likewise, they should not make extravagant claims or proclaim extraordinary skills. Such practices, however common they may be in the commercial world, are unethical in the practice of medicine because they are injurious to the public.

Freedom of choice of physician and free competition among physicians are prerequisites of optimal medical care. The *Principles of Medical Ethics* are intended to curtail abusive practices which impinge upon these freedoms and exploit patients and the public.

April 9, 1976

Legal activity concerning ethical restrictions on advertising paralleling the activity occurring in the antitrust field, has recently developed under the First Amendment to the *Constitution*. Two recent cases are of importance in this area. Historically, ethical and governmental restrictions on professional advertising had been based on the US Supreme Court decision in *Semler vs Oregon State Board of Dental Examiners*, 294 U.S. 608 (1935). That case upheld restrictions on advertising imposed by

statute, but that case was decided on due process and equal protection grounds. Traditionally, any reasonable basis underlying state enactments attacked on due process and equal protection grounds has been enough for the reviewing courts to uphold the enactment's constitutionality. In contrast to the any reasonable basis test, the review of the constitutionality of state enactments attacked on first amendment grounds is based on a significant governmental interest test. In applying the test the courts balance the interests of free speech against the countervailing interests of the state. In *Bigelow vs Virginia,* 421 U.S. 809 (1975) the US Supreme Court overturned the conviction of an editor who ran an advertisement for a New York abortion service in violation of a Virginia statute. The Court overturned the conviction and held that the statute as applied infringed on constitutionally protected speech. With reference to the balancing of interests referred to above, the court noted,

> The task of balancing the interests at stake here was one that should have been undertaken by the Virginia courts before they reached their decision.

A decision reached by the US Supreme Court three days after the Council's last meeting, but since reviewed by the Council, greatly expands the commercial free speech doctrine enunciated in *Bigelow.* In that case, *Virginia State Board of Pharmacy vs Virginia Citizens Consumer Council, Inc.,* ____ U.S. ____ (May 24, 1976), the Court, having referred to the *Semler vs Dental Examiners* case, states,

> The challenge now made, however, is based on the First Amendment. This casts the Board's justifications in a different light for on close inspection it is seen that the State's protectiveness of its citizens rests in large measure on the advantages of their being kept in ignorance. The advertising ban does not directly affect professional standards one way or the other.

In accordance with this comment, the Court held that Virginia has no significant interest in banning commercial advertising by pharmacists. While the Court noted that other professionals, including dentists, dispense services rather than standardized products, the Court goes no further than to observe that different factors, that is the infinite variety and nature of the professional services rendered and the consequent enhanced possibility for confusion and deception, may have a bearing on certain kinds of advertising by those professionals. In a similar context, the Court notes that restrictions on the time, place, and manner of advertising may be appropriate.

With this background before it, subsequently reinforced by the pharmacy advertising decision, the Council concluded that it would be folly for it to propose no action. However, the Council also recognizes that the legal activity described above is far from complete and that the doctrines enunciated are far from fully developed. For this reason, the Council is unable to propose definitive and final action at this time. In lieu of that the Council recommends the adoption of a limited moratorium on the enforcement of ethical violations of the *Principles of Ethics* relating to advertising. It will be noted that the provisions of the proposed resolution are not dissimilar to the statement concerning advertising issued by the American Medical Association. An appropriate resolution adopted unanimously by the Council (and approved by American Dental Association outside Counsel) is presented at the end of this report.

Reevaluation of the "Principles of Ethics": The 1975 House of Delegates adopted the following resolution (*Trans.* 1975:727):

Resolved, that the Council on Judicial Procedures, Constitution and Bylaws undertake a complete reevaluation of the *Principles of Ethics* and a report be submitted to the 1976 House of Delegates including answers to the following questions:

1. What do we mean by "Ethical Code"? The dictionary defines it as a code which governs a profession. Yet when new proposals are made for addition to our Code of Ethics we are told that they may be restraining in content and therefore viewed unfavorably in the courts. In this light our entire Ethical Code may be restraining. The term "Ethical" must be better defined by our Association.

2. Are we actually governed by a Code of Ethics *(Principles of Ethics)*? Since any member or non-member has such an excellent chance of overturning our ethical code, can we update our code realistically?

3. Is the code meaningful to the membership? If we cannot strengthen our code, then we are only to be allowed to govern ourselves relating to insignificant matters while matters of consequence overwhelm the profession.

To some extent the portion of this report entitled "Moratorium on disciplinary actions involving advertising" is responsive to the resolution. Nevertheless, for the reasons stated there, the Council is not in a position at this time to provide definitive solutions to the problems suggested by the resolution. As that portion of the report notes, several far reaching decisions have been handed down by the U. S. Supreme Court, but those decisions merely touch upon the threshold of the full scope of the inquiry posed by the resolution.

When and if the Federal Trade Commission case against the American Medical Association is before the Commission, the Association will undoubtedly wish to file an *Amicus Curiae* brief in support of the principal concepts in the American Dental Association *Principles of Ethics*.

For the reasons stated, the Council is unable to project the possible outcome of future litigation in this area and is constrained by existing litigation and the potential of future litigation from responding in a speculative way in the form of a legal opinion based on existing precedent.

Official Advisory Opinions: The Council acted to delete several advisory opinions for editorial reasons. In addition to these changes, the Council acted to delete one opinion and add another of particular significance to the membership.

The Council continued its surveillance of its advisory opinions which may conflict with the antitrust laws or with First Amendment rights. The basis for these judgments is fully reported in the Council's 1975 Annual Report (*Trans.* 1975:145). For the same reasons reported at that time, the Council acted to delete advisory opinion nine of Section 12 which provided,

A dentist who distributes his professional cards to persons eligible for dental care under a group health care plan, including persons not his patients of record, is engaged in unethical conduct even though he is the only dentist who has agreed to render services to the group.

Consequently, as noted in the Council's 1975 Report, it is in the view of the Council both legally and ethically permissible for a dentist to permit his name to be distributed to individual plan members.

The Council reviewed several inquiries concerning the use of additional degrees. In response to these, the Council adopted the following advisory opinion:

> The prohibition against the use of additional degrees and similar designations applies to material directed to the public, but not to material directed to professional colleagues. For example, the prohibition does not apply to curriculum vitae directed to the profession.

CONSTITUTION AND BYLAWS

Nomination For and Election to Councils: At the 1975 House, individuals were nominated from the floor to a Council on which more than one seat was to be filled. The *Bylaws* are silent on the procedure to be followed in this situation. The Council considered alternative approaches to this problem. One of these alternative resolutions proposed that such nominees be treated as undesignated and elected from among all nominees. The language of that resolution is follows:

> **Resolved,** that Chapter V, House of Delegates, Section 140, Election Procedure, of the *Bylaws* be amended by substitution to read is as follows:
>
> **Section 140. Election Procedure.** Elective officers, members of the Board of Trustees and members of councils and committees shall be elected by the House of Delegates except as otherwise provided in these *Bylaws*. Voting shall be by ballot, except that when there is only one candidate for an office, council or committee, such candidate may be declared elected by the Speaker. The Secretary shall provide facilities for voting. The polls shall be open for at least three (3) hours.
>
> a. When one is to be elected, and more than one has been nominated, the majority of the ballots cast shall elect. In the event no candidate receives a majority of the votes cast on the first ballot, the two (2) candidates receiving the greatest number of votes shall be balloted upon again.
>
> b. When more than one is to be elected, and the nominees exceed the number to be elected, the votes cast shall be non-cumulative, and the candidates receiving the greatest number of votes shall be elected.

However, the Council recommends the alternative approach, namely, that nominations from the floor be for a designated seat. An appropriate resolution is presented at the end of this report.

Admission of New Members: In its review of a wide range of antitrust and other potential legal problems, the Council has become aware of the problems associated with denial of association membership to an applicant. Since it is reasonable to predict that courts will assume that Association membership bestows an economic benefit, failure to adhere to due process in the event that an applicant is denied membership may result in legal reversal, may further involve violation of the antitrust laws, and may result in otherwise unnecessary litigation and consequent expense. For these

reasons the Council suggests that an internal appellate procedure be established under the Association's *Bylaws*. An appropriate resolution is presented at the end of this report.

Student Membership: Some ambiguity has been brought to the attention of the Council concerning the eligibility for student membership of certain dentists attending advanced education programs. For example, under one interpretation of the *Bylaws* a resident in otorhinolaryngology would have been denied student membership. It is the interpretation of the Council that a dentist formally enrolled and attending a full-time advanced education program in a recognized institution of higher learning is eligible for student membership. In addition to language intended to resolve this ambiguity, minor editorial corrections are also contained in the proposed language. An appropriate resolution is presented at the end of this report.

Appeal Briefs and Disciplinary Procedures: The Council has reviewed the present briefing and hearing schedule relative to disciplinary hearings. The Council suggests some minor revision in this schedule, the addition of a schedule for reply and rejoinder briefs, and modification of the schedule for hearing dates. In addition, a requirement is proposed that briefs be submitted to the opposing party. An appropriate resolution is presented at the end of this report.

Editorial Corrections: Three resolutions are presented to correct internal inconsistencies within the *Bylaws* or to conform the *Bylaws* with Association policy. Appropriate resolutions are presented at the end of this report.

Acknowledgement: In the past year, Dr. Elbert H. "Mike" Smith served as a consultant to the Council. Prior to that he served for eight years as a member of the Council, the last three of which he served as Chairman. The Council wishes to acknowledge with gratitude his fine contributions and outstanding leadership.

RESOLUTIONS

12. **Resolved,** that the Moratorium imposed upon the implementation of the privilege of announcing in more than one specialty under Section 18 of the *Principles of Ethics* (*Trans.* 1975:726) be allowed to lapse, and be it further

Resolved, that the educational criteria for announcement of limitation of practice in an additional specialty area as provided in the advisory opinion adopted by the Council on Judicial Procedures, Constitution and Bylaws is endorsed and reads as follows:

> A dentist who is presently ethically announcing limitation of practice in a specialty area, and who wishes to announce in an additional specialty area and who is qualified educationally in more than one recognized dental specialty by virtue of three years of advanced training in oral surgery or two years of advanced training in one of the other recognized dental specialties prior to 1967, but who was not permitted to announce limitation of practice in more than one area prior to the 1974 revision of Section 18, must submit documentation to the appropriate constituent society of successful completion of the requisite education in programs listed by the Council on Dental Education in each area for which he wishes to announce.

13. Resolved, that Section 7 of the *Principles of Ethics* be amended by the addition of a second paragraph to read as follows:

> In addition, when a patient visits or is referred to a specialist or consulting dentist for consultation
>
> 1. It is the obligation of the specialist or consulting dentist to continue to observe the patient's posttreatment condition until complete recovery has been accomplished or can reasonably be expected to follow.
> 2. It is the obligation of the specialist or consulting dentist, under ordinary circumstances, to return the patient to the referring dentist for future care.
> 3. It is the obligation of the specialist when there is no referring dentist to refer the patient for general dental care, when appropriate.

14. Resolved, that Section 18 of the *Principles of Ethics* be amended by the addition of a new paragraph following the first paragraph to read as follows:

> The specialty areas of dentistry approved by the American Dental Association and the designation for ethical announcement of limitation of practice are:
>
> Endodontics
> Oral Pathology
> Oral Surgery
> (or Oral and Maxillofacial Surgery)
> Orthodontics
> Pedodontics
> (or Dentistry for Children) (or Pediatric Dentistry)
> Periodontics
> Prosthodontics
> Dental Public Health

15. Resolved, that constituent and component societies apply until the 1977 House of Delegates meeting a moratorium to disciplinary actions against dentists for ethical violations involving advertising with the exception of advertising that is designed to solicit patients, and be it further

Resolved, that for the purpose of this resolution the term "solicit" means the attempt to obtain patients by persuasion or influence and includes but is not limited to a statement or claim which:

1) contains a misrepresentation of fact;

2) is likely to mislead or deceive because in context it makes only a partial disclosure of relevant facts;

3) contains a patient's laudatory statements about a dentist;

4) is intended or is likely to create false or unjustified expectations of favorable results;

5) implies unusual competence, other than as permitted under "Announcement of Limitation of Practice";

6) relates to dental fees other than a standard consultation fee or a range of fees for specific types of procedures without fully disclosing all variables and other relevant factors;

7) is intended or is likely to imply or to guarantee atypical results;

8) is intended or is likely to appeal primarily to a lay person's fears or similar emotions;

9) contains other representations or implications that in reasonable probability will cause an ordinary, prudent person to misunderstand or be deceived,

and be it further
Resolved, that the same moratorium apply to disciplinary actions against direct members of this Association

CONSTITUTION AND BYLAWS

16. **Resolved**, that Chapter IX, Councils, Section 20(A), Members, Nominations and Elections, of the *Bylaws* be amended by inserting after the third sentence the following sentence:

> When nominations are made by the Board of Trustees to elect more than one member to a council, a nomination or nominations made by the House of Delegates shall specify the nominee named by the Board of Trustees to be opposed.

so that the subsection will read:

> A. All councils, except as otherwise provided for in these *Bylaws*, shall be composed of five (5) members. Nominations for all councils shall be made by the Board of Trustees. Additional nominations may be made by the House of Delegates unless otherwise provided for in these *Bylaws*. When nominations are made by the Board of Trustees to elect more than one member to a council, a nomination or nominations made by the House of Delegates shall specify the nominee named by the Board of Trustees to be opposed.

17. **Resolved**, that Chapter I, Membership, of the *Bylaws* be amended by the addition of new Section 60 to read as follows:

> Section 60. Admission of Active Members: A prospective member whose application for membership is denied shall be entitled to appeal from that denial to his constituent society and the Council on Judicial Procedures, Constitution and Bylaws in that order in accordance with the procedures in Chapter XI, Section 20 C and D of these *Bylaws* in the same manner and governed by the same provisions as those involving the discipline of members,

and be it further
Resolved, that Chapter IX, Councils, Section 110(M)(c), Duties of the Council on Judicial Procedure, Constitution and Bylaws, of the *Bylaws* be amended by substitution to read as follows:

> To consider appeals from members of the Association, from applicants for membership in the Association, or from component or constituent societies subject to the requirements of Chapter XI, Section 20 of these *Bylaws*.

18. **Resolved**, that Chapter I, Membership, Section 20, Qualifications, Subsection C, Student Member, of the *Bylaws* be amended by substitution to read as follows:

C. **Student Member.** A pre-doctoral student of a dental school accredited by the Commission on Accreditation shall be classified as a student member of this Association and a member of the American Student Dental Association; or any dentist eligible for membership in this Association who is engaged full time in (1) an advanced training course of not less than one academic year's duration in an accredited school or residency program in areas neither recognized by the Association nor accredited by the Commission on Accreditation or (2) a residency program or advanced education program in areas recognized by the Association and in a program accredited by the Commission on Accreditation may be classified as a student member of this Association.

and be it further

Resolved, that Chapter I, Membership, Section 50, Dues and Reinstatement, Subsection A, Active Members, of the *Bylaws* be amended by substituting for those items designated (1) and (2) the following:

(1) an advanced training course of not less than one academic year's duration in an accredited school or residency program in areas neither recognized by the Association nor accredited by the Commission on Accreditation or (2) a residency program or advanced education program in areas recognized by the Association and in a program accredited by the Commission on Accreditation.

so that Subsection A will read as follows:

A. **Active Members.** The dues of active members shall be one hundred dollars ($100.00) due on January 1 of each year except that any dentist who is an active member of component and constituent societies of this Association and who is engaged full time in (1) an advanced training course of not less than one academic year's duration in an accredited school or residency program in areas neither recognized by the Association nor accredited by the Commission on Accreditation or (2) a residency program or advanced education program in areas recognized by the Association and in a program accredited by the Commission on Accreditation shall pay three dollars and fifty cents ($3.50) due on January 1 of each year until the December 31 following completion of such a residency or advanced education program.

19. **Resolved,** that Chapter XI, Principles of Ethics and Judicial Procedures, Section 20, Discipline of Members, Subsection D, Appeals, of the *Bylaws* be amended as follows:

1. By deletion of the third sentence and by substitution therefor of a paragraph to read as follows:

An appeal from any decision shall not be valid unless notice of appeal is filed within thirty (30) days and the supporting brief, if one is to be presented, is filed within sixty (60) days after such decision has been rendered. A reply brief, if one is to be presented, shall be filed within ninety (90) days after such decision is rendered. A rejoinder brief, if one is to be presented, shall be filed within one hundred five (105) days after such decision is rendered. After all briefs have been filed, a minimum of forty-five (45) days shall lapse before the hearing date. Omission of briefs will not alter the briefing schedule or hearing date unless otherwise agreed to by the parties and the Chairman of the appropriate appellate agency.

2. By the substitution of the word "or" for the word "of" in line 1652.

3. By deletion of the second sentence of Subsection (c), Briefs, and by substitution therefor of language to read as follows:

The briefs of the parties shall be submitted to the secretary of the constituent society or the chairman of the Council on Judicial Procedures, Constitution and Bylaws of this Association, as the case may be, and to the opposing party(ies) in accordance with the prescribed briefing schedule.

20. **Resolved,** that Chapter I, Membership, Section 40, Privileges, Subsection (A)(c) Active Member, of the *Bylaws* be amended by substitution to read as follows:

c. An active member under a disciplinary sentence of suspension shall not be privileged to hold office, either elective or appointive including delegate or alternate delegate, in this Association, to vote or otherwise participate in the selection of Association officials. This does not preclude the constituent or component societies concerned from limiting further the privileges extended exclusively by them to one of their members under suspension. A sentence of suspension shall not abrogate any contractual relation between the disciplined member and a third party.

21. **Resolved,** that Chapter II, Constituent Societies, Section 20, Name, of the *Bylaws* be amended by deleting the final words "or federal dental service within which it is chartered.", and be it further

Resolved, that Chapter VI, Board of Trustees, Section 90(K), Duties, of the *Bylaws* be amended by adding the following words after the words "United States" and by deleting the following words from the end of the sentence:

"in which no constituent society exists."

22. **Resolved,** that Chapter IX, Councils, Section 110, Duties, Subsection P, Council on Relief, of the *Bylaws* be amended by adding at the end of paragraph a. and at the end of the Subsection the words ", and the American Dental Association Disaster Victims Emergency Loan Fund.", and by adding at the end of paragraph b. the words ", and for the granting of emergency assistance loans to dentists who are victims of natural disasters.", and be it further

Resolved, that Chapter XVII, Finances, Section 30, Relief Fund, of the *Bylaws* be amended by substitution to read as follows:

Section 30 Relief and Disaster Funds:

A. Purposes: This Association shall establish the American Dental Association Relief Fund, fully detached from any other fund of the Association, for the purpose of granting financial aid to dentists, their dependents and survivors in accordance with any indenture of trust governing the Relief Fund and in accordance with rules and regulations formulated by the Council on Relief and approved by the Board of Trustees. This Association shall also establish the American Dental Association Disaster Victims Emergency Loan Fund, fully detached from any other fund of the Association, for the purpose of providing emergency assistance loans to dentists who are victims of natural disasters in accordance with any indenture of trust governing the Disaster Fund and in accordance with rules and regulations formulated by the Council on Relief and approved by the Board of Trustees.

B. Funds: The Relief Fund shall be held in the name of the American Dental Association Relief Fund and the Disaster Fund shall be held in the name of the American Dental Association Disaster Victims Emergency Loan Fund, and these funds shall be derived from cash, securities and other property transferred or appropriated to them by the Board of Trustees, contributions, bequests and earnings thereon.

Council on Legislation

Meetings: The Council met in Washington, D.C. on March 1-2. All members were present. The Council will meet again on June 21-22 in Chicago and on September 17-18 in Washington D.C.

Supplemental Report: In accordance with a 1975 House of Delegates directive, the Council will join with the Washington Office to present a supplemental report on final actions in Congress and the state legislatures (*Trans.* 1975:733).

House of Delegates Assignments to Council: The following actions of the 1975 House of Delegates are reflected in other commentary in this report or will be treated in the Council's supplemental report.

1. Consideration of supporting rescission of earnings test for determining entitlement to Social Security retirement benefits (*Trans.* 1975:733).
2. Opposition to federal legislation imposing on dental students the obligation to pay back federal or state funds made available to dental schools (*Trans.* 1975:707).
3. Relation of federal legislation to redistribution of dentists and reciprocity (*Trans.* 1975:718).

The Council also presented its recommendations to the Board of Trustees on Past President L. M. Kennedy's proposal to study the feasibility of sponsoring and supporting a bill to create a national program of dental care for indigent persons (*Trans.* 1975:736).

Extension of Health Manpower Act (S. 3239 and H.R. 5546): The House of Representatives passed its version of health manpower legislation in July 1975. Two objectionable provisions remain in that bill: one is an enrollment increase requirement as a

*American Medical Association

condition for receiving capitation grants for schools that are unable to establish an off-site clinical facility, the other optional requirement. The second objectionable provision is a requirement that any school applying for capitation grants must agree to obtain commitments from students entering schools that they will pay back the portion of capitation grants obtained in their behalf. At the Senate health manpower hearings in November 1975, Dr. Robert B. Shira, Association president, presented oral testimony. The Senate version of health manpower legislation is scheduled for floor action on June 14; it does not include a "student pay-back requirement," but it does contain objectionable features such as (1) enrollment increases as an optional requirement for dental schools needing capitation awards, (2) a second option for receiving capitation grants, establishment of a TEAM program, that mandates delegation of placement, contouring and finishing amalgam restorations as part of the program, (3) a model licensure and relicensure plan to be designed by HEW for use by states; $12 million is available for grants to states that adopt the model, and (4) nullification of state laws that "interfere with academic freedom," for example a state dental law that prohibits other than dentists from performing certain intraoral procedures. A special information bulletin was sent to all Association members urging them to write to their Senators in support of the Association's position on health manpower legislation. When the Senate takes up S. 3239 on June 14, Senator J. Glenn Beall (R-Md.), will offer amendments to moderate the burdensome capitation grant requirements for dental schools. The Council and Washington Office will strive to have the other objectionable features of the legislation removed during the conference between the Senate and House in late June or early July.

National Health Insurance: The Ways and Means health subcommittee of the House of Representatives has held hearings on national health insurance in several cities. The Council and Washington Office have cooperated with constituent societies that have presented testimony at these hearings. In November 1975, the Council Chairman, Dr. Paul W. Kunkel, testified before the Ways and Means subcommittee in Washington at the opening round of the series of NHI hearings. Those hearings were not directed to any specific bills but rather to costs and benefits projections. In February 1976, Dr. Robert C. Lauer, Columbus, Ohio, a member of the Association's Council on Dental Care Programs, was invited to testify as an expert before the House of Representatives Commerce Committee's subcommittee on health. Dr. Lauer's testimony was confined to dental benefits within a national health insurance plan. Also testifying as an invited expert was Dr. James Bawden, former dean of the School of Dentistry at the University of North Carolina. It is obvious that national health insurance will flourish as a campaign issue for the November Presidential election and will not emerge in any form during the remainder of the 94th Congress.

Professional Standards Review Organizations: No further hearings on PSROs were held since September 1975. The Association's corrective amendments (S. 153) sponsored by Senators Hansen (R-Wyo.), Beall (R-Md.), Hartke (D-Ind.), and Humphrey (D-Minn.) will be reintroduced in the next Congress.

Health Maintenance Organizations (H.R. 9019 and S. 1926): Legislation to facilitate the prócedure for obtaining qualification as a federally subsidized HMO passed the House in November 1975. One of the conditions for qualification, mandatory inclusion of preventive dental services, is removed in the House bill. The Senate HMO bill is stalled in committee because of controversy over a proposal to permit HMOs

to contract directly with practitioners in typical private practice settings. Existing law limits HMOs to contracts with group practices or independent practice associations.

Health Devices Regulation (S. 510 and H.R. 5545): The President in late May signed S. 510 into law. The medical devices law is essentially patterned upon the scheme for approving new drugs. Devices with long histories of safety and efficacy are placed in category I which means they must be properly labeled. Category II devices must meet standards of safety and efficacy; Association standards will be applied to most dental devices in category II. Category III devices must receive premarket clearance, that is scientific proof of their safety and efficacy.

Army-Air Force Dental Bill (H.R. 3042): The Council has cooperated with the Council on Federal Dental Services in an effort, thus far unsuccessful, to obtain hearings on H.R. 3042. In mid-May the Washington Office approached Representative Lucien Nedzi (D-Mich.), an influential member of the House of Representatives Armed Services Committee, to urge that his subcommittee hold hearings on the dental corps reform measure. The Councils and Washington Office will continue to press for action on H.R. 3042.

Children's Dental Health (S. 1466): The Senate passed an initial version of S. 1466 in July 1975 that included the Association-supported children's dental care plan, including federal funds for fluoridation projects in smaller communities. In late May, the Senate substituted a new version of S. 1466 that omits the children's dental care projects and the fluoridation authority. The new version contains a limited program of support for health education and disease control projects to avoid a threatened Presidential veto.

Medicare Amendments (S. 3205): Senator Herman Talmadge (D-Ga.), chairman of the Senate Finance Committee's health subcommittee, introduced legislation designed to reform the administration of the Medicare and Medicaid programs. A critical feature of the reform proposal is a new federal agency to monitor fraud and other abuses by providers of health care. The Council will testify against the new federal enforcement authority on the ground that existing local, state, and federal agencies are equipped to handle Medicare and Medicaid abuses. Hearings are anticipated in mid-July.

Medicare Dental Services (H.R. 11288): At the request of the American Society of Oral Surgeons, Representative James Corman (D-Calif.) has introduced a bill to amend the Medicare law to prohibit the denial of payment for services covered in the law when performed by dentists and to require reimbursement of inpatient hospital expenses associated with a dental admission.

HEW Appropriations: The American Association of Dental Schools joined with the Association in testimony before Senate and House appropriations subcommittees in support of funds for the National Institute of Dental Research and the PHS Dental Division. The Council also submitted testimony in support of increased funds for the Indian health program.

Congressional Budget Planning: The new budget procedure calls for adoption of recommended spending ceilings for major programs in advance of appropriation hearings. Both House and Senate budget committees recommended reductions in Medicare and Medicaid spending without reducing benefits.

Taxation of Federal Scholarship Funds: The Association's President, Dr. Robert B. Shira, submitted letters to the Chairmen of the Senate Armed Services and Finance Committees in support of legislation to restore the tax-exempt status of Armed Forces scholarship stipends. Dr. Shira also urged the granting of tax-exemption for all government scholarship awards.

Miscellaneous Legislation: The following bills are pending and will be reported on in the Council's supplemental report if later action is taken: S. 2908 to provide increased health benefits for veterans; H.R. 2525 to improve Indian health services; S. 1737 to regulate clinical laboratories; H.R. 2238 and H.R. 5664 to grant tax credits to dentists who practice in underserved areas; S. 1337 to replace Medicaid with federal block grants to states.

STATE LEGISLATION

The Council Secretary publishes a monthly report in *The Journal* on recent court cases of concern to dentistry and new state laws affecting the dental profession. The Council urges the delegates to scan those reports because they include all significant developments in dental law revisions, peer review immunity statutes, malpractice remedy statutes, and other important dental legislation.

Dental Law Revisions: Since the 1975 annual session, the following states have adopted important changes in their dental laws:

—Connecticut adopted a statutory provision prohibiting dentists from announcing as specialists unless they have completed two years of appropriate advanced education.

—Georgia has removed preceptorship training as a mechanism for qualifying for dental hygiene licensure.

—Illinois authorized the delegation of expanded functions to properly trained and supervised dental assistants. Functions not suitable for delegation are listed in the new law.

—Maine has added a public member to the dental examining board, authorized dental hygienists and assistants to take impressions for study models and confirmed the dentist's authority to take case histories and perform physical evaluations.

—Michigan has added a lay member to the state board of dentistry.

—Missouri has also confirmed by specific statutory language the authority of dentists to conduct physical evaluations of their patients.

—The Ohio and Texas boards of dentistry have adopted comprehensive regulations governing administration of general anesthesia in dental offices.

—Virginia has created a limited exemption for licensed nurse practitioners to perform intraoral procedures under supervision of a dentist and a strengthened prohibition against use of other than a dentist's name to identify his practice.

Peer Review Immunity Statutes: Since the 1975 annual session, the following states have adopted or expanded peer review immunity laws governing dental agencies: Alabama, California, Georgia, Hawaii, Indiana, Iowa, Louisiana, Maine, Montana, Oklahoma, Nebraska, and Texas.

Malpractice Remedies: The following states have adopted malpractice remedial laws governing dentists since the 1975 annual session: Arizona, California, Illinois, Maryland, Massachusetts, Michigan, New Jersey, North Carolina, South Carolina, South Dakota, Tennessee, Washington, and Wyoming.

These states include dentists under a part but not all of the remedial statutes: Florida, Nevada, and New York.

These states exclude dentists from malpractice remedial statutes: New Mexico and Pennsylvania.

Reimbursement for Dental Procedures under Medical or Health Plans: The following states joined more than 20 others in requiring medical insurance or Blue Shield type plans to reimburse for covered services provided by dentists acting within the scope of their licenses: Connecticut, Maine, Massachusetts, and New Hampshire.

RESOLUTIONS

This report is informational in nature and no resolutions are presented.

COUNCIL ON LEGISLATION:
SUPPLEMENTAL REPORT 1

Meetings: The Council met on June 21-22 in Chicago. A major part of this meeting was devoted to discussions with representatives of other national associations. The Council also will meet in Chicago on October 23.

Washington Office: Congressional and other federal activities featured in this report were developed by the Washington Office staff for the Council. In effect, this report is a joint effort of the Washington Office, the Council on Federal Dental Services, and the Council on Legislation since it supplements the annual reports of the two Councils and updates the Washington Office's periodic reports to the Board of Trustees.

General Comments on Congressional Activities: Although the 94th Congress addressed numerous health issues, only relatively few bills were finally enacted into law. However, much basic background work was completed so that early and continued activity with certain of these health issues such as Medicare and Medicaid reform and, of course, national health insurance can be expected in the 95th Congress. Additionally, the National Health Planning and Resources Development Act (P.L. 93-641) expires next year and will be subject to extensive hearings and to controversy.

Perhaps one of the most significant accomplishments of this Congress has been full implementation of new federal budget procedures. Under this program, the Congress establishes spending limits for all federal spending categories, including health care, and requires that authorizing legislation as well as appropriations bills comply with these predetermined ceilings. This process already has been of significance as numerous bills, including some health legislation, have been modified in order to comply with the spending limits established by the Budget Committees rather than the wishes of the committees of substantive jurisdiction. Certainly, this process will be a factor in any discussions of modifications in Medicare and Medicaid or of establishment of a national health insurance program.

Health Manpower: Clearly the major health legislation enacted during the 94th Congress was H.R. 5546, the Health Professions Educational Assistance Act. Efforts pertaining to this legislation literally were continued from the first to the last days of this Congress. President Ford did not sign the bill until October 12. The final compromise of the House and Senate met most of the objections raised by the American Dental Association and other major health groups.

Major changes which were made in the legislation that affect dentistry include the:

deletion of the so-called payback provisions of the House-passed bill that would have required students to reimburse the federal government for capitation grants received by schools;

deletion of the provisions of the Senate-passed bill that would have superseded state laws governing the training of dental auxiliary personnel;

deletion of the provisions of the Senate-passed bill that would have required dental schools to reserve a percentage of student places for National Health

Service Corps scholarship recipients;

deletion of a provision in the Senate-passed bill that would require development of federal standards for the licensure, relicensure, and continuing education of dentists and physicians;

deletion of the Senate amendment establishing federal licensure standards for radiologic technicians (including dental assistants) and for the accreditation of radiologic training programs;

removal of the TEAM programs as an option for schools' receipt of capitation funds and transfer of the TEAM authority to discretionary project grants; and

approval of an annual $4.5 million program of grants to assist general dentistry residency programs.

The conferees also acceded to an earlier action of the Senate which removed the stipulation that TEAM and expanded duty dental auxiliary training programs must include the "placing, carving and finishing of amalgam restorations" by dental auxiliary personnel.

Under the health manpower legislation, dental schools will be eligible for annual capitation grants of $2,000, $2,050, and $2,100 per student for fiscal years 1978, 1979, and 1980 respectively. In order to receive this assistance, dental schools will be required to provide assurances that 70 percent of their postgraduate training positions that are newly established after 1977 will be in general dentistry or pedodontics *and* either increase first-year enrollment or establish a program to train students in "areas geographically remote" from the main teaching site for a period of six weeks in the aggregate.

Student assistance will be available in the form of direct federal loans, an expanded program of National Health Service Corps scholarships, a new authority for federally insured loans providing an annual borrowing ceiling for individual students of $10,000 with a total per student limit of $50,000 and, a limited "no strings" scholarship program for first-year students determined to be in exceptional financial need. In connection with the new National Health Service Corps program, the Secretary of HEW will be required to consider comments of dental and medical societies regarding placement of Corps personnel, but the previous requirement of certification by such societies was omitted.

Construction grant assistance will be sharply curtailed. The revised construction grant authority is limited to a total annual payment of $40 million. Of that amount, $20 million is earmarked for ambulatory, primary care teaching facilities. Special project grant support is authorized for general dentistry residencies, TEAM, expanded duty dental auxiliary training, financial distress, start-up assistance for new and developing schools, and curriculum development, among others.

Throughout the efforts of the American Dental Association concerning health manpower legislation, exceptional support has been received from the officers and trustees, members of the Congressional Liaison service, constituent and component societies and others. In particular, the Council wishes to express its appreciation to the many members who wrote or contacted their Representatives or Senators, or both, during the deliberations on this legislation.

National Health Insurance: No further Congressional activity has taken place with regard to the subject of national health insurance since the submission of the previous report of the Washington Office to the Board and the Council's annual report. The

Democratic Platform included language endorsing what appears to be a national health insurance approach similar to that sponsored by Senator Kennedy and Representative Corman. Comments by Governor Carter since the convention have been in support of a national health insurance program, perhaps on a phased-in basis. However, Mr. Carter has not made statements as strongly as those in the Democratic Platform calling for financing of a national health insurance program through a payroll tax. President Ford and the Republican Platform do not support enactment of a full scale national health insurance program. The Ford Administration has called for a program of catastrophic health insurance for Medicare beneficiaries.

Medicare and Medicaid Amendments: The American Dental Association presented testimony to the Senate Finance Health Subcommittee concerning S. 3205, the Medicare and Medicaid Administrative and Reimbursement Reform Act. The Association's testimony called for a correction in the medical-dental overlap problems under Medicare and the developing overlap problems under Medicaid. In addition, the Association expressed concern with some of the administrative changes which are proposed in that bill. Also, the American Dental Association objected to the reimbursement modifications proposed in the bill and called for reimbursement under Medicare and Medicaid which is based on usual, customary and reasonable fees.

Extensive efforts were made in the Congress during the closing days of this session to adopt certain parts of S. 3205. After a great deal of legislative maneuvering, the Congress did adopt and send to President Ford language establishing an Office of Inspector General within the Department of Health, Education, and Welfare. This office is designed to increase the ability of the Department to audit the various Social Security Act health care programs as well as to investigate potential fraud and abuse under those programs.

Health Maintenance Organizations: President Ford has signed into law H.R. 9019, the Health Maintenance Organization Act Amendments of 1976. This legislation is designed to ease requirements which HMOs must meet in order to qualify for federal assistance. Included in the law is an amendment to delete the previous requirement that federally supported HMOs provide that preventive dental services for children be included among the basic benefits offered and that general dental services be available as an optional benefit for HMO enrollees.

In addition, the law restricts the previously required annual open enrollment requirement so that only HMOs which did not operate at a deficit in the prior years and which have been in existence for five years or more or have 50,000 or more members will have to meet limited open enrollment requirements. In addition, the law delays for four years a requirement that HMO charges be based on a community rating system.

HEW Appropriations: By the decisive margins of 312-93 in the House and 67-15 in the Senate, Congress voted on September 30 to override President Ford's veto of the fiscal 1977 Labor-HEW appropriation bill (H.R. 14232). The $56.5 billion spending plan, which exceeds the Administration's budget for the two federal agencies by $4 billion, now becomes law. Health programs within HEW are slated to receive slightly more than $5 billion for the fiscal year which began October 1. Within that sum, a total of $56.6 million was appropriated for the National Institute of Dental Research. This represents an increase of $3.4 million over the President's budget and $4.2 mil-

lion more than the comparable 1976 appropriation. Congressional passage of the HEW appropriation bill occurred prior to the enactment of the new health manpower law. As a result, funding for the health manpower programs of the Department (including the Division of Dentistry) will be provided through a separate continuing resolution until the 95th Congress convenes in January. At that point, Congress is expected to consider a supplemental appropriation bill to cover health manpower for the balance of fiscal year 1977.

Tax Reform: President Ford signed into law H.R. 10612, the Tax Reform Act, which includes several provisions of interest to dentistry. Among these are provisions exempting from taxation scholarship amounts received under the Armed Forces and National Health Service Corps scholarship programs for students who receive such assistance during 1976. Such students will receive tax exemptions for scholarship amounts received through 1979. However, students first receiving such scholarships beginning in 1977 will be taxed on these scholarship amounts. The law authorizes a tax exemption for loan amounts to health professions students which are forgiven for service in shortage areas. The new law also contains provisions to exempt from taxation amounts received by trade associations from exhibitors at annual meetings and similar functions regardless of whether the exhibitors sell their products on the floor of the exhibit hall. This overrules a previous position taken by the Internal Revenue Service. The bill also extends the investment tax credit for purchase of new equipment.

Lobbying: Legislation to greatly increase the recordkeeping and reporting requirements for lobbying organizations was passed by both the House and the Senate late in this session of Congress. However, because of certain jurisdictional questions among the committees involved and because of the lack of time, final agreement could not be reached in Congress with regard to lobbying legislation.

VA Omnibus Health Care Act: Congress has passed, and the President is expected to sign, the VA Omnibus Health Care Act (H.R. 2735). In addition to extending the previously enacted VA Physicians and Dentists Special Pay Act, the new law establishes a number of new comprehensive outpatient treatment programs for eligible veterans. For dentistry, the most important provision in the law authorizes an annual $4.8 million program to complete, on an outpatient basis, treatment programs for non-service connected dental conditions that were begun while a veteran was hospitalized for a medical disability. The final legislation as approved by Congress is a scaled down version of a more ambitious VA health care bill which passed the Senate on September 16. That proposal, originally introduced as S. 2908, would have also authorized an outpatient program of dental services without regard to service connection, an emergency dental care program for the relief of pain and infection, and a broad new program for preventive services. These provisions were eliminated in a substitute bill which passed the House of Representatives on September 29 and was agreed to by the Senate on October 1.

Indian Health Care Improvement Act: On October 1, President Ford signed into law the Indian Health Care Improvement Act (S. 522). The new law, which represents almost three years of Congressional effort, authorizes six major programs of federal assistance that are designed to improve the health services, facilities and health man-

power training for American Indians. Nine specific health services are earmarked in the public law, including for the first time line item funding for dental care programs. This latter provision authorizes $1.5 million and 80 new positions (1979) and $1.5 million and 50 positions (1980) to support an expanded program of direct and contract dental services.

Malpractice: Congress has passed and sent to the White House a bill (H.R. 3954) that would make the federal government the defendant in legal suits arising out of alleged malpractice on the part of military or civilian dentists and other health personnel in the Armed Services. President Ford is expected to sign the measure.

Defense Officer Personnel Management Act: Congress failed to reach agreement on a controversial bill (H.R. 3958) that proposed sweeping changes in the awarding of constructive credit for future dental and medical officers. Entitled the Defense Officer Personnel Management Act (DOPMA), the measure would have eliminated constructive credit from the computation of basic and retired pay and revised the formula used to determine years of constructive credit for purposes of establishing entry grade, time in grade and eligibility for promotion. Although the House of Representatives passed the DOPMA bill in September, the 94th Congress adjourned without Senate action on the proposal. Spokesmen for both Armed Services Committees have indicated that the legislation will be considered early in the next Congress. Most observers believe this will occur within the broader context of a complete Congressional review of compensation for federally employed health professionals. This will be necessitated by (1) the September 30, 1977 expiration of the major bonus and special pay for Armed Service, Public Health Service, and VA employed dentists and physicians, and (2) a requirement in the 1975 VA Special Pay law directing the Office of Management and Budget and the General Accounting Office to submit to Congress recommendations on the recruitment and retention of federal health workers and the feasibility of establishing a uniform pay system for such personnel. The two reports, which have been transmitted to Congress, are expected to serve as the basis for a broad range of Committee hearings in 1977 on future compensation levels for dentists and physicians in all federal agencies.

Army-Air Force Bill: The 94th Congress adjourned without taking action on the American Dental Association supported bill (H.R. 3042) that is designed to ensure that dental corps officers in the Army and Air Force have proper command authority over their own professional operations. As in previous years, opposition to the legislation from the Defense Department has proved to be the major obstacle to Congressional consideration of the measure. While prospects for early 1977 Committee hearings on the proposal remain uncertain at this junction, key staff aides to the House Armed Services Committee have recently expressed optimism in this area. A significant factor in this new attitude is the favorable impression which was made by the American Dental Association's response to an 11-point Pentagon memorandum opposing the Army-Air Force Dental Corps Reform bill. The Councils on Federal Dental Services and Legislation commend Major General Surindar N. Bhaskar, chief of the Army Dental Corps, for his exceptional and successful effort in having new regulations approved that markedly improve the Army Dental Corps administration and operation.

Federal Trade Commission: The Washington Office in cooperation with other Association agencies and interested organizations continues to monitor the activities of the FTC in connection with investigations of ethical proscriptions against advertising by professionals and state laws governing the practice of dentistry by unlicensed personnel.

Cooperation with ADPAC: The Council and the Washington Office have continued to work closely with ADPAC because of the distinct but important relationship between political action and legislative affairs. One new activity in this regard has been Washington Office participation in the ADPAC regional meetings which have been instituted this year. Dr. William Creason, the ADPAC board and staff have continued their efforts, including the implementation of new programs such as the regional meetings, to expand and improve the effectiveness of the political action program. It should be noted that these efforts have been most important in this election year.

Relations with Allied Dental Organizations: The Washington Office and the Council on Legislation have continued their efforts to work with other dental organizations and keep them informed of developments. Representatives of the various groups attended the Council's summer meeting and received extensive briefings. It is hoped that these joint meetings will result in a greater dialogue by these organizations with the ADA so that all issues of importance to the allied dental organizations will be discussed.

Visitations to Washington: Delegations of dentists from Michigan, Minnesota, North Carolina, Wisconsin and Massachusetts met in Washington with their Congressmen providing valuable assistance to the Association's legislative efforts, particularly with regard to the health manpower legislation.

Publications: The *Washington News Bulletin* is published monthly and is received by approximately 2,800 dental leaders. The Washington Office continues to contribute new stories on a regular basis to the *ADA News, The Journal of the American Dental Association,* and the *Leadership Bulletin.*

Representatives to Congress and the Administrative Agencies: In cooperation with the various agencies in the Headquarters Office, the Washington Office has prepared testimony and otherwise made presentations in connection with the following matters: Proposed District of Columbia Professional Income Tax (Statement -September 9, 1975); Specific Medicare Issues proposed amendments (Statement to House Subcommittees on Health, Committee on Ways and Means—September 19, 1975); H.R. 2525, The Indian Health Care Improvement Act (Statement to the House Subcommittee on Indian Affairs, Committee on Interior and Insular Affairs—September 26, 1975); Health Education and Disease Control Legislation (Letter to Chairman, House Subcommittee on Public Health and Environment, Committee on Interstate and Foreign Commerce- November 17, 1975); National Health Insurance Legislation (Statement to House Subcommittee on Health, Committee on Ways and Means—November 18, 1975); S. 989, and Related Bills, Health Manpower Legislation (Statement to Senate Subcommittee on Health, Committee on Labor and Public Welfare--November 18, 1975); Congressional Review of Administrative Rules and

Regulations (Letter to Chairman, House Subcommittee on Administrative Law and Governmental Relations, Committee on Judiciary—December 4, 1975); Benefits and Costs of National Health Insurance Proposals (Statement to House Subcommittee on Public Health and Environment, Committee on Interstate and Foreign Commerce—February 11, 1976), prepared for Dr. Robert Lauer; H.R. 10614, D. C. Medical and Dental Manpower Act extension (Statement to House Committee of the District of Columbia, Subcommittee on Education, Labor and Social Services—February 18, 1976); FY 1977 Appropriations for the Department of HEW (Statement to Senate Appropriations Committee, Subcommittee on Labor, HEW- March 17, 1976); FY 1977 Appropriations for the Department of HEW (Statement to House Appropriations Committee, Subcommittee on Labor, HEW—March 30, 1976); H.R. 12391, the Drug Safety Amendments of 1976 (Letter to Chairman, Subcommittee on Health, Committee on Interstate and Foreign Commerce- -April 23, 1976); FY 1977 Appropriations for the Indian Health Service Dental Services Branch (Statement to House Subcommittee on Interior, Committee on Appropriations—April 7, 1976); Congressional Review of Administrative Rules and Regulations (Letter to Chairman, Senate Subcommittee on Administrative Practice and Procedures, Committee on Judiciary—April 28, 1976); Tax Exemption for Armed Forces Health Professions Scholarship Program (Letter to Chairman, Senate Committee on Finance—May 10, 1976); House Armed Services Subcommittee on Military Compensation- May 12, 1976, Defense Officer Personnel Management Act; PSRO Amendments (Letter to Chairman, House Subcommittee on Oversight, Committee on Ways and Means—May 20, 1976); H.R. 5302, to establish an Office of Inspector General in the Department of HEW (Letter to Chairman, House Subcommittee on Intergovernmental Relations and Human Resources, Committee on Government Operations—June 2, 1976); Senate Subcommittee on Defense Appropriations—June 15, 1976, FY 1977 Navy Dental Research Appropriations; Oral Health Care for the Aged (Statement to the House Subcommittee on Health and Long-Term Care, Special Committee on Aging—June 24, 1976); H.R. 14289, The Drug Safety Amendments of 1976 (Letter to Chairman, House Subcommittee on Health, Committee on Interstate and Foreign Commerce- July 27, 1976); House Subcommittee on Public Health and Environment—August 3, 1976, Health Manpower Legislation; Medicare and Medicaid Administrative and Reimbursement Reform Act (Statement- August 9, 1976); Physician Reimbursement under Medicare (Statement—September 15, 1976); H.R. 15536, Medicare-Medicaid Anti-Fraud Act and H.R. 15390, a bill to establish an HEW Office of Inspector General (Statement—October 6, 1976).

This listing outlines the statements which have been prepared in the last year. It should be noted that the Association presented over 50 such statements during the course of the entire 94th Congress.

STATE LEGISLATION

The following report on state laws includes laws adopted since publication of the Council's annual report in *Annual Reports and Resolutions, 1976.*

Dental Law Revisions: Alaska has expanded the state board of dentistry to include five dentists, one dental hygienist and one member "with no direct financial interest in the

health care industry." The Alaska medical law recognized the right of dentists to use acupuncture.

Arizona has added a lay member to the state board of dentistry, but he may not participate in the giving or grading of licensure examinations.

Florida has added a dental hygienist to the board of dentistry who is limited to voting on matters relating to dental hygiene. All licensing agencies, including the board of dentistry, are directed to confine their regulatory activities to "preservation of health, safety and welfare of the public" and to take no action that would tend to "impinge upon the competitive marketplace."

Georgia has added as causes for suspending or revoking a dental license: "the excessive prescribing or administering of drugs or treatment, and the use of diagnostic procedures that are detrimental to the patient. . . ." The Georgia Board of dentistry is now permitted to define the scope of dental specialties.

Kansas continuing education requirements now include dental hygienists as well as dentists. An amendment to the Kansas healing arts law permits dentists who meet education and skill requirements to administer local or general anesthetics for surgery performed by physicians.

Maryland has clarified the authority of HMOs to permit them to employ licensed dentists and dental hygienists.

Minnesota provides for registration of dental assistants who graduate from a training program approved by the state board of dentistry. The board is authorized to define the functions of registered assistants and unregistered assistants. The Minnesota board of dentistry was expanded to include five dentists, one dental hygienist, one dental assistant and two public members.

Missouri has joined California, Maine, Michigan and Pennsylvania in defining the practice of dentistry to include "physical evaluation."

Rhode Island has defined the legal functions of dental assistants, including procedures that may not be delegated to them. The board has discretion to institute continuing education requirements for dentists and dental hygienists.

Tennessee now recognizes a certificate from the Southern Regional Testing Agency as a complete or partial substitute for the state board examinations.

Vermont has added two dental hygienists to the state board of dentistry who are limited to voting on dental hygienist matters. License renewals after May 1977 will require a showing that the dentist has completed training in emergency office procedures as prescribed by the board.

Peer Review Immunity Statutes: The following states have adopted or expanded peer review immunity laws governing dental agencies: Georgia, Maryland, New Hampshire, Rhode Island, Virginia and Wisconsin.

Malpractice Remedies: The following states have adopted or expanded malpractice remedial laws governing dentists: Alabama, Colorado, Delaware, Idaho, Illinois, Kansas, Louisiana, Maryland, Missouri, North Carolina, Oklahoma, South Carolina, Vermont and Tennessee. Hawaii includes dentists in part but not all of its remedial statute. Nebraska has excluded dentists from all parts of its remedial statute.

Authorization for Substitution of Drugs: The following states have authorized pharmacists to substitute drugs prescribed by dentists and physicians subject to specific limi-

tations such as: the drug substituted must be the generic equivalent of the prescribed drug; the substitute drug must be less expensive than the prescribed drug; and the prescribing practitioner's direction not to substitute must be obeyed: Alaska, Colorado, Connecticut, Delaware, Florida, Kentucky, New Mexico, Rhode Island, Virginia and Wisconsin.

Continuation of State Regulatory Boards: The following states have adopted laws (sunset laws) eliminating all state boards, including dental boards, unless the boards are able to justify their continuation: Colorado, Florida and Hawaii.

State Health Insurance Plan: Minnesota has pioneered in a controversial area—a state law requiring employers to provide health benefits to employees. The benefits are limited and no dental care is required except for some oral surgery. Of more importance to dentists is a new two-year pilot project providing dental care for low income persons 62 years of age and older.

Regulation of Radiation Users: Two states, Mississippi and Rhode Island, have enacted laws regulating users of radiation devices. In each state there is discretion to exempt classes of users upon a showing of minimal impact on health. Dentists are included on a statutory advisory committee for the radiation program. South Carolina has authorized a study of the effects of "over exposure to X rays in medical and dental treatment." The legislation requires consultation with the South Carolina Dental Association during the study.

Acknowledgement: As of this annual session, Dr. Paul W. Kunkel, Jr. will have completed two three-year terms on the Council, the last four years as chairman. Dr. Kunkel has been an outstanding advocate for the dental profession. His expertise and leadership will be missed greatly. The Council members and staff wish Dr. Kunkel and his family the very best.

Council of National Board of Dental Examiners

Meetings: The Council met in the Headquarters Building, Chicago, on May 20-21 and the Committee on Dental Hygiene met on February 12, 1976. Also, the Council held a special meeting to respond to a request from the American Association of Dental Examiners at the O'Hare Inn, Chicago, on November 22, 1975. Nineteen subcommittees met for a total of 52 days throughout the year and constructed 40 dental and dental hygiene examinations.

Participation: Satisfactory performance on National Board examinations is currently accepted as fulfilling or partially fulfilling the written examination portion of dental and dental hygiene licensure requirements in all US licensing jurisdictions except Alabama and Delaware. Consequently, virtually all dental and dental hygiene students take National Board examinations. National Board dental examinations are administered in two sections. Part I, which covers the basic sciences, is usually taken after two years of dental school. Part II, which covers the dental sciences, is usually taken about six months prior to graduation. The comprehensive dental hygiene examination is usually taken immediately prior to graduation.

In addition to students, about 700 graduate dentists take each part of the dental examination each year. Most of these are graduates of foreign dental schools. Some graduate dental hygienists are also examined, but the number is not large. The following table indicates the number of candidates examined during the last five years. In the table, candidates examined more than once are counted each time they were examined.

	1971	1972	1973	1974	1975
Dental, Part I	5,072	5,477	7,171	6,691	6,686
Dental, Part II	4,483	5,102	7,640	6,713	6,620
Dental Hygiene	3,069	3,752	4,588	4,818	5,126
Total	12,624	14,331	19,399	18,222	18,432

*American Association of Dental Schools
**American Dental Association
***American Association of Dental Examiners

The number of candidates taking dental examinations in 1973 was inflated by the addition of a third annual testing date that year and by students from some schools being examined earlier in their educational experience.

Examination Review Mechanism: The American Association of Dental Examiners expressed an interest in having representatives review National Board examinations before they are printed. The Council welcomes responsible review of its activities by any of its parent agencies: the American Association of Dental Examiners, the American Association of Dental Schools, or the American Dental Association. Therefore, provision for a committee representing any of these organizations to review draft National Board examinations was adopted. To date, only the American Association of Dental Examiners has indicated an interest in reviewing examinations. A review committee from that Association met on July 26-27, 1976.

Testing Graduates of Foreign Dental Schools: In 1969, California became the first US licensing jurisdiction to accept graduates of nonaccredited dental schools as candidates for dental licensure. Only the United States and Canada have provision for accrediting dental schools. Therefore, graduates of foreign dental schools are considered graduates of nonaccredited dental schools. In order to assist state boards needing to examine graduates of foreign dental schools, National Board eligibility was granted to these candidates. Initially, a graduate of a foreign dental school was required to submit an endorsement from a state board of dentistry to establish his National Board eligibility. Later, eligibility for Part I examinations was granted only on the basis of endorsements from accredited dental schools. This was to assist accredited dental schools in evaluating graduates of foreign dental schools seeking admission with advanced standing to a D.D.S. or D.M.D. degree program in this country.

Currently, 16 US licensing jurisdictions have provision to consider graduates of foreign dental schools as candidates for dental licensure. Between 1970 and 1975, 2,026 of these graduates participated in National Board programs. The Council believes that examining graduates of foreign dental schools has proved to be of assistance to state boards and, ultimately, of benefit to the public.

Testing Students Enrolled in Foreign Dental Schools: Because accredited dental schools do not have capacity to admit all qualified applicants, American citizens have entered dental schools in other countries. Several American citizens enrolled in foreign dental schools asked for the privilege of taking National Board Part I examinations while still students. Under existing National Board regulations, individuals educated in foreign dental schools are required to have graduated before being examined. Students enrolled in accredited dental schools, on the other hand, usually take both Part I and Part II before graduation.

The Council is unwilling to grant National Board eligibility to American citizens while excluding remaining students in foreign dental schools. The possibility of extending eligibility to all students enrolled in foreign dental schools, however, should be studied. The Council believes that National Board examinations should continue to be administered only in the United States and Canada. Based on experience with other examination programs, maintaining security in other countries is difficult. Even with this geographic limitation, the Council feels an endorsement procedure to insure that only bonafide students who have completed appropriate basic science

courses in foreign dental schools are granted eligibility. Before eligibility is extended to students enrolled in foreign dental schools, however, effects on accreditation in this country need to be studied. Although National Board eligibility requirements were not modified, a subcommittee was appointed to study endorsement and accreditation issues for report back during the 1977 Council meeting.

Special Dental Auxiliary Examinations: Discussion of testing dental auxiliary personnel on intraoral procedures that, until recently, have not been delegated was included in the Council's 1975 annual report. National Board dental hygiene results are recognized by states that define dental hygiene practice differently. Fairness to candidates dictates that coverage be limited to functions that a dental hygienist is allowed to perform in a majority of states. On the other hand, public responsibility requires applying the same minimum performance standard for each intraoral procedure to all individuals permitted to perform the procedure. As a service agency to state boards, the Council has played a role in defining minimum knowledge requirements for dental and traditional dental hygiene functions. Consequently, if either dental or traditional dental hygiene procedures are assigned to other categories of dental personnel, Council assistance in transferring minimum knowledge standards seems appropriate. Reconciling fairness to candidates with public responsibility requires, in the Council's opinion, a new examination program.

At its 1975 meeting, the Council agreed to construct examinations for dental hygienists and dental assistants covering functions considered delegable in some but not the majority of states. Examinations were to be developed only at the request of state boards. It was hoped that if more than one state chose to use this service, sections of examinations covering functions permitted in several states could be identical. The Council envisioned eventually having a module, a set of questions, for each nontraditional function delegated in any state. Then, an examination could be prepared for a new state by selecting appropriate modules.

Administration of nontraditional dental auxiliary examinations was also discussed at the 1975 Council meeting. The Council's charge covers administering examinations to dental hygienists, but not dental assistants. The Certifying Board of the American Dental Assistants Association, which operates within the purview of the American Dental Association, conducts a written examination for dental assisting. At the suggestion of the Certifying Board, it was agreed that new dental assisting examinations requested by state boards would be prepared and normed by the Council but administered by the Certifying Board.

During the last year, the Council has developed only one examination for nontraditional functions. Although functions covered were limited, developing an appropriate examination proved difficult and time-consuming. Based upon this experience, it is doubtful that the Council could respond to requests for more comprehensive examinations promptly enough to be of assistance to state boards. In order to avoid this potential problem, the Council now intends to begin as soon as possible the development of modular examinations covering functions recently delegated to dental auxiliary personnel in some states.

In developing examinations for procedures not traditionally delegated to dental auxiliary personnel, the Council is not promoting delegation of additional functions in any state. The Council's single interest is to be able to provide assistance to any state requesting it. If this type service is not provided by the dental profession, it may be

sought from agencies less interested in or less able to maintain the high performance standards for dentistry that the American public currently enjoys.

RESOLUTIONS

This report is informational in nature and no resolutions are presented.

Council on Relief

Gorski, Alexander F., New York, 1977, chairman
Pettey, Claude V., Jr., Mississippi, 1977, vice-chairman
Buechler, Alvin A., South Dakota, 1978
Caputi, Anthony A., Rhode Island, 1978
Podruch, Louis L., Wisconsin, 1976
Shuck, J. Vincent, secretary

Meeting: The Council met in the Headquarters Building, Chicago, on April 12-13, 1976 with all members present. Dr. Claude V. Pettey, Jr. was elected vice-chairman for the year ending with the Council's 1977 meeting.

Relief Fund Investment Committee: As trustees of the American Dental Association Relief Fund, the Council members elected Drs. Alexander F. Gorski (ex officio member), Anthony A. Caputi, and Louis L. Podruch to serve with Dr. James W. Etherington, the Association's Treasurer, as the Relief Fund Investment Committee in accordance with Article III of the Relief Fund's *Indenture of Trust*.

1975-1976 Relief Fund and Disaster Fund Campaign: For the second year, the Council used a consulting firm to assist with the Annual Campaign. Information on tests conducted during the 1974-1975 Campaign has improved campaign procedures and has contributed to the success of the current Campaign. As of May 1, 1976, the Relief Fund had received $242,211.00 in contributions: the Disaster Fund had received $29,023.00. These amounts establish new contribution records for each Fund and represent the first time every constituent society has exceeded its Relief Fund goal.

The Council gratefully acknowledges the careful analysis of financial activities provided by the Association's Accounting Department and the resourceful planning recommendations provided by the Bureau of Public Information.

Grants to Relief Recipients: As of May 1, 1976, the Relief Fund had provided financial assistance through grants to 130 eligible recipients during the Council's fiscal year. The average monthly payment to recipients is $258. The total amounts of grants is approximately $324,000, one-half of which is borne by the income fund of the American Dental Association Relief Fund Trust and one-half by constituent and component society relief trusts.

Relief Fund Investments: As of May 1, 1976, the Principal Fund's investment portfolio contained securities with a market value of $3,320,605. In addition, cash and securities in the Income Fund amounted to $395,693.

Disaster Loan Program: As of May 1, 1976, loans totalling $35,000 have been awarded to natural disaster victims. Funds available for loans to disaster victims as of May 1, 1976 are $53,066.

Relief Fund Quotas: The Council establishes Relief and Disaster Fund quotas for each constituent society based on society membership and the national campaign goal. Contributions received in excess of the Relief Fund quota are applied to the Disaster Fund until each state's Disaster Fund quota is attained. After the Disaster Fund quota is reached, any additional money is again applied to the society's Relief Fund contributions.

At its August 1975 session, the Board of Trustees adopted a resolution that will allow a constituent society to request an increase in its Relief Fund quota to reflect the society's Relief Fund expenditures during the previous year. In the event a constituent society experiences a large number of relief grant recipients, it is possible for the society to considerably reduce its Relief Fund assets. When this occurs, it is important to ensure that an equitable portion of contributions is returned. An increase in the quota could diminish the amount allocated to the Disaster Fund, thereby increasing the amount of the regular refund since refunds are based upon a percentage of contributions allocated to the Relief Fund.

During its April 1976 meeting, the Council established the following guidelines to assist those constituent societies requesting a Relief Fund quota increase:

1. Requests should be submitted to the Council office by January 1 of the current campaign year and stipulate the amount of increase.
2. The increased quota should be based on the previous year's actual Relief Fund expenditures, such as grants and related administrative expenses.
3. The new quota will apply to the current campaign year only.

Amendment to "Indenture of Trust": Presently, the Trustees of the Relief Fund elect an Investment Committee to approve the activities of the Fund's investment counsellor. The Committee has noted that it is often impractical to abide by Article III of the *Indenture of Trust,* which stipulates that investments made by the professional investment counsel be approved in writing by a majority of the Investment Committee.

In order to amend the duties of the Investment Committee and thereby achieve a more functional definition of the Committee's duties, the Council believes that a revision to the current *Indenture of Trust* is appropriate. In suggesting the revision, the Council gave attention to policies of the Board of Trustees and the Committee on Finance and Investments as they pertain to professional investment counsel.

RESOLUTION

23. Resolved, that Article III of the American Dental Association Relief Fund *Indenture of Trust* be amended to read:

> That part of the Trust Property which the Trustees deem available for investment shall be invested by them in assets legal from time to time for investment by trustees under the law

of the State of Illinois. The Trustee shall from time to time, with the approval of the Board of Trustees of the Association employ an investment counsellor. Such professional investment counsel shall be either advisory to the Investment Committee in all matters relating to the investment policies and practices of the Trust Property or may be given discretionary authority by the Investment Committee to buy and sell securities for the portfolio provided that the investment counsel promptly reports to the Trustees through the Council on Relief Secretary, each purchase and sale of a security as soon as completion of any such transaction is confirmed. The Trustees shall from time to time select two of their members who together with the Treasurer of the Association shall constitute the Relief Fund Investment Committee. The Committee shall monitor the activities of the investment counsel and make recommendations to the Trustees on investment programs.

Council on Scientific Session

Meetings: The Council met in McCormick Place, Chicago, on October 24-25, 1975 just prior to the opening of the annual session, and on October 30 at the conclusion of the session. The Council also met at the Las Vegas Hilton Hotel, January 19-21, 1976. Dr. Louis J. Hendrickson, General Chairman for the 1976 annual session, was in attendance for a part of the meeting. On April 26-27, 1976 the Council met again in the Headquarters Building. Dr. George Kearns, second vice-president, represented Committee A of the Board of Trustees at the April meeting.

Appreciation: The Council expresses its appreciation to Dr. Curt J. Gronner, Illinois, for his devoted service to Council activities during the past six years. The Council also wishes to acknowledge the cooperation of its consultants for their assistance and advice in Council affairs.

Report of the 1975 Annual Session: The 116th annual session of the American Dental Association was a combined meeting with the 63rd World Dental Congress in observance of the 75th anniversary of the *Fédération Dentaire Internationale.* Because of the combined meeting, the scientific session and display of technical exhibits presented in McCormick Place and McCormick Inn were scheduled for an additional day. The scientific and technical exhibit areas were opened on Sunday morning to permit early registrants to enter the exhibit halls. Sixteen meeting rooms were required to present the programs selected for the scientific session Sunday afternoon through Thursday afternoon. In addition to the essays, scientific session lectures, clinical lectures, motion pictures, and limited attendance seminars several special programs were presented.

In cooperation with the *Fédération's* Committee on Scientific Assembly a series of six half-day conferences were held covering international concepts of dentistry. Two of the conferences were devoted to the results of a study of how five nations are meeting the challenge of increasing delivery of dental care, sponsored by the *Fédération's* commissions on Public Dental Health Services and Dental Practice and the World Health Organization. These were presented with simultaneous interpretation in English, Spanish, German, French, and Japanese.

A special one-day conference, "Dentistry Internationale: Delivery of Services in the Americas," was sponsored by the Council on Dental Health, Council on International Relations, and Pan American Health Organization with simultaneous interpretation in Spanish and English. A two-day National Symposium on Dental Health Education in Schools with an accompanying exhibit area was organized by the Bureau of Dental Health Education.

Six outstanding clinicians were presented on a live, closed circuit, color television program which originated and was viewed in the ballroom of McCormick Inn. Two completely equipped operatories were installed on a specially built stage where each clinician could be observed live by the audience during his half-day program. Multiple color receivers were set up along the sides of the room to permit the audience to also see closeups of all demonstrations.

Other special programs included an international conference on forensic dentistry presented by the Working Group on Forensic Odontology of the *Fédération's* Commission on Dental Research and the American Society of Forensic Odontology, two patient education seminars prepared by the Bureau of Dental Health Education, a daily mini self-assessment program conducted by the American College of Dentists, and daily multimedia presentations for the dental health care team by Dr. Bruce Larrick, Gainesville, Florida. A one-day program on prosthodontics was also presented by Dr. John P. Frush, Glendale, California.

The table clinic area was open on Sunday, Tuesday, and Wednesday afternoons. A special program was held in the table clinic area on Tuesday morning featuring the major manufacturers of dental handpieces. A qualified representative from each of the companies presided at a table clinic to instruct dentists and their auxiliary personnel on the maintenance and repair of handpieces that can take place in the dental operatory.

On Monday afternoon, the student table clinic program sponsored by Dentsply International, Inc., York, Pennsylvania, presented outstanding student clinicians representing 46 dental schools in the United States and Puerto Rico. The Council is extremely grateful to Dentsply International for its 17th year of sponsorship of this part of the scientific session.

Twenty-six limited attendance seminars were scheduled with each of the 13 outstanding speakers presenting their seminars twice during the session. Thirty-five national and international program participants were selected to act as hosts and discussion leaders at lunch and learn sessions scheduled Monday through Thursday.

A Prevention Center located adjacent to the scientific and educational exhibit area was open daily to all attending the meeting. The Center was divided into six major areas: (1) Self-Evaluation Center, (2) Plaque Control Area, (3) Nutrition and Fluoride Section, (4) Creative Restorative Dentistry Section, (5) Library, and (6) Obligatory Systemic Diagnosis for the Dentist. The Council wishes to thank the following for their planning and participation in the Prevention Center: Illinois Society of Oral Surgeons, Illinois Academy of General Dentistry, Illinois Society of Periodontists, Illinois Dental Hygienists Association, and Illinois Dental Assistants Association.

Plaques were presented to 116 speakers for their participation in the essay and seminar programs. Over 1,000 recognition certificates were presented to other participants in the scientific programs.

The Council hosted a reception on Monday evening honoring participants in the sci-

entific session. Dr. Lynden M. Kennedy, Association President, and Mrs. Kennedy joined the Council members and their wives in the reception line welcoming over 1,000 guests.

Total registration for the 1975 annual session was 21,895. Included were 6,697 member dentists, 1,511 dentists from other countries, 656 student members, 1,690 dental assistants, 1,646 dental hygienists, 197 laboratory technicians, 362 dental dealers, and 5,887 guests. Also registered were 3,249 technical exhibitors.

The Council expresses its appreciation to the General Chairman of the 1975 annual session, Dr. George Kearns, and to other members of the Committee on Clinics and Motion Pictures for their excellent cooperation. The Council also wishes to express its disappointment in the meeting room facilities of McCormick Place and the necessity of using meeting rooms in McCormick Inn to accommodate a part of the scientific session and an outstanding television program which was poorly attended because of its location.

Award winners of the 1975 Student Table Clinic Program presented to the House of Delegates on Wednesday, October 29, were as follows:

Category I, Clinical Application and Techniques

Steven A. Tilliss, University of Iowa, first; Brant A. Bradford, University of Colorado, second; Ilze Irene Eglitis, Loyola University, third; Stephen Singer, State University of New York at Stony Brook, honorable mention.

Judges: Frederic Custer, Edwardsville, Illinois, *chairman;* L. W. Bimestefer, Dundalk, Maryland; Gordon J. Christensen, Denver; Alex Koper, Inglewood, California; Howard B. Menell, New York; George E. Mullen, Brooklyn, New York; Raymond S. Murakami, Washington, D.C.; Patric D. Toto, Maywood, Illinois.

Category II, Basic Science and Research

Jean Wm. Farah, University of Michigan, first; Salvatore A. Leone, University of Southern California, second; Frank P. Lombardi, Jr., Georgetown University, third; Ivette Rodriguez-Quesada, University of Puerto Rico, honorable mention.

Judges: George G. Blozis, Columbus, Ohio, *chairman;* Leroy D. Cagnone, San Francisco; Jack L. Stewart, Kansas City, Missouri; Marlin F. Troiano, Jersey City, New Jersey.

First, second, third, and honorable mention awards of $150, $100, $50 and $25 respectively were made in each of the two categories.

Certificate awards were made to the following Scientific and Educational Exhibits:

Government Agencies: US Drug Enforcement Administration, first; Armed Forces Dental Services, second; US Public Health Service, Department of Health, Education and Welfare, Division of Dentistry, third; National Institute of Dental Research, honorable mention.

Institutions and Associations: Bergen County Dental Society, Bergen County Health Department, Fairleigh Dickinson School of Dentistry, first; University of Alabama School of Dentistry, second; American Dental Assistants Association, third; University of Illinois at the Medical Center, honorable mention.

Individuals: J. R. Mellberg, R. H. Larson, H. R. Englander, first; David Marshall, second.

Industrial Agencies: General Mills, Inc., first.

Judges: Albert J. Monsees, Kansas City, Missouri, *chairman;* W. Robert Biddington, Morgantown, West Virginia; Paul V. Ladd, Miami, Florida.

Special Meetings of the Council at the 1975 Annual Session: A briefing session was held with members of the Committee on Clinics and Motion Pictures on Saturday, October 25.

An orientation breakfast meeting was held Sunday, October 26, for section officers, judges of the student table clinics and scientific and educational exhibits, consultants and the chairmen of the Committee on Clinics and Motion Pictures. Also in attendance were Dr. G. H. Leatherman, Executive Director, *Fédération Dentaire Internationale,* and Dr. George Kearns, General Chairman, Committee on Local Arrangements. The Council chairman honored each of the 13 retiring section officers for their outstanding service to the Council over the past three years. The complete schedule for the scientific session was reviewed and specific details were given concerning judging activities, meeting room responsibilities, program policies, and other related scheduled events.

A breakfast critique was held on Tuesday, October 28, for the judges participating in the scientific session. This meeting continues to provide the Council with valuable information to be considered in planning future programs.

During the days of the meeting, the Council met with each of the 1976 section chairmen and vice-chairmen to discuss the suggested essay programs for the Las Vegas meeting.

A breakfast meeting critique of the entire scientific session was held on Wednesday, October 29, for chairmen and vice-chairmen of the 14 sections, consultants, and the chairman and vice-chairman of the Committee on Clinics and Motion Pictures. The comments at this critique session were tape recorded and later transcribed for distribution to all in attendance.

Special Committee to Study Association's Annual Session: Dr. J. Frank Chimienti, Council member, served as a member of the special committee which met in the Headquarters Building on June 9-10, 1975, and on January 12-13, 1976. The Council secretary and assistant secretary served as staff consultants. The final report of the special committee was presented to the March 1976, session of the Board of Trustees. Council chairman, Dr. Lyle A. Brecht, was in attendance.

1976 Annual Session: The scientific session will be held in the Las Vegas Convention Center opening with the display of scientific and educational exhibits on Sunday morning, November 14. All scientific meeting rooms, the table clinic program and the

motion picture program will begin in the afternoon and continue daily through Wednesday afternoon, November 17. Twelve limited attendance seminars and 20 lunch and learn sessions will be scheduled during the days of the meeting. An extended lecture program of a day and a half on practice administration will be presented by recognized authorities on the subject. The dental handpiece repair clinic will again be presented as a special table clinic program because of its popularity at the 1975 annual session. The Council received many more applications for the lecture programs than could possibly be accommodated during the program time available.

Future Program Plans: Extended lecture programs, seminars, and combined sessions of appropriate sections will be given greater emphasis in future programming. General sessions featuring authorities in the health sciences will also be considered for the scientific session.

RESOLUTIONS

This report is informational in nature and no resolutions are presented.

Special Report on Dental Auxiliary Utilization and Education

Council on Dental Education

INTRODUCTION

The 1975 House of Delegates adopted or referred several resolutions which directed that the Council on Dental Education initiate a study of dental auxiliary utilization and education. Those resolutions follow:

> **Resolved,** that the Council on Dental Education sponsor a national workshop on expanded duty dental auxiliary training and utilization, and be it further
> **Resolved,** that the participants in this workshop represent in the majority those full-time practitioners, both specialists and general practitioners from all sections of the country, who utilize auxiliaries, and be it further
> **Resolved,** that following the workshop the appropriate agency of the American Dental Association be directed to study and further define, for related agencies (public and private) those functions where formal education requirements may be required for expanded duty dental auxiliaries, and make a report to the 1976 House of Delegates. (*Trans.* 1975:697)

> **Resolved,** that the Council on Dental Education develop for consideration by the 1976 House of Delegates a position statement on functions which should be delegated to auxiliaries. (*Trans.* 1975:705)

> **Resolved,** that the American Dental Association reaffirm its policy that expanded functions should be performed under the direct supervision of the dentist, that they be in accordance with respective state dental practice acts, and that they be performed only by auxiliaries who have formal education and training, and be it further
> **Resolved,** that states be urged to recognize certification by the Certifying Board of the American Dental Assistants Association or enrollment in an education program accredited by the Commission on Accreditation of Dental and Dental Auxiliary Educational Programs as the minimum qualifications of a dental

assistant for training in intraoral expanded functions which require formal education as defined in the *Compilation of Facts Related to the Teaching of Expanded Functions,* and be it further

Resolved, that final decisions on delegation of expanded functions to dental assistants be made by the state society and state board of dentistry on the basis of established and appropriate standards of qualifications. (*Trans.* 1975:704)

During its December 1975 meeting, the Council defined the general scope of activity that would be required to respond to the House directives. In view of its commitments to accreditation and other activities and the extent of effort required to develop a report on dental auxiliary utilization and education, the Council decided to appoint an advisory committee to assist in the conduct of the study. A special advisory committee composed of eight private practitioners, two dental educators, and two auxiliaries was appointed. The committee included: Dr. L. M. Kennedy, who served as chairman; Drs. D. Walter Cohen, Arthur A. Dugoni, Ijourie S. Fisher, Robert E. McDonnell, James F. Mercer, Jack M. Osburne, Jack H. Pfister, Louis G. Terkla, James C. Weig, Lloyd W. Wolford, and Mrs. Jennie Schafer.

The committee's primary responsibility was to provide guidance to the Council in developing recommendations for House consideration. In addition, the committee assisted in planning the national workshop and identifying resource material for the workshop and Council study. The Council wishes to publicly thank the members of the committee who so ably and diligently carried out this charge.

The Board of Trustees demonstrated its commitment to the study through provision of financial support. The Council expresses its appreciation to the Board for its support and the appropriation of approximately $39,000 in special funds for the study and workshop.

In planning the workshop, the committee reviewed and revised the invitational list developed by the Council and considered by the Board to assure that the House mandate would be met and all groups would be represented. The 1975 House had directed that a majority of workshop participants be full-time practitioners who utilize dental auxiliaries. Therefore, each constituent dental society was extended two invitations and each state board of dentistry one invitation to achieve the majority mandated by the House.

The workshop was to be convened as a national forum for exchange of opinions on dental auxiliary expanded functions, not as a legislative body. Therefore, the advisory committee and the Council considered it essential to include representatives of all groups and agencies that are directly affected by Association decisions on this subject and representatives of dental and dental auxiliary education, dental and dental auxiliary organizations, and the federal dental services were invited in limited numbers. Only with such representation could the workshop be a valid and useful resource for the Council's study.

In view of the strong interest in expanded functions practicing dentists are known to have and the delegates' vigorous support of the House resolutions, it was expected that state societies would be anxious to send representatives to the workshop. The committee and Council monitored preregistration to assure that the House mandate would be met. Early review of preregistration indicated that the representation of state societies and state boards was not as great as had been anticipated. The Council attempted to increase the representation through follow-up letters and telephone con-

tacts, and some additional representatives were named. The Board also secured additional representation from previously unregistered constituent dental societies.

Immediately prior to the workshop, preregistration indicated that there would be a majority of full-time practitioners. However, the Council was disappointed when only 121 full-time practicing dentists actually registered at the workshop whereas 123 representatives of other groups registered. Registration records indicate that only 66 of the 108 invited constituent dental society representatives and only 28 of the 51 invited state board representatives attended. Twelve state societies were not represented at all and 20 had only one representative. Information on representation of states is summarized on page 211.

During the initial workshop session, participant representation became the subject of controversy. Therefore, to ensure that opinions of full-time practitioners would receive the attention the House had intended, it was decided that the practitioners would be polled separately on any question where there was a close division of opinion. It is the conclusion of the Council that the invitational list for the workshop was appropriately balanced to afford an opportunity for input from all affected groups and that the workshop was a valid resource for the study of expanded functions.

Workshop participants reviewed Association policy on auxiliary utilization and education, reports of research in dental auxiliary expanded functions, and information on the status of legal provisions for delegation of expanded functions to dental assistants and dental hygienists. Following this review, they considered philosophy and principles that should guide Association policy on expanded function auxiliary utilization, functions that could be delegated to dental assistants and/or dental hygienists, education and training requirements that would be needed to prepare auxiliaries for those functions, and credentialing mechanisms that should be employed to qualify expanded function auxiliaries.

Workshop deliberations were a major reference for the committee and Council in developing this report. The report includes a position statement on functions which could be delegated to dental assistants and/or dental hygienists and education and training which should be required for the performance of these functions as requested by the House. In addition, it includes a statement of philosophy on and principles for auxiliary utilization and education which the Council recommends to the House for its review, consideration and adoption to reaffirm existing policy and/or establish new policy where needed.

This report is presented in three parts. The first two are informational and the third requires action by the House. Information on research in expanded functions, dental auxiliary manpower and dentist productivity, auxiliary educational systems and legal provisions for the delegation of expanded functions is summarized in Part I, "Resource Information." The Council's rationale for and recommendations on philosophy and principles, functions that could be delegated, education and training that should be required for performance of expanded functions, and recommendations for future study and action are presented in Part II, "Rationale for and Recommendations on Dental Auxiliary Utilization and Education." In Part III, "Position Statement on Utilization and Education of Dental Assistants and Dental Hygienists," the Council presents statements on philosophy and principles, functions which could be delegated and education and training requirements for House consideration.

WORKSHOP ON DENTAL AUXILIARY EXPANDED FUNCTIONS:
REPRESENTATION OF STATE SOCIETIES

States represented by one participant were Alabama, Arizona, Delaware, Florida, Hawaii, Idaho, Iowa, Kentucky, Massachusetts, Michigan, Mississippi, Montana, Nevada, New Jersey, North Carolina, North Dakota, South Carolina, Tennessee, Texas, and Utah.

States represented by two or more participants were Colorado, Connecticut, Illinois, Indiana, Kansas, Louisiana, Minnesota, Missouri, Nebraska, New Hampshire, New Mexico, New York, Ohio, Oregon, Pennsylvania, Vermont, Virginia, Washington, and Wisconsin.

PART I: RESOURCE INFORMATION

The Council analyzed available information on research and experimental programs in dental auxiliary training and utilization, the dental auxiliary education system, legal provisions for delegation of functions, and methods of credentialing dental auxiliaries. The information was provided as background for workshop participants. From its review and analysis of the information, the Council identified that which it considered pertinent for reference of the House.

Research: The Association established a policy on experimentation in assignment of additional functions to dental hygienists and dental assistants in 1961. The policy encouraged initiation of research projects to determine the impact that utilization of dental assistants and/or dental hygienists in different roles could have on the profession's ability to provide more dental services. At that time, the Association identified six areas in which investigation was needed to develop the information required to make decisions on utilization of auxiliary personnel. (*Trans.* 1961:222) Those areas were:

1. Systematic evaluation of the potential of the dental hygienist and dental assistant to perform all routine procedures not requiring the knowledge and skill of the dentist.
2. Determination of the time required to train the dental hygienist and dental assistant to perform the new duties under investigation.
3. Determination of the best pedagogical methods and techniques for presenting the new material.
4. Assessment of the relative cost of the training of the dental hygienist and dental assistant to perform expanded duties as compared to the cost of training present dental personnel.
5. Evaluation of the effect on the dentist's productivity and quality of service through expansion of duties of the dental hygienist and dental assistant.
6. Determination of methods for controlling the use of dental hygienists and dental assistants to prevent practices not in the public interest.

Research projects from 1961 through 1974 were primarily designed to investigate

dental hygienists' and dental assistants' potential to perform given functions. Most projects also addressed the length of time and pedagogical methods required to prepare dental hygienists and dental assistants to perform new functions. There has been virtually no investigation of the relative cost of preparing dental hygienists and dental assistants to perform expanded functions as compared to the cost of educating dentists. Further, the limited research to evaluate the effect of utilization of expanded function dental hygienists and dental assistants on the dentist's productivity has produced widely varying information. No project specifically directed to determining methods for controlling the use of dental hygienists and dental assistants to prevent practices not in the public interest has been reported.

Between 1961 and 1970 five expanded function experimental programs were conducted and reported to the Council. Two of the five projects were conducted by university dental schools and the remaining three were conducted by federal dental services. All five were designed to determine the potential for utilization of dental assistants in expanded roles. Findings indicate with indisputable facts that, with formal instruction, selected dental auxiliaries can be trained to perform, under the supervision of the dentist, given intraoral functions at a level of performance comparable to that of dentists. The investigations also indicate that performance of given intraoral functions by dental auxiliaries in the settings in which the projects were conducted resulted in an increase in the number of services provided. In those settings, services were provided to special populations such as military personnel, American Indians, or indigent patients.

From 1970 through 1974, an additional 12 projects were initiated and reported. To fill a void in the information, several of the projects were directed to determining the potential for utilization of dental hygienists in expanded roles. The projects corroborated the findings of the previous investigations and added evidence that dental hygienists can be trained to perform functions which extend beyond their traditional role, with quality comparable to that of dentists or dental students. Progress in and results of the projects have been published and reported to the House.

Four projects have been designed specifically to determine whether it is feasible to incorporate instruction in expanded functions in established curricula. One was designed to determine changes that would be required in two-year dental assisting curricula, one to determine changes that would be required in two-year dental hygiene curricula, and two to determine changes that would be required in baccalaureate degree dental hygiene curricula. The results of each of these projects indicated that significant changes in curriculum content, sequence, and learning experiences were needed. The extent of change required was dependent in part on the scope of functions included in each project. There has been no project to investigate changes that would be required to incorporate expanded function training in a one-year dental assisting program.

In the Council's opinion, previous research allows certain decisions to be made about delegation of expanded functions to assistants or hygienists with given education for levels of utilization currently permitted in several states. However, additional attention must be directed to the remaining three areas of investigation identified by the profession in 1961 before effective long-range decisions can be made. Those areas of investigation include assessment of the cost of educating dental hygienists and dental assistants to perform expanded functions as compared to the cost of educating dentists, evaluation of the effect of utilization of expanded function dental hygienists and dental assistants on the dentist's productivity, and determination of methods for con-

trolling the use of dental hygienists and dental assistants to prevent practices not in the public interest.

Of these three areas of investigation, the Council believes that priority should be given to evaluating further the impact of expanded function auxiliary utilization on dentist productivity in private practice settings. In the Council's view, it is important that the Association assume responsibility for further extension of research in practice settings to determine, on an objective and practical basis, what functions should be delegated, how delegated functions should be assigned, and whether new types of auxiliaries are needed to guarantee evolution of a system of dental care delivery that will extend care to all segments of society. This research also is needed to determine the functional roles auxiliaries should play in delivery of care and the type and extent of education and training required to prepare individuals to fill those roles. Until such information is available, the profession can only make interim decisions and will be hampered in development of a sound program for dental auxiliary utilization and education.

Studies to determine the relative cost of educating dental assistants, dental hygienists, and dentists also are needed but will be meaningful only if the information is evaluated in relation to retention of specific manpower pools in the workforce. The Council urges appropriate agencies of the Association and related organizations to take immediate steps to develop accurate data on number and work life-span of manpower by category. Finally, research to determine reliable methods for controlling utilization of dental hygienists and dental assistants is particularly important in light of the increasing interest of government in credentialing and quality control. Association efforts should be directed to studying the entire area of credentialing auxiliaries and identifying appropriate actions to prevent inappropriate and detrimental intervention by government in aspects of health care delivery that rightfully belong in the private sector.

Manpower and Productivity: Data from the Association's Bureau of Economic Research and Statistics collected in 1970 indicate that on the average the dentist employing a full-time dental assistant is 36.2 percent more productive than a dentist working without any dental auxiliary personnel. When a part-time dental hygienist is added to the team, the average productivity increases 49.8 percent above that of dentists working without auxiliary personnel; and when a full-time dental hygienist is added, the average productivity increase is 96.9 percent. Employment of two full-time dental assistants results in a 99 percent increase in productivity above that of a dentist working without any auxiliary personnel. These findings have been corroborated in other studies over a period of years.

When information on the percentage of dentists who currently employ dental assistants and dental hygienists is considered, it is evident that the potential productivity of the current system has not been achieved. In the Council's view, dentistry should capitalize on this most feasible and accepted method of increasing productivity. The Council believes that in meeting any increase in demand for care the gap between potential effect of utilization of assistants and hygienists on production and actual utilization should be closed, and that efforts to attain that goal should receive high priority.

Productivity increases resulting from the addition of expanded function auxiliaries to the dental team vary. Information from the United States Public Health Service study conducted in the 1960's in Louisville, Kentucky indicated that, when three

expanded function assistants were added to the baseline team which included traditional chairside assistants, productivity increased from 63 to 84 percent. When a fourth expanded function assistant was added to the team, productivity increases ranged from 110 to 133 percent over the baseline. It should be noted that although more research is needed, some studies have suggested that dentists can efficiently and effectively supervise no more than one or two expanded function auxiliaries.

In 1971, the University of Alabama initiated a study in the dental school facilities to determine the impact of expanded function dental assistants on dentist productivity. Results indicated that a dentist working with one expanded function assistant and three chairside assistants in a three-chair operatory could treat an average of 4.58 more patients a day than a dentist working in a two-chair operatory with two chairside assistants and no expanded function assistant. Production was increased by ten patients a day when the dentist worked with two expanded function assistants and four chairside assistants in a four-chair operatory.

A study to determine the impact of expanded function assistants on the delivery of dental services in private practice settings was conducted in the early 1970's by the University of the Pacific. The study indicated that patient visits per eight-hour day were increased by 33.8 percent in the office of a dentist using two expanded function dental assistants. There was an increase of 29.2 percent in patient visits per day for a pedodontist using one expanded function dental assistant. This study also addressed the cost benefit of utilizing expanded function dental auxiliaries in private practice. Findings indicated that use of expanded function auxiliaries is a cost effective method of extending dental services.

It should be noted that in all studies of productivity the team included chairside assistants working in traditional roles as well as expanded function assistants or hygienists. Therefore, research suggests that productivity increase from addition of an expanded function assistant or hygienist is influenced by utilization of chairside assistants in traditional roles.

Data on manpower productivity was used cautiously in the Council's deliberations. Various indices such as income, number of patients, and number of patient visits have been used to measure productivity. However, the data clearly indicate that by any measure there is an increase in productivity when dental assistants and dental hygienists are utilized in traditional roles. Data also indicate that addition of an expanded function auxiliary or auxiliaries to the dental team produces an additional increase in productivity.

Data on supply of dental assistants are limited and of questionable reliability. Estimates of number of assistants do not recognize the different roles dental assistants play in dental practice or the range of their education. Dental assistants who perform general office duties, those who function in the specialized chairside assisting role and those who function in other roles are included in manpower estimates. The Association's Bureau of Economic Research and Statistics estimates that there were approximately 113,000 employed dental assistants in the workforce in 1975. The actual number of assistants currently employed who have completed formal education programs of various lengths and levels is not known. Data from the Association's Division of Educational Measurements indicates that approximately 36,000 dental assistants have graduated from accredited programs since 1965. Since 1948, a total of 37,300 dental assistants have been examined and certified by the Certifying Board of the American Dental Assistants Association. That number includes dental assistants who prior to 1960 did not graduate from an accredited program. Of the total number of dental

assistants who have ever been certified, 17,196 hold current certification which requires that the assistant meet annual continuing education requirements. The number of dental assistants who have been certified and are not currently certified but are still in the workforce is not known. It is anticipated that an additional 4,800 graduates of accredited programs will be certified by fall 1976.

Estimates of the work life-span of dental assistants are limited and questionable. Statistics for the year 1974 from the Department of Health, Education, and Welfare's Bureau of Health Manpower indicate that the percentage of dental assistants who have worked five or more years range by state from 8 to 41.5 percent. An average of 28 percent of dental assistants in all states have worked five or more years. Because the data include dental assistants who have had formal education and those who have been trained on-the-job, and does not take into account the total number of years available for work, it is of little value. However, it does suggest that frequently quoted work life-span figures may be low.

Although the available information is inadequate, there is more data on the supply and work life-span of dental hygienists. Annually, the Council on Dental Education updates figures on licensed and practicing dental hygienists. The baseline for the estimates are the Department of Health, Education, and Welfare statistics from 1965. In fall, 1975 the number of licensed dental hygienists was 52,100 and the number of practicing dental hygienists was estimated to be 32,000. The number of licensed and practicing dental hygienists will be increased by approximately 4,800 by fall 1976 when spring 1976 graduates are licensed. These figures are significantly higher than those frequently quoted and present a more optimistic picture of dental hygiene manpower.

Work life-span figures for dental hygienists are not meaningful unless they take into account the number of years since graduation. It should be noted that the number of graduates of dental hygiene programs has tripled in the past ten years and, thus, the maximum potential work life-span of a significant portion of the workforce has been ten years or less. The only meaningful figures on work life-span for hygienists, therefore, are those which represent the percent of time hygienists have worked since graduation. In 1975, all licensed dental hygienists residing in the State of Michigan were surveyed to determine work life-span. Ninety percent of those contacted responded to the survey. Of those responding, 74 percent had worked 75 percent or more of the time available since graduation. This information has been corroborated by studies in the State of Washington and other states. Also, the study of Michigan hygienists indicated that the percentage of dental hygienists graduating in any given year who stay in the workforce diminishes by year in the first twenty years after graduation, but increases markedly after that time as they return to work. If this pattern continues the influx of a significant number of hygienists who graduated from the 89 programs developed in the 1960's will again have impact on the manpower pool in the 1980's and the influx of graduates resulting from program growth in the 1970's will again have impact in the 1990's.

A relationship between work life-span of women and level of education has been determined. Department of Labor statistics indicate that the higher the level of educationed attained, the longer women stay in the workforce. This factor should be considered when making decisions about auxiliary utilization and education.

Data on and projections of the number of dental and dental auxiliary programs and graduates for the years 1965 through 1985 are provided in the following table.

Data on and Projections of Number of Dental and Dental Auxiliary Programs and Graduates, 1965-1985, by Five-Year Intervals

Yr	No. of Dental Assisting Programs	No. of Dental Assisting Graduates	No. of Dental Hygiene Programs	No. of Dental Hygiene Graduates	No. of Dental Programs	No. of Dental Graduates
1965	64	1,242	56	1,492	49	3,181
1970	171	2,955	121	2,465	53	3,749
1975	273	5,972	183	4,568	59	4,969
1980	325	7,325	237	5,390	60	5,442
1985	354	8,200	270	5,990	60	5,814

Educational Resources: The Association adopted educational standards for dental hygiene in 1947 and for dental assisting in 1961. Since the standards were adopted, a national dental auxiliary system of significant potential has been developed. As of May 1976 there were 183 accredited dental hygiene programs throughout the country. Only two states, Alabama and Nevada, do not have an accredited dental hygiene program. The number of dental hygiene graduates in spring 1976 was estimated to be 4,800. There are 273 accredited dental assisting programs in 46 of the 50 states. The number of dental assisting graduates in spring 1976 was estimated to be 7,000.

There has been a dramatic increase in the number of new dental assisting and dental hygiene programs during the past decade. Between 1966 and 1976, 129 dental hygiene programs were developed. During the same period, 194 dental assisting programs were developed.

Dental hygiene curricula are conducted in accredited, not-for-profit institutions of higher education that offer college-level programs leading to an associate or higher degree. Forty-one dental hygiene programs are located in the university dental school setting; 39 in four-year colleges or universities; 91 in community colleges; and 15 in technical colleges/institutes.

Dental assisting curricula are conducted in the same types of institutions which conduct dental hygiene programs, and in addition are conducted in vocational schools, proprietary schools and recognized federal service training centers. Of the 273 dental assisting programs, 20 are located in dental schools; 13 in four-year colleges or universities; 150 in community colleges; 29 in technical colleges/institutes; 54 in vocational schools, and 6 in proprietary schools. Also, there is an accredited correspondence program sponsored by a dental school.

Data on program development indicate that educational institutions respond to identified needs for curricula and incentives such as funds for program development. It is unlikely that community colleges' interest in developing programs in health-related fields will diminish in the foreseeable future. Further, the potential of dental schools has not been reached. However, many factors including availability of financial resources, the goals and objectives of the universities and their policies regarding level of curricula influence dental schools' ability to respond to the need for dental auxiliary programs. Roles other than offering an educational program that the university dental school might play in the training of expanded function dental auxiliaries have not been explored adequately. The education and training of expanded function auxiliaries requires input from dental educators. The Council believes that the Association must work closely with the American Association of Dental Schools and dental school administrators in identifying an appropriate and realistic role for dental education in the preparation of an expanded function auxiliary workforce.

Legal Provisions: Information from surveys by and reports of the Association's Council on Legislation and Division of Educational Measurements, and the Department of Health, Education, and Welfare's Division of Dentistry were utilized by the Council in assessing the current status of legal provisions for delegation of expanded functions to dental assistants and dental hygienists; and changes in provisions between 1967 and 1975. A report on the 1975 survey of licensing jurisdictions on legal provisions for delegation of functions to dental assistants and dental hygienists was provided to workshop participants and has been distributed to all constituent dental societies and examining boards.

It is notable that data from the 1975 survey by the Division of Educational Measurements indicate that over half of the licensing jurisdictions in the United States and its territories have provisions to delegate expanded functions to dental assistants and dental hygienists. The number of jurisdictions which have provisions for delegation of functions to assistants and those which have provisions for delegation to hygienists are about the same. The one notable exception is administration of local anesthetic agents which is not reported to be delegatable to dental assistants in any jurisdiction, but is delegatable to hygienists in nine jurisdictions. Also, there is slightly more delegation to hygienists of functions such as placing and removing temporary restorations; placing, carving, and polishing amaglam restorations; placing, contouring, and finishing composite resin or silicate cement restorations, and performing preliminary oral examinations. In addition, the Council noted that functions which historically have been delegated to the hygienist, such as applying anticariogenic agents and polishing coronal surfaces of teeth, have been delegated less frequently to dental assistants than other functions which are new to both auxiliaries.

Forty-six of the 52 licensing jurisdictions responded to the 1975 survey. Some states did not respond because changes in legal provisions were in process. Of the 21 functions included in the survey, four are functions that the 1975 House of Delegates considered to be inappropriate for delegation. Those functions include administration of local anesthetic agents, which may be delegated to dental hygienists in nine jurisdictions; placing amalgam restorations, which may be delegated to dental assistants in six jurisdictions and hygienists in eight jurisdictions; carving amalgam restorations, which may be delegated to dental assistants in five jurisdictions and to dental hygienists in nine jurisdictions; and placing and finishing composite resin or silicate cement restorations, which may be delegated to dental assistants in four jurisdictions and to hygienists in seven jurisdictions. In the Council's view, differences in provisions among the states further support the need for a national policy that recognizes regional and state differences in demand for care and the need for more extensive utilization of dental auxiliaries to provide care in some geographic areas. The summary of data by function from the 1975 survey follows.

Number of Jurisdictions with Provisions for Delegating Specific Expanded Functions to Dental Assistants and/or Dental Hygienists Fall 1975

	Dental Assistants	Dental Hygienists
Make radiographs	38/46	NA
Take impressions for study casts	21/46	32/46
Place periodontal dressings	10/40	23/43
Remove periodontal and surgical dressings	24/44	36/45
Remove sutures	28/44	36/45
Apply topical anesthetic agents	23/45	NA
Perform preliminary oral examination	10/44	NA
Polish coronal surfaces of teeth	17/46	NA
Apply anticoriogenic agents topically (i.e., fluoride)	29/46	NA
Administer local anesthetic agents	0/45	9/46
Place rubber dam	33/47	35/44
Remove rubber dam	32/46	34/45
Place matrix	18/46	24/45
Remove matrix	22/45	24/45
Place temporary restorations	10/44	23/46
Remove temporary restorations	12/44	19/46
Place amalgam restorations	6/46	8/46
Carve amalgam restorations	5/46	9/46
Polish amalgam restorations	13/46	34/46
Place and finish composite resin or silicate cement restorations	4/46	7/44
Remove excess cement from coronal surfaces of teeth	22/45	NA

Note: The number on the right of the slash (/) is the total number of jurisdictions which provided information on the specific function. The number on the left of the slash (/) is the total number of jurisdictions which permit delegation of the function.

NA, traditional dental hygiene functions; therefore, not applicable.

Although many jurisdictions have provisions for delegation of expanded functions, few require formal expanded function training or a performance examination. More jurisdictions require training in specific expanded functions for assistants than for hygienists, but the total number of jurisdictions requiring any special training is very small. Because, in general, hygienists must be graduates of an accredited program to be eligible for licensure examination, jurisdictions may assume that expanded function training will be provided in the educational program. This assumption cannot be made for dental assistants, because the majority of assistants are not graduates of educational programs.

Jurisdictions have been encouraged to recognize certification by the Certifying Board of the American Dental Assistants Association as a prerequisite for expanded function training but only one state responding to the survey has such a requirement. That state requires certification as a prerequisite for training in six of the 15 delegatable functions, but requires formal training and examination by the training program faculty for all 15. Thus it is evident that although few jurisdictions specify qualifications of dental assistants for delegation of expanded functions, those that do, consider formal education rather than certification the essential qualification.

The survey indicates that only a few jurisdictions require certification for performing some functions. The number of jurisdictions restricting delegation of functions to certified dental assistants varies from no jurisdictions for the majority of functions to six jurisdictions for two functions.

In general, registration of dental assistants is not a requirement for performance of expanded functions. The number of jurisdictions reporting a registration requirement varies by function. The maximum number is seven jurisdictions which require

registration of dental assistants who make radiographic surveys and place and remove rubber dams.

It should be noted that functions identified by the 1975 House of Delegates as not delegatable because of their significance and complexity have been delegated in some jurisdictions without any requirement of formal education or examination. For example, only two of the six jurisdictions with provisions for delegating placing and carving amalgam restorations to dental assistants have a formal education and examination requirement. Only one jurisdiction specifies a training requirement for dental hygienists who place amalgam restorations. This situation underscores the need for a position statement on educational requirements for expanded functions as identified by the 1975 House.

PART II: RATIONALE FOR AND RECOMMENDATIONS ON DENTAL AUXILIARY UTILIZATION AND EDUCATION

Philosophy and Principles: As stated previously, information on the impact of expanded function dental auxiliaries on dental care delivery is limited. However, in the Council's view, there is sufficient information to make recommendations on some aspects of dental auxiliary utilization and education as requested by the House.

The Council used facts as the basis for its recommendations and conclusions. It realized that demand for care differs from need and that demand fluctuates creating a dimension that must be considered in developing national policy. Geographic differences in demand and need have caused the Association to take the position that ultimately decisions on utilization of auxiliaries should be made by the individual state and dentist. However, the Council agrees with the House that a national position on expanded functions and education for those functions is necessary to assure that dentistry will continue to exert leadership in the development of the dental care delivery system and specifically the role and function of dental auxiliaries in that system.

It is the Council's observation that the growth and vitality that dentistry has exhibited over the past century is the result of its acknowledgement of the need for research, experimentation, and orderly change. To maintain this vitality, the profession must continue to be sensitive to society's needs. In recent years, the greatest challenge to health professions has been the charge that they are not responding to demands for health care. Regardless of the accuracy of the charge, it has persisted and the profession must continually demonstrate its commitment to providing quality care to the American people.

The Council believes that the private practice system of health care delivery is preferable. It will continue to be feasible if the profession plans carefully for change to accommodate increases in demands for care as they occur. Changes in dental care delivery must be cost effective and provide access for all people. It is the Council's conviction that an orderly and prudent evolution of auxiliary utilization will significantly improve dentistry's capability for providing quality dental care.

In approaching its assignment, the Council gave primary consideration to what is in the best interests of the public on a long-term basis. The Council is unequivocally opposed to any positions, policies, and programs which would create a second level of dental care.

The Council believes caution should be employed to avoid development of one auxiliary at the expense of another or at the expense of the provision of critical aspects of care. Any decision which would ultimately cause regression in the gains made through effective utilization of assistants and hygienists could negate gains from utilization of expanded function auxiliaries or new categories of auxiliaries. The Council strongly believes that first priority should be given to maximum utilization of chairside dental assistants and dental hygienists; and that utilization of expanded function auxiliaries, either assistants, hygienists or new categories, should be an extension of the delivery capacity that exists today.

In addition, the Council strongly believes that defining roles of auxiliaries by adding individual functions is an approach that is no longer needed or appropriate. Role definition is the first priority and from that definition functions can be delineated to fill the roles. Therefore, there is need to define the role of each auxiliary in relation to the role of dentists, other auxiliaries, and different patterns of dental care delivery. As the role of the general practitioner and specialist are defined further or revised, the role of auxiliaries should be reassessed. This necessarily requires additional research and experimentation in utilization of different types of auxiliaries in the actual practice system. One reason for today's dilemma is the fact that such data are not available and decisions are being made within a vacuum.

In the Council's view, the introduction of expanded function auxiliaries will not, in itself, resolve the multitude of problems which confront the profession in responding to demands for care from all segments of the population on a long-term basis. Decisions on the role and function of auxiliaries and provisions for their education and credentialing must be in harmony with other Association programs to continue to meet the profession's commitment. The Council is also of the conviction that what is needed now is a firm philosophical and policy base for utilization and education of expanded function auxiliaries, guidelines for education, and experimentation to determine the effect of introduction of various types of auxiliaries on the actual provision of care to patients in the private practice of dentistry.

Although over the years the House has adopted resolutions which represent philosophy and principles which should underlie decisions on delegation of expanded functions and establishment of education and training requirements, the resolutions do not constitute a clear and comprehensive statement of the Association's position on this subject. As the House indicated, a statement is needed to provide direction for Association programs and activities and guidance to organizations, agencies, federal and state legislative bodies, and other outside interest groups to assure that dentistry's position is clearly presented. Therefore, the following statement of philosophy on and principles for utilization and education of auxiliaries is being submitted to the House for its consideration. The statement is again included in Part III of this report for House action.

Statement of Philosophy on and Principles for Utilization and Education of Dental Auxiliaries

Philosophy for Utilization and Education of Dental Auxiliaries: As a health profession, dentistry is committed to improving the health of the American public by providing the best quality of dental care to all people of the nation. This commitment dictates that dentistry assume

responsibility for assuring that there will be adequate manpower and appropriate standards of education and training for all personnel who participate in the provision of dental care. In addition, this responsibility extends to identification of the need for specific types of auxiliaries and establishment of appropriate controls on the delivery of services provided by those auxiliaries.

The purpose of delegating expanded functions to dental auxiliaries is to improve the productivity of the dentist for the ultimate purpose of making dental health services available to all people. Thus, functions should be identified and delegated to dental auxiliaries when the demand for specific services exceeds the capacity of dentists to provide them. Further, any delegation of functions must result in maintaining or improving the quality of care and increasing the availability of services at a reasonable cost, with assurances of quality control.

The Association believes that nothing should restrict the capacity of the profession to investigate and consider various methods of dental care delivery, including increased utilization of dental assistants and dental hygienists in traditional as well as extended roles; and that the dental practitioner must be involved in determining the appropriate implementation of results of such investigation.

The dentist is responsible for patient services and in carrying out that responsibility makes decisions on the most effective utilization of auxiliaries within established provisions for such utilization. Those provisions must be included in practice acts and provide assurance to the dentist that auxiliaries will have appropriate education and training and meet whatever additional criteria are needed to guarantee competence.

Principles of Dental Auxiliary Utilization and Education: The Association subscribes to the following principles in applying its philosophy of dental auxiliary utilization:

1. Only functions which do not require the composite judgment, knowledge, and skill attained through dental education and which contribute to a meaningful role in dental care delivery should be delegated.

2. Individual states or jurisdictions should make the final decisions on which functions may be delegated and the qualifications for performance of those functions.

3. In making decisions on which functions may be delegated, jurisdictions should recognize that demands for care may vary within the jurisdiction and that utilization of expanded function auxiliaries by some dentists may be necessary.

4. Final decisions on delegation of functions should be made by the dental practitioner in compliance with legal provisions in the jurisdiction.

5. The initial step in increasing the dentist's productivity should be full utilization of traditional dental assistants and dental hygienists.

6. Decisions on delegation of expanded functions should be based on what is in the best interest of the patient.

7. Transfer of functions from the dentist or from one auxiliary to another should not result in a lessening of quality or dilution of procedures which have been proven effective in preventing and treating dental and oral disease.

8. The primary purpose of delegating expanded functions is to increase the capacity of the profession to provide care.

9. Provisions for delegation of functions to dental auxiliaries must take into account the complexity of the function and the knowledge and skill required to carry it out.

10. Provisions for delegation of expanded functions should include general specifications of education and training requirements.

11. Provisions for delegation of expanded functions should include specification of supervision by the dentist.

12. Provisions for delegation of any expanded functions should include, in addition to education and training requirements, assurance of quality control through credentialing by an appropriate agency.

13. The need for consistency in identification of auxiliaries, definition of their roles and assurances of competence should be recognized by states or jurisdictions in decisions on provisions for delegation of functions.

14. Decisions on delegation should be based not only on ability of the auxiliary to perform functions but also on consideration of cost effectiveness and efficiency in delivery patterns.

15. Decisions on delegation of functions to dental assistants and/or hygienists or establishment of new auxiliaries should be based on valid research that includes investigation of the feasibility and practicality of utilizing auxiliaries in such roles in actual practice settings.

16. Dental practitioners should be involved in decisions regarding the application of research in the practice setting and the implementation of research findings.

17. Expanded function education and training should be conducted only in settings with the resources needed to provide appropriate preparation for clinical practice and development of the auxiliaries' understanding of his/her role in delivering care in relation to that of the dentist.

Functions Which Could Be Delegated: The Council could not and did not attempt to identify all functions which have been or in the future might be delegated to auxiliaries. However, in the Council's opinion consideration of functions which have been included in research projects, are legally delegated in some jurisdictions, and/or are included in guidelines for Expanded Function Dental Auxiliary (EFDA) Programs or Training in Expanded Auxiliary Management (TEAM) Programs was reasonable as they represent potential expanded functions which have been identified by various groups. A list of such functions was compiled for the workshop. Functions that dental assistants traditionally have performed and those that are recognized specifically as dental hygiene functions by all jurisdictions were not included because the Association already has positions on delegation of and educational standards for these functions.

From the list of expanded functions, the Council identified those which, in its opinion, could be delegated. That opinion is the result of thoughtful study of the information produced by research and experience; and the consensus of workshop participants, particularly the practicing dentists. As noted previously, over half the jurisdictions in this country have provisions for delegating several functions. If the profession in these jurisdictions has endorsed such delegation, as it must have if the laws have been enacted, then the Council believes the functions can be considered delegatable.

In its study of the groups of functions that were considered delegatable by the Association until fall 1975, and for which at least seven jurisdictions have provisions for delegation to dental assistants and/or dental hygienists, the Council weighed all the objective evidence which would support or refute their delegation, and the consensus of workshop participants. The Council agrees that preparation of teeth should not be delegated to auxiliaries. However, despite the fact that some members of the profession may not wish to delegate placing and carving or contouring dental restorations, or administering local anesthetic agents, the Council found that research has clearly indicated that these functions can be performed adequately by appropriately trained auxiliaries under the dentist's supervision without adverse affect on patients. Research also has indicated that performance of these functions contributes to the productivity of the dentist.

It is recognized that delegation of the functions with appropriate supervision by the employing dentist can extend services when there is a demand to be met. To continue a policy that may inhibit the dentist's ability to provide services is detrimental to the well-being of the public and threatens the survival of the profession. To maintain its credibility, the profession must be in a defensible position when it establishes

policy. The Council believes that the profession must admit that certain functions can be performed by auxiliaries and that delegation of those functions increases productivity. The profession is also obligated to identify those functions which should not be delegated, either because they require the composite knowledge, skill and judgment of the dentist or because they do not positively influence productivity. It is not appropriate to expend valuable resources to train auxiliaries to perform functions which should not be delegated or which do not increase productivity.

Decisions on delegation of specific functions to dental assistants and/or dental hygienists should be predicated on evidence that the auxiliary can, with appropriate education and training, perform the function with quality comparable to the dentist; the capability, or potential capability, of the educational system to provide appropriate education and training; the effect of delegation on extending the dentist's capacity to provide care; and indications that demands for care do, or will, warrant such delegation.

The fact that the Association takes a position that given functions *could* be delegated does not require that all dentists delegate those functions, or that all jurisdictions enact legislation to enable delegation. If the Association took the position that given functions should be delegated it would have different implications and most likely different impact. The Council has *not* taken the position that the functions *should* be delegated, and therefore, acceptance of the recommendations would *not* be a mandate. The Council's recommendations do not require uniformity in number and type of functions delegated, but can provide the dentist and the public assurance of acceptable educational qualifications for any auxiliary who performs expanded functions, just as there are assurances of acceptable educational qualifications for dentists and dental hygienists. It is understood that delegation in some states could influence the establishment of similar provisions in other states. However, the Council believes that extension of the boundaries of delegation does not occur if the decisions are not sound.

The Council calls attention to the fact that the practice of dentistry is more than the performance of functions which constitute the technical procedures of dentistry, and that a dentist is more than the sum of his/her functions. Those aspects of dentistry that are not quantifiable represent the difference between a profession and a technical field and between ability to assume responsibility for delivery of health care services and ability to perform functions which constitute part of a health care service. It is a fact that some functions can only be performed by the dentist because effective performance of the functions is dependent upon judgments that require synthesis and application of knowledge acquired in professional dental education. It also is a fact that the ability to perform single tasks or functions does not in itself provide the capability for performing in a functional role. Functions should be grouped on logical, practical bases to constitute a role that is effective in delivery of care. Thus, the Council concluded that delegation of functions should not be based solely on evidence of ability to perform a task or function, but must be based on recognition of logical configurations of functions which would permit auxiliaries to assume an efficient and effective role in delivery of dental care.

As the private practice delivery system changes, it will be necessary for the profession to continue to identify functions that could be delegated and recommend appropriate education for preparation of auxiliaries to perform those functions. Therefore, the Council has identified functions, which, in its opinion, serve as examples for additional delegation as information becomes available and need to extend services war-

rants. The profession's resources can be directed to further development of the educational system to accommodate preparation of auxiliaries for identified roles. As roles change the educational system can be modified to reflect those changes.

Categories of Auxiliaries: While proliferation of a number of highly specialized auxiliaries is undesirable, the current limitation of categories to the dental assistant, dental hygienist, and dental laboratory technician may not be practical in relation to delivery of care and may have inhibited establishment of appropriate educational qualifications and other credentials such as registration. The Council believes that the Association should reassess its position that no categories of auxiliaries other than the dental assistant, dental hygienist, and dental laboratory technician be recognized. That belief is based on the observation that, in fact, states have established new classifications to accommodate new roles assigned to the dental assistant and/or hygienist. Without those classifications it was not possible to establish education and training requirements and regulatory controls that are appropriate for different functional roles. The fact that classifications vary among those states is of concern. The Council believes that the need for classifications or new categories should be addressed to avoid the problem of unnecessary and unwieldy proliferation of classifications or categories of auxiliaries which the Association has attempted to avoid.

Dental Auxiliary Resources: It has been documented and is widely recognized that utilization of competent chairside assistants is a major factor in increasing the dentist's productivity. The Council believes that the significance of the competent chairside assistant's role should be emphasized. Further, the Council supports formal education for chairside assisting functions.

While it is desirable that all dental assistants who perform chairside assisting functions be graduates of formal education programs, it is not feasible to require formal education at this time. However, in the Council's view, it is feasible and essential to require formal education for dental assistants who perform expanded functions which have direct effect on the patient's well-being. This can be accomplished through modification of existing educational and regulatory systems.

It is recognized that all types of educational institutions in all communities do not have the resources to provide education in expanded functions which require a science base and clinical practice. The Council believes those institutions that do not have these resources should continue to provide formal education programs for chairside assisting, an educational program that is becoming increasingly important. Those institutions which do have the resources to provide instruction in expanded functions should consider modifying programs to prepare individuals for new roles as providers of intraoral services as legal provisions for expanded function assistants are enacted.

In the Council's view, delegation of traditional dental hygiene functions to dental assistants has produced some of the same problems that delegation of dentist's functions to assistants and hygienists has produced. The Council believes the profession must seriously question the direction it has taken in delegation of hygiene functions. Future decisions should recognize the importance of the services the dental hygienist performs and the adverse effect of fragmenting the oral prophylaxis. Caution should be used in reassigning dental hygiene functions to avoid deterioration in the quality and provision of preventive services.

It is also of serious concern to the Council that in making decisions on delegation of functions the profession has not fully utilized the resource it has in dental hygiene.

In view of the increase in hygiene manpower, it is no longer necessary to exclude the dental hygienist from consideration in delegating expanded functions. The educational background of the hygienist and the well-developed dental hygiene educational system with resources for providing science instruction and clinical practice offer a potential that should be utilized. As the dental hygiene workforce continues to increase, the number of hygienists will allow for more diversification of their functions. And it has been proven that preparation for more diverse roles can be included in dental hygiene educational programs. It also has been determined that delegation of restorative functions to hygienists is feasible. The Council believes that in addition to considering delegation of restorative functions to hygienists, dentistry should explore and emphasize the hygienist's potential expanded role in preventive dentistry and periodontics.

Recommendations for Delegation: As stated previously, it is the view of the Council that it is not feasible or necessary at this time to identify all functions which might be considered for delegation. The list of functions considered during the workshop and by the Council was not all-inclusive and, with exception of orthodontics, was not representative of functions that might be delegated in specialty practices.

Therefore, the Council selected those functions which are part of services typically provided in general dentistry practices and which have been included in research projects. The profession's position on delegation of these functions can be applied to others which are of comparable difficulty and require the same or parallel background. Thus, the recommendations of the Council are presented for guidance in establishing provisions for delegation of expanded functions. In general the Council's recommendations reflect the consensus of workshop participants.

Functions of the dental assistant, such as instrument transfer and other chairside assisting procedures, and functions of the dental hygienist, such as scaling, which form the established roles of these auxiliaries were not included in the workshop deliberations, and in the Council's opinion should not be reassigned.

In determining which functions could be delegated, the Council found it necessary to define given functions more specifically or place qualifications on their performance. The specifications or qualifications are included in the statements of those functions. In some instances, the specifications or qualifications define the difference in the scope of the procedure which could be delegated to an assistant, and the scope of the procedure which has traditionally been, or could be, delegated to a hygienist. As an example, the Council has qualified removal of excess cement by the dental assistant. Delegation of the removal of cement has evolved from research in training dental assistants to perform orthodontic functions. Specifically, the experimentation was in training dental assistants to remove cement from orthodontic bands and the adjacent tooth surfaces after placing the bands. The delegation of this function has not been qualified or restricted, but in the Council's opinion, should be. The Council believes that removal of cement from coronal surfaces of teeth following placement of orthodontic bands or restorations could be delegated, but believes that removal of cement from surfaces below the gingival margin should not be delegated to dental assistants. Removal of subgingival cement essentially is a scaling procedure and requires instrumentation which could cause irreparable damage to the periodontium. The Council does not believe that delegation of this function, when it has significance in maintaining the integrity of the periodontium, is justifiable. The dentist is responsible for determining that the margins of restorations are adequate, and in

making that determination can and should perform the subgingival instrumentation required to remove the excess cement and finish the margins.

The Council is also of the opinion that the application of pit and fissure sealants and placement of silicate cement and composite restorations can be delegated to dental assistants and dental hygienists only with specific qualification. These procedures could not be delegated when they are used to stabilize teeth or for temporary restoration of teeth in fixed partial denture procedures. Therefore, the statements of these functions are qualified.

The term preliminary oral examination has different connotations. Therefore, the Council has substituted more specific statements for this function which reflect its opinion and that of workshop participants on what could be delegated to dental assistants. The Council believes that inspection of the oral cavity to identify and chart carious lesions, existing restorations and missing teeth could be delegated to a dental assistant with appropriate education and training.

Although there was general consensus among workshop participants that soft tissue curettage is a function which could be delegated to dental hygienists and several states have provisions for delegation, the Council believes qualification of the function is appropriate. Therefore, the term is qualified as "closed soft tissue curettage", which means the removal of tissue lining the periodontal pocket without surgical retraction of the gingiva.

Although the majority of all workshop participants and all seven workshop groups agreed that placing and carving amalgam restorations, and placing and contouring silicate cement and composite resin restorations could be delegated, the practicing dentists were evenly divided on the question with 40 in favor of and 40 against delegation. The Council believes these functions could be delegated with appropriate supervision. Research has demonstrated that they can be performed with quality by an auxiliary with adequate education and training. And, in some dental practice settings where productivity increases are indicated, the performance of these functions is compatible with the roles of dental auxiliaries.

In addition, the Council believes administration of local anesthetic agents could be delegated to dental hygienists. It is reasonable in terms of the educational background and licensure of hygienists and practical in terms of practice patterns and other functions dental hygienists perform. While local anesthesia may not be required for all patients, there is sufficient evidence that soft tissue curettage generally requires local anesthesia. Regular subgingival instrumentation would be performed more adequately if the hygienist were able to use specific methods of pain control. In some states hygienists with appropriate education have been able to administer local anesthetic agents for several years in conjunction with their clinical procedures, and there has been no cause for litigation or revocation of the function. Nurses, paramedics, and emergency care personnel with comparable or no formal education routinely give injections which have even more serious implications. It is not responsible, in the view of the Council, to deprive the patient of comfort and inhibit the hygienist's ability to perform an adequate service by prohibiting delegation of this function to the hygienist in conjunction with root planing and soft tissue curettage. Therefore, the Council believes delegation of this function to hygienists with adequate controls is warranted. However, the Council does not believe there is justification for delegating the function for other purposes and therefore is recommending specific restrictions.

The following position statement on delegation of expanded functions is being submitted to the House for its consideration. The statement is again included in Part III of this report for House action.

Statement on Expanded Functions Which Could Be Delegated to Dental Assistants and/or Dental Hygienists

The American Dental Association endorses expanded utilization of dental auxiliaries when such utilization is in accord with its Philosophy on and Principles for Utilization and Education of Dental Auxiliaries. As a health profession, it is incumbent on dentistry to provide guidance to all agencies, organizations, and legislative bodies which have interest in or responsibility and authority for decisions related to utilization of dental personnel. It also is incumbent on the profession to assure that those decisions will not adversely affect the health and well-being of the public. In meeting these responsibilities the profession is obligated to identify those functions or procedures which should only be performed by the dentist.

The following functions and procedures should not be delegated to dental auxiliaries because effective and safe performance is dependent upon making judgments that require synthesis and application of knowledge acquired in professional dental education. The functions include but are not limited to:

1. Diagnosis and treatment planning.
2. Surgical or cutting procedures on hard or soft tissue.
3. Prescribing drugs, medicaments and preparing work authorizations.
4. Taking impressions for fabrication of fixed or removable restorations or appliances.
5. Making occlusal adjustments.
6. Performing pulp capping and pulpotomy procedures.
7. Placing and adjusting fixed and removable prosthodontic appliances.

It is the considered judgment of the profession that certain functions in addition to those which have traditionally been performed by dental assistants and/or dental hygienists can be delegated. This position does not require, or even suggest, that all dentists delegate these functions or that all jurisdictions enact legislation to enable delegation; and should *not* be considered a mandate. When, and if, legal provisions are enacted for delegation of the functions they should include specifications of education and training, supervision by the dentist, and regulatory controls that will assure protection of the public.

The ultimate decision on what functions will be delegated should be made by the dentist for the purpose of extending his care. The lists of functions are not all-inclusive. Other functions which are comparable in nature; do not require the knowledge, judgment and skill of the dentist; and contribute to a functional role for an auxiliary could be considered for delegation.

In addition to the traditional functions performed by dental assistants, the following functions could be delegated to *assistants:*

1. Inspecting the oral cavity including charting carious lesions, existing restorations and missing teeth.
2. Polishing coronal surfaces of teeth following examination or inspection and removal of hard deposits by the dentist or dental hygienist.
3. Removing excess cement from supragingival surfaces of teeth and restorations.
4. Finishing and polishing amalgam restorations.
5. Applying anticariogenic agents topically.
6. Applying topical anesthetic agents prescribed by the dentist.
7. Removing sutures by direction of the dentist.
8. Placing periodontal dressings.
9. Removing periodontal dressings.
10. Taking impressions for study casts.
11. Placing and removing rubber dams.
12. Placing and removing matrices and wedges.

13. Placing and removing temporary sedative intracoronal restorations with hand instruments.
14. Applying cavity liners and bases as directed by the dentist.
15. Condensing and carving amalgam restorations.
16. Placing and contouring silicate cement and composite resin restorations in individual teeth.
17. Applying pit and fissure sealants to individual teeth.

In addition to the traditional functions performed by dental hygienists, the following functions could be delegated to *hygienists:*

1. Finishing and polishing amalgam restorations.
2. Performing closed soft tissue curettage.
3. Administering local anesthetic agents in conjunction with root planing and closed soft tissue curettage.
4. Removing sutures by direction of the dentist.
5. Placing periodontal dressings.
6. Removing periodontal dressings.
7. Taking impressions for study casts.
8. Placing and removing rubber dams.
9. Placing and removing matrices and wedges.
10. Placing and removing temporary sedative intracoronal restorations with hand instruments.
11. Applying cavity liners and bases as directed by the dentist.
12. Condensing and carving amalgam restorations.
13. Placing and contouring silicate cement and composite resin restorations in individual teeth.
14. Applying pit and fissure sealants to individual teeth.

Educational Requirements: Dental practice is the application of knowledge, skill and judgment in making diagnoses, formulating treatment plans and providing care; therefore, the education of the dentist crosses all cognitive domains. Formal education is required to prepare the dentist for his/her complete role as a health professional.

Education of auxiliaries who perform, or will perform expanded functions should be designed for the parallel purpose of preparing the auxiliary for his/her total role. The dental assistant and dental hygienist apply knowledge, skill and judgment of different scope and depth, which have relevance in the delivery of care. The educational requirements for dental assistants and dental hygienists are based on their total role and recognize the most complex, rather than the most elementary functions. The fact that elementary tasks or functions do not require a significant amount of education or training is recognized through emphasis in the curriculum, particularly the time allocation; not by eliminating components which allow the assistant or hygienist to perform a functional role. The nature of functions also is recognized in determining the level of education required for the particular auxiliary and the appropriate setting for that education. It is logical that the level, scope and length of education for intraoral functions differs significantly from that required for dependent supportive functions which do not directly affect the well-being of the patient.

As stated previously, the Council believes the profession should not continue to consider expanded functions as isolated units, but should consider them as groups of related units which form configurations that are compatible with patterns of practice.

Therefore, in the Council's view, it is not practical to continue to train auxiliaries for single functions in the dental office. It is not economically sound for the dentist whose practice warrants utilization of an expanded function auxiliary to devote time to preparing for and providing instruction in expanded functions, and evaluating objectively the results of that instruction.

Further, there is no evidence to support continued delegation of expanded functions without specific educational requirements. Configurations of functions require education that crosses cognitive domains, as dental education does, and it would not be considered appropriate to prepare the dentist for the same functions in other than formal programs. Auxiliaries who have performed functions in the research programs with quality comparable to the performance of the same functions by dentists had formal education. The educational system has responded in the past to the need for preparing dental assistants and hygienists for specific roles, and will respond in the future if there is evidence that formal education is necessary and recognized by the profession as the appropriate means of preparing auxiliaries for expanded roles.

In addition, the provision of separate educational programs for individual functions is not economical or sound. Educational programs are taxed when instructional units are too limited in scope and individuals are moving in and out of the system to acquire the knowledge and skill to perform a single function. And, the application of pertinent background knowledge is diminished when the time interval between acquisition of the knowledge, and learning which requires its application is increased. As a result the need for review and repetition is increased. Separation of related aspects of knowledge and skill also ignores the positive effect that integration of these aspects has on the quality of learning. Finally, it is not feasible to maintain regulatory controls when auxiliaries within a category are individually qualified for different functions. And legal provisions in some jurisdictions require that an auxiliary have the qualifications to perform all functions assigned to the category to be credentialed for that category.

For these reasons the Council believes that short-term courses to provide instruction in isolated functions as a means of preparing auxiliaries to perform those functions should be continued only to qualify the existing workforce. This position and the stated rationale do not apply to continuing education for updating knowledge and skill.

The Council believes that planning should be initiated to incorporate instruction in expanded functions in educational programs accredited by the Commission on Accreditation of Dental and Dental Auxiliary Educational Programs, and that the type of setting and resources required to assure competence of graduates and continued high quality of dental care be determined. It is the opinion of the Council that all instruction of new auxiliaries in expanded functions should be provided within accredited programs which have the resources by 1986. It is recognized that recommendations for formal education and training cannot be implemented immediately. However, the Council believes they represent goals which give evidence of the profession's commitment to assuring continued high quality of dental care. With one exception, applying anticariogenic agents topically, the Council's recommendations on educational requirements agree with the consensus of workshop participants.

The following position statement on educational requirements for expanded functions is being submitted to the House for consideration. The statement appears again in Part III of the report for House action.

Statement on Educational Requirements for Expanded Functions Which Could Be Delegated to Dental Assistants and/or Dental Hygienists

The nature of expanded functions which constitute a direct service to the patient and, either have been or could be delegated to dental assistants and dental hygienists, requires that the auxiliary be prepared to perform those functions through formal education and training. Formal education and training is defined as a planned sequence of instruction of specified content, structured to meet stated educational objectives and to include evaluation of attainment of those objectives. Such instruction is provided by an institution or facility that is recognized by a system of higher education and has education as a primary or major purpose.

The provision of short-term formal education and training for individual expanded functions, or groups of functions, is considered an acceptable method of preparing auxiliaries who are currently in the workforce to perform legally permitted functions. It is the Association's position that when functions are assigned, short-term courses should be provided only to prepare the existing workforce to meet all qualifications for performing the functions.

The Association urges dental societies, state boards of dentistry and dental schools to work with recognized educational institutions and training centers in developing courses of instruction for dental assistants and/or dental hygienists who are in the workforce. Such courses should include clinical instruction and practice and comply with established guidelines of the American Dental Association's Council on Dental Education.

It is the Association's position that ultimately all instruction in expanded functions that require formal education should be provided in educational programs accredited by the Commission on Accreditation of Dental and Dental Auxiliary Educational Programs. The Association urges those educational institutions with the resources for expanded function instruction to develop educational programs, or modify programs, to prepare dental assistants and/or dental hygienists for their respective roles in dental care delivery as increased delegation occurs.

The Association believes the following expanded functions which could be delegated to *dental assistants* require formal education.

1. Inspecting the oral cavity including charting carious lesions, existing restorations and missing teeth.
2. Polishing coronal surfaces of teeth following inspection or examination by the dentist and removal of hard deposits by the dentist or dental hygienist.
3. Removing excess cement from supragingival surfaces of teeth and restorations.
4. Finishing and polishing amalgam restorations.
5. Applying anticariogenic agents topically.
6. Placing periodontal dressings.
7. Removing periodontal dressings.
8. Taking impressions for study casts.
9. Placing and removing rubber dams.
10. Placing and removing matrices and wedges.
11. Placing and removing temporary sedative intracoronal restorations with hand instruments.
12. Applying cavity liners and bases as directed by the dentist.
13. Condensing and carving amalgam restorations.
14. Placing and contouring silicate cement and composite restorations in individual teeth.
15. Applying pit and fissure sealants to individual teeth.

The Association believes the following expanded functions which could be delegated to *dental hygienists* require formal education.

1. Finishing and polishing amalgam restorations.
2. Performing closed soft tissue curettage.
3. Administering local anesthetic agents in conjunction with root planing and closed soft tissue curettage.
4. Placing periodontal dressings.
5. Removing periodontal dressings.
6. Taking impressions for study casts.
7. Placing and removing rubber dams.
8. Placing and removing matrices and wedges.
9. Placing and removing temporary sedative intracoronal restorations with hand instruments.
10. Applying cavity liners and bases as directed by the dentist.
11. Condensing and carving amalgam restorations.
12. Placing and contouring silicate cement and composite resin restorations in individual teeth.
13. Applying pit and fissure sealants to individual teeth.

Credentialing: The Council believes that there is even more reason today to identify appropriate methods for regulating utilization of dental assistants and dental hygienists than there was in 1961 when the Association indicated this as one of the six areas of research. Although there is need for further study, some information on existing provisions for credentialing dental assistants and dental hygienists for traditional and expanded roles is pertinent and was considered by the Council.

The fact that dental hygienists are licensed does not in itself preclude alterations in the role of hygienists as some have suggested. In fact, a great deal of change in legal provisions for delegation of functions to dental hygienists has occurred in the past nine years. Further, licensure of hygienists has allowed the dental profession to offer quality assurance to the public for dental hygiene services. In general, mandatory credentialing mechanisms such as licensure are employed only when the functions of the particular category of personnel have a direct effect on the health and welfare of the public. The Council would take strong exception to any steps which might undermine this quality assurance.

Certification by the Certifying Board of the American Dental Assistants Association has been the quality control mechanism for performance of dental assistants in traditional roles. Certification historically has been a voluntary credentialing mechanism, and, with very few exceptions, has continued to be such for dental assistants. Although the profession has encouraged certification of traditional dental assistants, it has not universally recognized or required certification as a qualification for functioning in traditional dental assisting roles.

The question of what credentialing mechanism or mechanisms might be the most appropriate and effective in assuring the public of competence of auxiliaries who perform expanded functions requires additional study. Although the profession supports certification for the traditional dental assistant, it is not recommending or endorsing any specific credentialing mechanism for expanded function dental assistants at this time. Therefore, the Council is not resubmitting the resolution that certification be a prerequisite for expanded function training for dental assistants (*Trans.* 1975:704) which was referred by the 1975 House for further study. The Council, however, believes that identification of appropriate credentialing mechanisms for expanded functions auxiliaries to assure their competence should receive highest priority.

Recommendations for Future Study and Action: The recommendations made in this report should serve as the base for a national policy on expanded function dental auxiliary utilization and education. However, a study of less than one year's duration could not and did not address all aspects of this subject. To assure that preparation and utilization of expanded function auxiliaries proceeds in an orderly and responsible manner, the Council makes the following recommendations for future study and action:

1. Research should be undertaken to determine the feasibility and practicality of utilizing auxiliaries in expanded roles in private practice settings. Dentists engaged in the private practice of dentistry should be involved in planning the research and in decisions on implementation of the findings.
2. The Association should direct immediate attention to studying and identifying appropriate mechanisms for credentialing auxiliaries for the performance of expanded functions.
3. The Association should urge states and regions to identify the need for, and develop educational programs to prepare, dental assistants and dental hygienists for traditional roles where need indicates.
4. The Association should develop comprehensive educational guidelines for education and training in expanded functions for use by states and educational institutions where need exists.
5. Where need exists, short-term formal education courses in expanded functions should be developed by recognized educational institutions and training centers in consultation with state and local dental societies and dental examining boards to accommodate the preparation of the existing workforce.
6. Planning should be initiated to incorporate, by 1986, instruction in those expanded functions recognized by the American Dental Association in educational programs which have the resources and are accredited by the Commission on Accreditation of Dental and Dental Auxiliary Educational Programs.
7. The Association and related agencies should take immediate steps to develop accurate data on number and work life-span of dental auxiliary manpower by category.
8. The Association should work with the American Association of Dental Schools to identify an appropriate and realistic role for dental education in the preparation of an expanded function auxiliary workforce.

PART III: POSITION STATEMENT ON UTILIZATION AND EDUCATION OF DENTAL ASSISTANTS AND DENTAL HYGIENISTS

As stated previously the Council agrees with the House that a national position on expanded functions and education for those functions is necessary to assure that dentistry will continue to exert leadership in the development of the dental care delivery system. The worldwide recognition American dentistry has earned is the result of the profession's acknowledgement of the need for continued research, experimentation and orderly change to respond to society's needs.

The statements reflect the Council's realization that there are geographic differences in demand for care and that demand fluctuates. The Council believes that these differences are accommodated by the positions that final decisions on what functions *may* be delegated should rest with the individual state or jurisdiction, and that it is the dentist who should make the decision, in compliance with legal provisions, on what functions *will* be delegated.

The introduction of expanded function auxiliaries will not, in itself, resolve the multitude of problems which confront the profession, and positions on expanded functions must be in harmony with other Association positions and policies. The Council believes the statements present a firm philosophical and policy base for utilization and education of expanded function auxiliaries and constitute a clear and comprehensive statement for reference of organizations, agencies, federal and state legislative bodies and other outside interest groups. Recommendations on what functions could be delegated and what the educational requirements should be are predicated on evidence from research; the capability, or potential capability of the educational system to provide appropriate education and training, and the effect of delegation on increasing the dentist's potential for providing care.

It is emphasized that the practice of dentistry is more than the performance of functions which constitute the technical procedures of dentistry, that a dentist is more than the sum of his functions, and that there are functions which can only be performed by the dentist. It is the Council's opinion that to continue to make decision on whether given functions can be delegated on the basis of consideration of a single function is inappropriate and will result in a fragmentation of dentistry that is not in the best interest of the public and profession. It is only when functions are considered in relation to a meaningful auxiliary role that sound decisions can be made, and appropriate educational requirements established.

The fact that the Association takes a position that given functions *could* be delegated does not require that all dentists delegate those functions, or that all jurisdictions enact legislation to enable delegation. The Council has not taken the position that the functions *should* be delegated and therefore acceptance of the recommendations would *not* be a mandate. Further, acceptance of the Council's recommendations would not require uniformity in number and type of functions delegated throughout the country, but would provide the dentist and the public assurance of acceptable educational qualifications for any auxiliary who performs expanded functions in any jurisdiction.

The following statement is presented to the House with the recommendation that it be adopted.

RESOLUTION

24. **Resolved,** that the American Dental Association Statement on Expanded Function Dental Auxiliary Utilization and Education be adopted.

AMERICAN DENTAL ASSOCIATION STATEMENT ON EXPANDED FUNCTION DENTAL AUXILIARY UTILIZATION AND EDUCATION

Philosophy on and Principles for Utilization and Education of Dental Auxiliaries

Philosophy for Utilization and Education of Dental Auxiliaries: As a health profession, dentistry is committed to improving the health of the American public by providing the best quality of dental care to all people of the nation. This commitment dictates that dentistry assume responsibility for assuring that there will be adequate manpower and appropriate standards of education and training for all personnel who participate in the provision of dental care. In addition, this responsibility extends to identification of the need for specific types of auxiliaries and establishment of appropriate controls on the delivery of services provided by those auxiliaries.

The purpose of delegating expanded functions to dental auxiliaries is to improve the productivity of the dentist for the ultimate purpose of making dental health services available to all people. Thus, functions should be identified and delegated to dental auxiliaries when the demand for specific services exceeds the capacity of dentists to provide them. Further, any delegation of functions must result in maintaining or improving the quality of care and increasing the availability of services at a reasonable cost, with assurances of quality control.

The Association believes that nothing should restrict the capacity of the profession to investigate and consider various methods of dental care delivery, including increased utilization of dental assistants and dental hygienists in traditional as well as extended roles; and that the dental practitioner must be involved in determining the appropriate implementation of results of such investigation.

The dentist is responsible for patient services and in carrying out that responsibility makes decisions on the most effective utilization of auxiliaries within established provisions for such utilization. Those provisions must be included in practice acts and provide assurance to the dentist that auxiliaries will have appropriate education and training and meet whatever additional criteria are needed to guarantee competence.

Principles of Dental Auxiliary Utilization and Education: The Association subscribes to the following principles in applying its philosophy of dental auxiliary utilization:

1. Only functions which do not require the composite judgment, knowledge, and skill attained through dental education and which contribute to a meaningful role in dental care delivery should be delegated.
2. Individual states or jurisdictions should make the final decisions on which functions may be delegated and the qualifications for performance of those functions.
3. In making decisions on which functions may be delegated, jurisdictions should recognize that demands for care may vary within the jurisdiction and that utilization of expanded function auxiliaries by some dentists may be necessary.
4. Final decisions on delegation of functions should be made by the dental practitioner in compliance with legal provisions in the jurisdiction.
5. The initial step in increasing the dentist's productivity should be full utilization of traditional dental assistants and dental hygienists.
6. Decisions on delegation of expanded functions should be based on what is in the best interest of the patient.
7. Transfer of functions from the dentist or from one auxiliary to another should not result in a lessening of quality or dilution of procedures which have been proven effective in preventing and treating dental and oral disease.
8. The primary purpose of delegating expanded functions is to increase the capacity of the profession to provide care.
9. Provisions for delegation of functions to dental auxiliaries must take into account the complexity of the function and the knowledge and skill required to carry it out.

10. Provisions for delegation of expanded functions should include general specifications of education and training requirements.

11. Provisions for delegation of expanded functions should include specification of supervision by the dentist.

12. Provisions for delegation of any expanded functions should include, in addition to education and training requirements, assurance of quality control through credentialing by an appropriate agency.

13. The need for consistency in identification of auxiliaries, definition of their roles and assurances of competence should be recognized by states or jurisdictions in decisions on provisions for delegation of functions.

14. Decisions on delegation should be based not only on ability of the auxiliary to perform functions but also on consideration of cost effectiveness and efficiency in delivery patterns.

15. Decisions on delegation of functions to dental assistants and/or hygienists or establishment of new auxiliaries should be based on valid research that includes investigation of the feasibility and practicality of utilizing auxiliaries in such roles in actual practice settings.

16. Dental practitioners should be involved in decisions regarding the application of research in the practice setting and the implementation of research findings.

17. Expanded function education and training should be conducted only in settings with the resources needed to provide appropriate preparation for clinical practice and development of the auxiliaries' understanding of his/her role in delivering care in relation to that of the dentist.

Exponded Functions Which Could be Delegated to Dentol Assistonts and/or Dentol Hygienists

The American Dental Association endorses expanded utilization of dental auxiliaries when such utilization is in accord with its Philosophy on and Principles for Utilization and Education of Dental Auxiliaries. As a health profession, it is incumbent on dentistry to provide guidance to all agencies, organizations, and legislative bodies which have interest in or responsibility and authority for decisions related to utilization of dental personnel. It also is incumbent on the profession to assure that those decisions will not adversely affect the health and well-being of the public. In meeting these responsibilities the profession is obligated to identify those functions or procedures which should only be performed by the dentist.

The following functions and procedures should not be delegated to dental auxiliaries because effective and safe performance is dependent upon making judgments that require synthesis and application of knowledge acquired in professional dental education. The functions include but are not limited to:

1. Diagnosis and treatment planning.
2. Surgical or cutting procedures on hard or soft tissue.
3. Prescribing drugs, medicaments and preparing work authorizations.
4. Taking impressions for fabrication of fixed or removable restorations or appliances.
5. Making occlusal adjustments.
6. Performing pulp capping and pulpotomy procedures.
7. Placing and adjusting fixed and removable prosthodontic appliances.

It is the considered judgment of the profession that certain functions in addition to those which have traditionally been performed by dental assistants and/or dental hygienists can be delegated. This position does not require, or even suggest, that all dentists delegate these functions or that all jurisdictions enact legislation to enable delegation; and should *not* be

considered a mandate. When, and if, legal provisions are enacted for delegation of the functions they should include specifications of education and training, supervision by the dentist, and regulatory controls that will assure protection of the public.

The ultimate decision on what functions will be delegated should be made by the dentist for the purpose of extending his care. The lists of functions are not all-inclusive. Other functions which are comparable in nature; do not require the knowledge, judgment and skill of the dentist; and contribute to a functional role for an auxiliary could be considered for delegation.

In addition to the traditional functions performed by dental assistants, the following functions could be delegated to *assistants:*

1. Inspecting the oral cavity including charting carious lesions, existing restorations and missing teeth.
2. Polishing coronal surfaces of teeth following examination or inspection and removal of hard deposits by the dentist or dental hygienist.
3. Removing excess cement from supragingival surfaces of teeth and restorations.
4. Finishing and polishing amalgam restorations.
5. Applying anticariogenic agents topically.
6. Applying topical anesthetic agents prescribed by the dentist.
7. Removing sutures by direction of the dentist.
8. Placing periodontal dressings.
9. Removing periodontal dressings.
10. Taking impressions for study casts.
11. Placing and removing rubber dams.
12. Placing and removing matrices and wedges.
13. Placing and removing temporary sedative intracoronal restorations with hand instruments.
14. Applying cavity liners and bases as directed by the dentist.
15. Condensing and carving amalgam restorations.
16. Placing and contouring silicate cement and composite resin restorations in individual teeth.
17. Applying pit and fissure sealants to individual teeth.

In addition to the traditional functions performed by dental hygienists, the following functions could be delegated to *hygienists:*

1. Finishing and polishing amalgam restorations.
2. Performing closed soft tissue curettage.
3. Administering local anesthetic agents in conjunction with root planing and closed soft tissue curettage.
4. Removing sutures by direction of the dentist.
5. Placing periodontal dressings.
6. Removing periodontal dressings.
7. Taking impressions for study casts.
8. Placing and removing rubber dams.
9. Placing and removing matrices and wedges.
10. Placing and removing temporary sedative intracoronal restorations with hand instruments.
11. Applying cavity liners and bases as directed by the dentist.
12. Condensing and carving amalgam restorations.
13. Placing and contouring silicate cement and composite resin restorations in individual teeth.
14. Applying pit and fissure sealants to individual teeth.

Educational Requirements for Expanded Functions Which Could Be Delegated to Dental Assistants and/or Dental Hygienists

The nature of expanded functions which constitute a direct service to the patient and, either have been or could be delegated to dental assistants and dental hygienists, requires that the auxiliary be prepared to perform those functions through formal education and training. Formal education and training is defined as a planned sequence of instruction of specified content, structured to meet stated educational objectives and to include evaluation of attainment of those objectives. Such instruction is provided by an institution or facility that is recognized by a system of higher education and has education as a primary or major purpose.

The provision of short-term formal education and training for individual expanded functions, or groups of functions, is considered an acceptable method of preparing auxiliaries who are currently in the workforce to perform legally permitted functions. It is the Association's position that when functions are assigned, short-term courses should be provided only to prepare the existing workforce to meet all qualifications for performing the functions.

The Association urges dental societies, state boards of dentistry and dental schools to work with recognized educational institutions and training centers in developing courses of instruction for dental assistants and/or dental hygienists who are in the workforce. Such courses should include clinical instruction and practice and comply with established guidelines of the American Dental Association's Council on Dental Education.

It is the Association's position that ultimately all instruction in expanded functions that require formal education should be provided in educational programs accredited by the Commission on Accreditation of Dental and Dental Auxiliary Educational Programs. The Association urges those educational institutions with the resources for expanded function instruction to develop educational programs, or modify programs, to prepare dental assistants and/or dental hygienists for their respective roles in dental care delivery as increased delegation occurs.

The Association believes the following expanded functions which could be delegated to *dental assistants* require formal education.

1. Inspecting the oral cavity including charting carious lesions, existing restorations and missing teeth.
2. Polishing coronal surfaces of teeth following inspection or examination by the dentist and removal of hard deposits by the dentist or dental hygienist.
3. Removing excess cement from supragingival surfaces of teeth and restorations.
4. Finishing and polishing amalgam restorations.
5. Applying anticariogenic agents topically.
6. Placing periodontal dressings.
7. Removing periodontal dressings.
8. Taking impressions for study casts.
9. Placing and removing rubber dams.
10. Placing and removing matrices and wedges.
11. Placing and removing temporary sedative intracoronal restorations with hand instruments.
12. Applying cavity liners and bases as directed by the dentist.
13. Condensing and carving amalgam restorations.
14. Placing and contouring silicate cement and composite restorations in individual teeth.
15. Applying pit and fissure sealants to individual teeth.

The Association believes the following expanded functions which could be delegated to *dental hygienists* require formal education.

1. Finishing and polishing amalgam restorations.
2. Performing closed soft tissue curettage.
3. Administering local anesthetic agents in conjunction with root planing and closed soft tissue curettage.
4. Placing periodontal dressings.
5. Removing periodontal dressings.
6. Taking impressions for study casts.
7. Placing and removing rubber dams.
8. Placing and removing matrices and wedges.
9. Placing and removing temporary sedative intracoronal restorations with hand instruments.
10. Applying cavity liners and bases as directed by the dentist.
11. Condensing and carving amalgam restorations.
12. Placing and contouring silicate cement and composite resin restorations in individual teeth.
13. Applying pit and fissure sealants to individual teeth.

Minority Report to Proceedings

Workshop on Dental
Auxiliary Expanded Functions
March 31, April 1-2, 1976
Hyatt Regency Chicago
Chicago, Illinois

The following Minority Report was transmitted on October 26, 1976 to Dr. John R. Champagne, chairman of the ADA Council on Dental Education, by Mr. Gerard J. Haddican, executive secretary of the Louisiana Dental Association.

Because of the far-reaching and tremendously important conclusions indicated through the "Proceedings of the Workshop on Dental Auxiliary Expanded Functions" dated July 22, 1976, we as participants in this workshop feel the necessity to file a minority report.

Resolution 864 of the 1975 House of Delegates reads as follows:

> **Resolved,** that the Council on Dental Education sponsor a national workshop on expanded duty auxiliary *training* and *utilization,* and be it further
> **Resolved,** that the participants in this workshop represent in the majority those full-time practitioners, both specialists and general practitioners from all sections of the country, who utilize auxiliaries, and be it further
> **Resolved,** that following the workshop the appropriate agency of the American Dental Association be directed to study and further define, for related agencies (public and private) *those functions* where *formal education* requirements may be required for expanded duty dental auxiliaries, and make a report to the 1976 House of Delegates.

While recognizing and being extremely grateful to the Council on Dental Education, both staff and members, and to Dr. L. M. Kennedy and the advisory committee, for their efforts to structure the workshop according to this resolution, we the authors of this report feel that the intent of this resolution was not met for the following reasons.

In researching the list of participants, we find that only 112 full-time practitioners participated in the workshop groups and 119 others (dental assistants, dental hygienists, dental auxiliary educational representatives, dental hygiene educational representatives, HEW representatives, consumer representatives, etc.) participated together with 19 classified as observers. On the participation list are four full-time practitioners and seven others who were not listed in the workshop groups. This would make a total of 116 full-time practicing dentists and 126 others plus 19 observers for a grand total of 261 participants.

This proportion is sufficient to be in non-compliance with Resolution 864 but the

real reason we feel non-compliance with this resolution exists is that while the House of Delegates wished to have input from all segments of the population and the profession, at no time did it infer that decisions affecting the delegation of duties and the utilization of expanded duty auxiliaries would be made by any other segments but dentists, the majority of whom would be full-time practicing dentists.

To further support the contention that Resolution 864 was violated, we find that even after determining that the majority of participants would not be full-time practicing dentists, the individual workshop groups were set up and not one of these groups had a majority of full-time practicing dentists. This meant that HEW representatives, dental assistants, dental hygienists, TEAM researchers, etc. collectively had a stronger voice in each group than the full-time practitioner. We feel there is enough diversification of opinion among dentists that it is not necessary to confuse the issue or fight block votes of representatives from various sources whose opinions were predictable before a single word was spoken.

The dentists must employ these people so they, and they alone, should have the final determination of the policy in all issues involving the American Dental Association.

While the degree of unanimity reflected in the report was true in many cases, it does not exist for the following:

10. Place temporary restorations.
15. Apply cavity liners and bases.
16. Place amalgam restorations.
17. Carve amalgam restorations.
21. Administer local anesthetics.
39. Fit mouth guard appliances.
42. Adapt and place pre-formed crowns on deciduous teeth.
47. Placing and contouring composite restorations.

As further evidence that any expression of opinion by the full-time practicing dentist was futile, on pages 34-35 of the "Proceedings" a separate vote of full-time practitioners was taken on the statement on research and only 16 voted in favor of this statement; whereas, the total workshop voted 121 for and 84 against, so it was adopted.

Vital issues such as packing and carving amalgams and administration of local anesthetics were also tested by separate vote and none of these received a majority vote of the full-time practicing dentists.

It is the opinion of the authors of this report that Resolution 864, which directed that this workshop be established, wished to assure that the full-time practicing dentist, who comprises approximately 90 percent of the membership of the American Dental Association, would have an opportunity to have his say, since he must ultimately use and compete in any delivery system using expanded duty auxiliaries. Instead, the results of this conference reflect a coalition of educators and auxiliaries. This result would have been predictable based on past experience with TEAM grants, expanded duty auxiliary programs, etc., if no workshop had been held.

In the Special Report on Dental Auxiliary Utilization and Education, listed in *Annual Reports and Resolutions, 1976* on pages 132-162, there are only four procedures on the dental assistants' list and five on the dental hygienists' list that merit challenge.

They are as follows:

1. Placing (not removing) temporary sedative intracoronal restorations with hand instruments.
2. Applying bases (not cavity liners) as directed by the dentist .
3. Condensing and carving amalgam restorations.
4. Placing and contouring silicate cement and composite resin restorations in individual teeth.
5. (Hygienists only) Administering local anesthetic agents in conjunction with root planing and closed soft tissue curettage.

All other issues exhibited a far greater degree of unanimity.

Since most of the challengeable issues involve more direct participation of auxiliaries in the productive procedures of dentistry, we ask that these be stricken from the list until more research is done and the following questions have been answered:

1. Does the demand for dentistry in this country exceed the capability in the foreseeable future of dental manpower to produce over the next ten years?
2. Since present research indicates that expanded duty auxiliaries do not replace the conventional dental assistant but must be used together, what will this do in the average dental practice as far as fees are concerned?
3. Does the utilization of expanded duty auxiliaries lend itself to clinical practice rather than private practice?
4. With the present incursion by denturists into the productive ends of dentistry, is it wise to possibly further fragment the practice of dentistry by training auxiliaries to perform the functions listed above?

There are many other questions, but the principal question revolves around demand and production. In Louisiana, the Leonard Davis Institute survey on manpower was recently completed and the results indicate the population will remain relatively constant through 1986 —a rate of increase of 0.88 percent. Based on the present manpower productivity as exists today, a net increase of 68 dentists would be needed by 1986. Based on the present dentists graduating from Louisiana State University, we will have a net increase of 700 dentists by 1986. These figures conclusively prove there is really no need to devise ways to increase production of dentistry in Louisiana. The same results were realized in Pennsylvania and Indiana where similar surveys have been conducted.

In summary, the conditions set forth in Resolution 864 were not met. Auxiliaries were allowed to vote on vital issues which should be the sole prerogative of dentists. Manpower surveys indicate that dental manpower in the next ten years will be able to produce far in excess of the predictable demand for dentistry regardless of third party or national health insurance programs.

We supply this information to the Board of Trustees and the House of Delegates to use in their discussion regarding the Special Report on Dental Auxiliary Utilization and Education.

Signed: Eugene J. Fortier, Jr., DDS
F. Ralph Dauterive, DDS

The following have joined as signatories to this report: Dennis A. Johnson, DDS, Golden Valley, Minn.; Leonard Giannone, DDS, Springfield, Ill.; Wisconsin Dental Association; Bobby R. Beard, DMD, Jackson, Ala.; Donald A. Igel, DDS, Omaha, Neb.; Caswell J. Farr, DDS, Bellingham, Wash.; Wilfred D. Whiteside, DDS, Corpus Christi, Tex.; D. F. Hord, DDS, Kings Mountain, N.C.; John William Stone, DDS, Topeka, Kan.; Donald J. Sirianni, DMD, Milwaukee, Ore.; and, Board of Trustees, Florida Dental Association.

Cosmetic Dentistry

Joint Report of Councils
on Dental Care Programs
and Dental Health

Background Statement: The 1975 House of Delegates requested the appropriate agencies of the Association to study the concept of "cosmetic dentistry" (*Trans.* 1975: 683, Resolution 910) and report their findings to the 1976 House of Delegates.

Cosmetic Dentistry: "Cosmetic Dentistry" has been defined as encompassing those dental services which are performed solely for the purpose of improving appearance. When treatment is performed to improve form or function or to prevent or correct pathologic conditions, such treatment should not be considered cosmetic.

Such a definition is intended to identify services performed for "esthetic" reasons only, but raises difficulties in that it ignores the fact that esthetic considerations frequently cannot be separated from form and function or from the patient's psychological well-being. Accordingly, the Councils on Dental Care Programs and Dental Health believe that "cosmetic dentistry," as a generic term for many services which may be performed for several reasons on a judgmental basis, must always be used with explicit regard for these factors and viewed in context with them.

With regard to prepayment, it is recognized that dental insurance programs are not expected to cover the costs of all the dental services a patient may be receiving. It is recognized, as well, that some dental services may be provided primarily for improving the appearance and, as such, can be reasonable exclusions from coverage on that basis, so long as that exclusion is clearly explained to purchasers.

However, the Councils believe that the use of the term "cosmetic dentistry" in a contract should not include services performed in part for esthetic reasons but also for additional reasons which the attending dentist has determined to be important to the total dental health of the patient.

Commission on Licensure

Doerr, Robert E., Michigan, 1978, chairman
Shellenberger, Robert E., Indiana, 1977, vice-chairman
Barrett, C. F., Iowa, 1978
Chavaar, Ashur G., District of Columbia, 1976
Cole, Robert J., Florida, 1978
Connolly, James E., Massachusetts, 1978
Cook, John, Washington, 1976
Durham, John G., Missouri, 1978
Haines, Lee E., New Mexico, 1977
Klooster, Judson, California, 1977
Kozal, Richard A., Illinois, 1977
LaCour, Larry D., Louisiana, 1976
Mihalski, Edmund R., Pennsylvania, 1976
Schlansker, William P., New York, 1978
Coady, John M., staff director

Meetings: The Commission met in the Headquarters Building, Chicago, on November 19-20, 1975, and March 31-April 1, 1976. In addition to Commission members, consultants representing dental students, dental auxiliaries, and the public participated in both meetings. Thomas Gamba, a dental student enrolled at Temple University, served as American Student Dental Association representative; Kathleen Mast, a dental hygienist selected by the American Dental Hygienists' Association, served as dental auxiliary representative; and Robert A. Sutter, a Chicago businessman recommended by Kiwanis International, served as public representative.

Controls Necessary to Fulfill Public Responsibility: The Commission's 1975 annual report, which appeared in the September 1975 edition of *The Journal,* contained a working draft "Statement on Controls Necessary to Fulfill Public Responsibility." As requested by the 1975 House of Delegates, priority attention was given to refining policy recommendations contained in the Controls Statement for report back this year (*Trans.* 1975:716). The working draft was distributed to state dental and dental hygiene associations, state boards of dentistry, dental and dental hygiene schools, and national dental organizations with a request for comments. A total of 46 written replies were received. Commission members, communicating within their trustee districts, received additional input on a less formal basis. Finally, feedback was received from a workshop group assigned the topic "Documentation for Licensure by Credentials" at the 1976 Conference of Dental Examiners and Dental Educators.

The written response received from the American Dental Hygienists' Association deserves individual mention. That association reported being in the process of developing guidelines that jurisdictions could use for licensing dental hygienists by credentials. The Commission commends the American Dental Hygienists' Association for its initiative and was pleased to note that draft guidelines propose graduation from an accredited dental hygiene program as the minimum educational requirement for dental hygiene licensure by credentials.

In refining the Controls Statement, the Commission concluded that the original draft contained recommendations of different types. Sections dealing with the purpose of licensure and sound moral character contained statements which seemed appropriate for adoption as Association policy. In contrast, specific ways that theoretical knowledge and clinical skill might be documented were intended as suggestions. It is the Commission's hope that experience gained by state boards using the system proposed will lead to further refinement of the credentialing process. To make this distinction clear, the Commission separated the Controls Statement into proposed policy statements and proposed guidelines. Proposed policy statements extracted from the Controls Statement are discussed first.

Purpose of Licensure: The Commission believes that dental licensure is for the protection of the public and for no other purpose. It is not for the protection of the profession. It is not to control the supply of dental manpower. Public responsibility requires that dental licenses not be issued to the unqualified. Likewise, public responsibility requires that dental licenses be issued to all who are qualified if they seek licensure in the jurisdiction.

Based upon reaction to the original Controls Statement, there seems to be general agreement with this description of the purpose of licensure, at least within the profession. In order to prevent those outside the profession from misinterpreting Association licensure policies, *the Commission on Licensure recommends that a resolution defining the purpose of dental licensure be adopted and included in all publications of Association licensure policies.* An appropriate resolution appears at the conclusion of this report.

Definition of Terms: Individual states typically require a candidate for dental licensure to possess the following:

1. Sound moral character
2. Satisfactory educational credentials
3. Satisfactory theoretical knowledge of dental and basic biomedical sciences
4. Satisfactory clinical skill

Additionally, many states require a candidate for licensure to understand the state's dental law and be in good physical health. All of these clearly relate to competence to provide dental service to the public. Consequently, the two types of licensure systems considered by the Commission, licensure by examination and licensure by credentials, are identical in terms of characteristics required. The only difference between the two systems is in the mechanisms used to evaluate theoretical knowledge and clinical skill.

Theoretical knowledge and clinical skill of an applicant for dental licensure are most often measured by examination: a written examination for theoretical knowledge and a performance examination for clinical skill. This mechanism might be termed licensure by examination. In contrast, a mechanism in which a candidate's theoretical knowledge and clinical skill are evaluated on the basis of his past performance in dental practice might be defined as licensure by credentials. It should be noted that requiring a candidate for licensure to pass an examination on the state dental law or to submit to a physical examination is not incompatible with either licensure by examination or licensure by credentials as defined here.

The licensure mechanism that the Commission terms "licensure by credentials" has been discussed using other words. "Licensure by criteria approval," "licensure by endorsement" and "licensure on the basis of meeting specific professional criteria" have been used almost interchangeably with "licensure by credentials." Further, through usage, the word "reciprocity" covers all four terms plus a system of mutual recognition of licenses between states. Historically, the American Association of Dental Examiners objected to the word "endorsement" because it was equated to a blanket endorsement of any dental license ever issued without reference to the individual. The Commission agrees that use of the term "endorsement" is inappropriate. The Commission prefers "licensure by credentials" because it seems most descriptive, but would accept any term agreed upon by the profession.

Sound Moral Character: Before considering specific aspects of either licensure by examination or licensure by credentials, it seems appropriate to deal with one element common to both: the requirement of sound moral character. If moral character could be assessed accurately and fairly, dental licenses might be issued on the basis of sound moral character alone. A dentist whose moral character dictates making the welfare of his patients his primary consideration would maintain satisfactory theoretical knowledge and clinical skill without being required to do so, and he would not attempt procedures beyond his ability. It should be noted that a large majority of dentists exhibit sound moral character when evaluated by this or any other reasonable criterion.

Difficulty in measuring moral character not only prevents the sound moral character requirement from dominating licensure but also creates apprehension that this requirement even exists. Some dentists fear that isolated, minor, long ago, or incorrectly reported incidents might prevent them from being licensed in some states. The Commission knows of no case in which the moral character requirement has been used inappropriately and trusts that this will not happen in the future. Nevertheless, the sensitivity of the moral character requirement should be recognized. The Commission agrees with those who object to licensure applications inquiring into religious preferences, race, fraternal memberships, marital status, or planned location of practice. Demographic data, if needed, can be gathered after licenses are issued. Therefore, *the Commission on Licensure recommends that each state board of dentistry review its application for licensure to insure that only data related to an individual's qualifications to provide dental treatment are required.* An appropriate resolution appears at the end of this report.

One response to the Commission's request for input on the Controls Statement reported that, because of difficulty in defining good moral character, a state is eliminating the moral character requirement. The Commission considers this a move in the wrong direction. There are character flaws in some individuals that make them unsuitable for licensure in any state. Far from being objectionable, an attempt to identify applicants with character flaws seems essential to protecting the public. For example, the Commission considers intentional submission of false information as conclusive evidence of unsatisfactory moral character. Therefore, *the Commission on Licensure recommends that credentials and application data of all candidates for licensure be verified before licenses are issued.* An appropriate resolution appears at the end of this report. It should be noted that this recommendation applies equally to candidates for licensure by examination and candidates for licensure by credentials.

Licensure by Examination: In resolutions adopted by the 1973 House of Delegates, the Association endorsed requiring all candidates for a first license to pass written and clinical examinations (*Trans.* 1973:711). The Commission supports this principle; however, requiring a candidate seeking licensure in several jurisdictions to pass separate written and clinical examinations for each jurisdiction seems redundant and wasteful.

Widespread acceptance of National Board credentials as fulfilling or partially fulfilling the written examination requirement goes a long way toward eliminating the problem of repeated written examinations. Currently, National Board credentials are recognized by all US licensing jurisdictions except Alabama and Delaware. Some states place a time limit on accepting National Board scores. For example, Florida and Arizona recognize National Board results only if earned within five years prior to licensure. Because public responsibility requires that licenses be issued on the basis of current competence, placing a time limit on accepting the results of any examination seems reasonable. The Commission, however, believes a five-year time limit to be unnecessarily restrictive. Therefore, *the Commission on Licensure recommends that satisfactory performance on Part II of National Board Dental Examinations within ten years prior to applying for a state license be considered adequate testing of theoretical knowledge.* National Board Part II examinations cover dental sciences which a practicing dentist uses on a regular basis. National Board regulations require a candidate to have passed the Part I battery which covers the basic biomedical sciences before taking Part II examinations, but there is no limit on the time interval between taking the two Parts or on the number of times a candidate can retake Part II after having passed Part I. Consequently, the Commission's recommendation is not in conflict with requiring all candidates to pass a comprehensive examination at least once.

The previous recommendation is incorporated in proposed *Guidelines for Licensure* (Appendix). A resolution related to the proposed *Guidelines* appears at the end of this report.

Regional clinical testing services, where used, have reduced the need for candidates applying for licensure in several jurisdictions to take repetitive clinical examinations. Unfortunately, almost half of US licensing jurisdictions do not participate in a regional clinical testing service. The Commission on Licensure supports Association policy encouraging the development of regional clinical examinations in regions where none exists (*Trans.* 1973:711).

In the Commission's opinion, regional clinical testing services provide an incomplete solution to repetitious clinical testing. This is not meant to detract from the concept of regional examinations which the Commission supports fully. But, a candidate might wish to be licensed in states participating in different regional clinical testing services. To provide a more comprehensive solution, *the Commission on Licensure recommends that satisfactory performance within the last ten years on any state or regional clinical examination, at least equivalent in quality and difficulty to the state's own clinical examination, be considered adequate clinical testing for licensure provided that the candidate for licensure:*

(a) *Is currently licensed in another jurisdiction.*

(b) *Has been in practice since being examined.*

(c) *Is endorsed by the state board of dentistry and the committee of the constituent society in the state of his current practice.*

(d) *Has not been the subject of final or pending disciplinary action in any state in which he is or has been licensed.*

(e) *Has not failed the clinical examination of the state to which he is applying within the last three years.*

This recommendation, which is also incorporated into proposed *Guidelines for Licensure,* contains several modifications from the Commission's original proposal. The phrase "at least equivalent in quality and difficulty to the state's own clinical examination" was inserted to recognize that clinical examinations vary. Variance in licensure standards from state to state is, in the Commission's view, incompatible with licensure solely for the protection of the public. There seems no justification for subjecting patients in one state to a lower standard of dentistry than would be acceptable elsewhere. Nevertheless, obtaining consensus on an appropriate minimum standard is not an easy task. Although regional clinical testing services and the Council of Dental Examinations National Testing Service of the American Association of Dental Examiners have made significant progress, uniformity has not yet been obtained.

No aspect of the Commission's original report proved more controversial than reference to peer review. Some respondents felt information from peer review committees essential to licensure by credentials. Others favored keeping peer review separate from licensure in order to avoid peer review taking on punitive aspects. The Commission replaced the reference to peer review in condition "c" with the words "the appropriate committee of the constituent society" in order to allow decisions on whether peer review committees should become involved in credentialing to be made at the state level. Regardless of the committee used to furnish information, the Commission believes that conducting peer evaluations to provide relevant information to state boards of dentistry is a professional responsibility. Further, information should be provided for dentists who are not Association members on the same basis as it is for members.

Finally, condition "d" was strengthened to insure that licensure by credentials is not used to escape pending disciplinary action.

Licensure by Credentials: The underlying premise of licensure by credentials is that an evaluation of a practicing dentist's professional competence based upon his past performance can provide as much protection to the public as would an evaluation based upon examinations. By adopting the following resolution (*Trans.* 1975:715), the 1975 House of Delegates accepted this premise:

> **Resolved,** that the American Dental Association, through its constituent societies, strongly encourage state boards of dentistry to establish criteria by which dentists could be licensed by credentials to permit the freedom of interstate movement while retaining those controls necessary to fulfill the public responsibilities of the respective state boards.

Reaction to the original Controls Statement indicated that some within the dental profession have not accepted the concept of licensure by credentials. Objections included states' rights arguments, concern that verified credentials might be difficult to obtain and a suggestion that unqualified candidates might be able to slip by under licensure by credentials. Although objections to licensure by credentials were voiced by a majority of those responding to the Commission's request for input, the concerns expressed merit discussion.

Licensure is by definition a governmental function. In this country licensure is handled at the state level, and the Association supports this concept (*Trans.* 1973:711). Recognizing licensure as a responsibility of state governments, however, does not prohibit the Association from making recommendations on licensure. On the contrary, Association objectives of encouraging improvement in the health of the public and promoting the art and science of dentistry seem to require that the Association provide suggestions for consideration at the state level.

The Commission agrees that state boards, working alone, might have difficulty obtaining complete credentials of a practitioner. Cooperation of the applicant might prevent this problem. For example, an applicant for licensure by credentials might be asked to contact credentialing sources freeing them to provide relevant information. Because licensure by examination would be available to applicants not wishing to provide this type of cooperation, asking for an applicant's assistance would not seem objectionable.

The suggestion that a few unqualified candidates might be licensed by credentials is difficult to refute. A state board's dual responsibilities to reject unqualified applicants and to license all who are qualified require some difficult decisions regardless of the evaluative mechanism used. In establishing licensure by credentials, a state might set as its goal being at least as sure of the competence of those licensed by credentials as it is of those licensed by examination.

This discussion would not be complete without mention of a significant advantage of licensure by credentials over licensure by examination. While examinations measure ability, credentials relate to performance—the quality of service actually provided. Regrettably, performance need not equal ability. For protecting the public, the quality of service a dentist consistently provides seems more important than the quality of service he is able to provide at any one given time.

Eligibility for Licensure by Credentials: The Commission on Licensure believes that all candidates for licensure by credentials should be required to fulfill certain basic educational and practice requirements. Mechanisms for documenting current theoretical knowledge and current clinical skill discussed later in this report are meant to apply only if these basic requirements are met.

The minimum standard of dental education in the United States is graduation from a D.D.S. or D.M.D. educational program accredited by the Commission on Accreditation of Dental and Dental Auxiliary Educational Programs. The Commission on Accreditation is recognized by the US Office of Education and the Commission on Post-Secondary Accreditation. *The Commission on Licensure recommends that graduation from an accredited dental school be considered minimum satisfactory education for licensure by credentials.* This recommendation was generally accepted by respondents and remains unchanged from the Commission's original proposal.

Regarding basic practice requirements, *the Commission on Licensure recommends that licensure by credentials be available only to a candidate who:*

(a) *Is currently licensed in another jurisdiction.*

(b) *Has been in practice or full-time dental education for a minimum of five years immediately prior to applying.*

(c) *Is endorsed by the state board of dentistry and the appropriate committee of the constituent society in the state of current practice.*

(d) *Has not been the subject of final or pending disciplinary action in any state in which he is or has been licensed.*

(e) *Has not failed the clinical examination of the state to which he is applying within the last three years.*

These conditions have been changed from the Commission's original proposal. In its discussion, the Commission considered dental teaching as an aspect of practice. Because this assumption caused confusion, being more specific seemed desirable. Stating that practice or teaching experience should come immediately prior to applying for licensure by credentials corrects a deficiency in the Commission's original proposal. Suggested practice experience was reduced to five years. Because the record a dentist establishes over a five-year period seems more than an adequate basis for evaluating his professional competence, the Commission viewed this change as mechanical. Finally, reference to peer review committees was again replaced, and the provision about disciplinary action was again strengthened.

Basic education and practice requirements discussed in this section are incorporated in the proposed *Guidelines for Licensure.*

Credentials for Current Theoretical Knowledge: For a system of licensure to be effective in protecting the public without precluding the competent dentist from moving his practice, provision should be made to consider those who do not meet the criterion of having passed National Board Part II examinations within ten years prior to applying for a new state license. Guidelines recommended by the Commission as alternate documentation of current knowledge were designed with the thought that fulfilling any one of them would be sufficient to waive the written examination requirement provided that basic educational and practice requirements are met.

1. Successful completion of an accredited advanced dental education program in the last ten years.

Stipulating that advanced education programs be accepted only if two years or more in length was suggested. Because this would exclude one year general practice residency programs, the Commission favored the original wording. It should be noted that accreditation standards require a minimum of one year for general practice residency programs and a minimum of two years for dental specialty programs.

2. A total of at least 180 hours of acceptable formal scientific continuing education in the last ten years, with a maximum credit of 60 hours for each two-year period.

This guideline has been criticized because 180 hours of continuing education credit could be obtained in a single aspect of dentistry. In the Commission's view, inclusion of the adjective "acceptable" responds to this concern. Individual jurisdictions may establish distribution requirements for acceptable continuing education.

It was noted that continuing education record keeping systems are not available to all who might wish to qualify under the previous guideline. Although this may cause mechanical problems, it did not seem related to the Commission's assignment.

3. Successful completion of a recognized specialty board examination in the last ten years.

4. Teaching experience of at least one day per week or its equivalent in an accredited dental education program for at least six of the last ten years.

Those who objected to giving credit for teaching experience noted that it could be in a single subject. While the Commission recognizes this concern, Commission members believe that contact with faculty members in other disciplines and resulting discussions provide a means by which teachers maintain current theoretical knowledge. Successful completion of a fellow's or master's examination of the Academy of General Dentistry was proposed in the original Controls Statement as one alternate mechanism for documenting current theoretical knowledge. This alternative has been deleted. Because these examination programs are not yet in operation, including them in the proposed *Guidelines for Licensure* seemed premature.

Credentials for Current Clinical Skill: For a system of licensure to be effective in ensuring protection of the public without precluding the competent dentist from moving his practice, provision should be made to consider those who do not meet the criterion of having passed a clinical examination conducted by a state board or a regional clinical testing service within ten years prior to applying for a new state license. A recommendation that successful completion of a recent state or regional clinical examination be considered adequate evidence of current clinical skill does not imply that those who have not passed a state or a regional clinical examination within the last ten years do not have adequate clinical skill. Rather, they should be required to submit alternate documentation of current clinical skill for licensure by credentials. Guidelines recommended by the Commission as alternate documentation of current clinical skill were developed with the thought that fulfilling any one of them would be sufficient to waive the clinical examination requirement provided that educational and practice requirements previously discussed are met.

1. Successful completion of an accredited general practice residency or dental internship within the last ten years.

Qualifying under this guideline would fulfill the current theoretical knowledge requirement as well as the current clinical skill requirement.

2. Successful completion of an accredited dental specialty education program in a clinical discipline within the last ten years.

Concern was expressed that specialty education might not insure current clinical skill in all aspects of dentistry. This issue is addressed in the following section. Again, qualifying under this guideline would be sufficient for both the current theoretical knowledge and the current clinical skill requirements.

3. A total of at least 180 hours of acceptable clinically oriented continuing education in the last ten years, with a maximum credit of 60 hours for each two-year period.

Because clinically oriented continuing education is a type of formal scientific continuing education, meeting this requirement would be sufficient for the current theoretical knowledge requirement as well as the current clinical requirement. The converse, however, is not necessarily true. Not all formal scientific continuing education is clinically oriented.

Comments about the word "acceptable" and record-keeping systems made in relation to use of continuing education credit as documentation of current theoretical knowledge apply equally to this guideline.

> 4. Clinical teaching of at least one day per week or its equivalent in an accredited dental education program, including hospital-based advanced dental education programs, for at least six of the last ten years.

This guideline is a condensation of two guidelines contained in the original Controls Statement. Again, it is a more specific version of a guideline suggested for current theoretical knowledge. Because clinical teachers are probably subject to more extensive peer review than any other group of dentists, the Commission believes that clinical teaching experience provides adequate proof of clinical competence.

> 5. Presenting case histories of patients treated by the candidate in the last five years, with preoperative and postoperative radiographs and photographs, covering procedures required on the state clinical examinations, for discussion with the state board.

The Commission recognizes that individuals attempting to qualify under this guideline may present cases representing their best work. By discussing these cases in terms of how treatment might have been modified under various sets of conditions, members of a state board of dentistry should be able to assess the applicant's typical performance. If state board members are not satisfied with the discussion provided by a particular applicant, satisfactory completion of the state's clinical examination could be required.

State Licensure of Dental Specialists: The Commission's study of dental licensure in 1976 was not limited to refining the draft Controls Statement. The first of the additional aspects considered was licensure of dental specialists.

Thirteen states have provisions to issue licenses to dental specialists. In each case, the aspirant to a specialty license must hold a general dental license. The Commission's interest in state licensure of dental specialists does not relate to whether a state should or should not have specialty licensure. This issue is a separate question, and there are good arguments on both sides.

The Commission's interest is in supporting the concept of *all* categories of licensed dentists being able to obtain licensure in a different jurisdiction on the basis of credentials, assuming credentials of the individual meet the requirements of the state in question.

In the Commission's view, it is unreasonable to require an established, recognized dental specialist to demonstrate technical proficiency in procedures he may not have employed since graduation from dental school and successful performance on his initial licensure examination.

Concerns have been expressed about the dental specialist who might obtain a license on the basis of his specialty credentials, then decide to revert to general practice without having demonstrated that he is still qualified in general dentistry. This concern may be real, but not more so for the specialist newly licensed in the state than for the specialist who has been licensed in the state for 20 years.

However, in order to overcome this type of reservation and to facilitate the licensure of dental specialists on the basis of specialty credentials, the Commission suggests that states with this concern consider having an agreement, such as follows, executed prior to issuing a dental license on the basis of specialty credentials.

> I understand that (name of state) Dental License Number (00000) was issued on the basis of my credentials in (name of recognized dental specialty). Should I discontinue limiting my practice to (name of recognized dental specialty), I agree to surrender (name of state) Dental License Number (00000). Should I wish to practice general dentistry in (name of state), I will reapply for a license either on the basis of examination or on the basis of credentials in general dentistry.

The vast majority of specialists would find no difficulty in signing such an agreement because they would have no interest in returning to general practice. The few who might would probably not sign the agreement and place themselves in jeopardy in the future. Thus, they would not be licensed on the basis of their specialty credentials.

The Committee on Licensure recommends that states consider developing provisions for making licensure by credentials available to qualified dental specialists. An appropriate resolution appears at the end of this report.

Multiple Licenses: There are two basic reasons for a dentist having more than one state license. The first involves a dentist who practices near or on both sides of a state border. The Commission finds no argument with such multiple licensure, provided patients are not abandoned because of seasonal or sporadic practice.

The other reason for a dentist maintaining more than one state license usually relates to the possibility of his changing the location of his practice at some future date. Because state dental licensure has traditionally been based on demonstration of current theoretical knowledge and current clinical skill through examination, many dentists have taken licensure examinations in another state with the thought that they might wish to move at some future date, perhaps 15 or 20 years in the future. In the Commission's view, for a state to honor a license on the basis of examination results 15 or 20 years old, without knowing what the applicant had been doing in the interim, is a disservice to the people of the state.

The Commission is not suggesting that states become more restrictive in issuing license, but rather that licenses be issued on the basis of current credentials rather than on the basis of outdated examination results. In the Commission's view, this can be accomplished by having each state make provision for active and inactive licenses. Only those currently practicing in the state would have active licenses. Those who obtain a license and do not enter practice in that state within some time period, perhaps two years, would automatically be moved to an inactive status. If, at some future date, a dentist wished to reactivate his license, his educational and examination credentials would be on file; he would merely have to apply and verify for the state board that he had been in ethical practice elsewhere. This system has worked

well in Oregon and Florida, and perhaps elsewhere. The system of verifying activity while the dentist was not in practice has avoided the possibility of multiple licenses being abused by the small percentage who might use a second license to escape adverse consequences of their actions.

The Commission on Licensure recommends that states be urged to develop mechanisms for issuing active and inactive licenses to enhance public protection. An appropriate resolution appears at the end of this report.

Enforcement Provisions: Responsibility for self-regulation is among the distinguishing differences between professions and occupations. Self-regulation in the dental profession is accomplished primarily through ethics, grievance, and peer review committees. However, another important aspect of self-regulation has been the willingness of the dental profession to cooperate with the public and state governments.

Implied in the Commission's position on multiple state licenses is the assumption that each state board is in command of the situation in terms of monitoring practice within the state. In a recent survey, several state boards indicated that staffing provided them was insufficient. The most frequent need expressed was for more investigators. Whether more thorough policing in states feeling the need for more investigators would uncover illegal practices by licensed dentists is questionable. Of greater concern might be illegal dentistry provided by unlicensed individuals. Regardless of potential results of investigations, however, complete enforcement of state dental practice acts seems essential for protecting the public. In the Commission's opinion, the dental profession should assist state boards of dentistry in obtaining the support needed to meet this goal.

The Commission on Licensure recommends that constituent societies, in consultation with state boards of dentistry, be urged to study the need for greater state support for enforcement of the dental practice act. It is further recommended that, if need is established, constituent societies assist state boards in obtaining additional state support. An appropriate resolution appears at the end of this report.

The Commission believes that the previous recommendation should be viewed as a first step toward dealing with enforcement provisions. Studying the need for greater state support for state boards of dentistry may reveal other aspects of enforcement provisions in which organized dentistry can be of assistance in protecting the public.

Consistent with concepts contained in the "Position Statement on Federal Intervention in Licensure" adopted by the 1975 House of Delegates (*Trans.* 1975:718), it is hoped that enforcement provisions can be dealt with at the state level.

Relicensure: Within the profession, there has been a clear trend toward consideration of relicensure standards. States that have instituted continuing education requirements for licensure renewal have recognized the need for something other than automatic renewal upon payment of a licensure or registration fee. In the Commission's view, the traditional pattern of a dental license, once issued, being automatically renewable for life, will cease to exist. It is merely a matter of time. Rather than have relicensure standards developed by outside forces, the Commission feels that the profession should take the initiative. One reason for suggesting a limit on recognition of National Board written and state or regional clinical examination results relates to the Commission's view that a competent system of licensure by credentials could be adapted readily to a system of relicensure.

Whatever the cycle and whenever it comes, relicensure should be, in the Commission's view, based on credentials rather than on examinations. A regular cycle of reexamination in the written portion of licensure requirements might be feasible, though not very popular. A regular cycle of reexamination in the demonstration or clinical portion of licensure requirements would be not only unpopular, but also impossible of accomplishment. Even if this were not so, the Commission would support relicensure being based on credentials rather than on examinations. Public responsibility requires that attention be directed to the quality of service a professional does provide rather than to the quality of service he is capable of providing.

The Commission on Licensure recommends that states study mechanisms of licensure by credentials for potential use as relicensure standards. An appropriate resolution appears at the end of this report.

Future of the Commission: The Commission on Licensure was established by the 1974 House of Delegates for the specific purpose of studying all matters related to licensure. Although the study of all matters related to a subject as complex and important as dental licensure could probably go on indefinitely, the Commission was clearly established as a temporary agency.

The Board of Trustees encouraged the Commission to either complete its assignment with the 1976 annual session or list aspects of licensure that need further study with projected time requirements. Commission members appreciate the Board's concern about the proliferation of Association agencies. Further, the Commission has attempted to respond to the major concerns of the profession in the area of licensure. Unless the House of Delegates wishes the Commission to refine some of its recommendations or consider some other specific aspect of licensure, continued operation of such a large study group might not be necessary. On the other hand, licensure is directly related to all three of the Association's constitutional objectives. In view of the dynamic nature of the dental profession, it seems unlikely that any licensure mechanism will remain appropriate indefinitely. Therefore, assigning the study of licensure to a permanent Association agency seems essential.

The Board of Trustees is in the process of evaluating the mission and effectiveness of all Association agencies. The Commission suggests that, as a part of this evaluation, consideration be given to assigning the study of licensure to a permanent agency, preferably one with examiner and educator members as well as representatives from the general membership. Until the study of licensure can be permanently assigned, retention of the Commission seems desirable.

RESOLUTIONS

25. Resolved, that the American Dental Association believes licensure to be solely for the protection of the public and opposes use of licensure for any other purpose.

26. Resolved, that the American Dental Association requests each state board of dentistry to review its application for licensure to insure that only data related to the individual's qualifications to provide dental treatment are required.

27. Resolved, that the American Dental Association encourage state boards of den-

tistry to verify credentials and application data of all candidates for licensure before licenses are issued.

28. Resolved, that the *Guidelines for Licensure* be approved and transmitted to each state board of dentistry for consideration.

29. Resolved, that each constituent society, in consultation with its state board of dentistry, be urged to develop mechanisms of licensure by credentials for dental specialists.

30. Resolved, that each constituent society, in consultation with its state board of dentistry, be urged to develop a mechanism for issuing active and inactive licenses to enhance public protection.

31. Resolved, that such constituent society, in consultation with its state board of dentistry, be urged to study the need for greater state support for enforcement of the state dental practice act, and be it further
Resolved, that, if need is established, the constituent society in consultation with its state board of dentistry, consider developing mechanisms to obtain additional state support for enforcement of the state dental practice act in the public interest.

32. Resolved, that each constituent society, in consultation with its state board of dentistry, study mechanisms of licensure by credentials that have the potential for use as relicensure standards.

APPENDIX

GUIDELINES FOR LICENSURE

Dental licensure is intended to insure that only qualified individuals provide dental treatment to the public. Among qualifications deemed essential are satisfactory theoretical knowledge of basic biomedical and dental sciences and satisfactory clinical skill. These guidelines suggest alternate mechanisms for evaluating the theoretical knowledge and clinical skill of applicants for licensure.

Licensure by Examination: It seems essential that each candidate for a first license be required to demonstrate satisfactory theoretical knowledge and clinical skill on examinations: a written examination for theoretical knowledge and a clinical examination for clinical skill. Requiring a candidate who is seeking licensure in more than one jurisdiction to demonstrate his theoretical knowledge and clinical skill on separate examinations for each jurisdiction, however, seems unnecessary duplication.

Written examination programs conducted by the Council of National Board of Dental Examiners have achieved broad recognition by state boards of dentistry. National Board dental examinations are conducted in two parts. Part I covers basic biomedical sciences; Part II covers dental sciences. It is recommended that satisfactory performance on Part II of National Board dental examinations within ten years prior to applying for a state dental license be considered adequate testing of theoretical knowledge. National Board regulations require a candidate to pass Part I before participating in Part II. Consequently, this recommendation excludes Part I only from the time limit.

No clinical examination has achieved as broad recognition as have National Board written examinations. Clinical examinations used for dental licensure are conducted by individual state boards of dentistry and by regional clinical testing services. It is recommended that satisfactory performance within the last ten years on any state or regional clinical examination at least equivalent

in quality and difficulty to the state's own clinical examination be considered adequate testing for clinical skill provided that the candidate for licensure:

(a) is currently licensed in another jurisdiction;

(b) has been in practice since being examined;

(c) is endorsed by the state board of dentistry and the appropriate committee of the constituent society in the state of his current practice;

(d) has not been the subject of final or pending disciplinary action in any state in which he is or has been licensed;

(e) has not failed the clinical examination of the state to which he is applying within the last three years.

Licensure by Credentials: The American Dental Association believes that an evaluation of a practicing dentist's theoretical knowledge and clinical skill based upon his performance record can provide as much protection to the public as would an evaluation based upon examinations. Issuing a license using a performance record in place of examinations is termed licensure by credentials.

All candidates for licensure by credentials might be required to fulfill basic education and practice requirements. It is recommended that graduation from a dental school accredited by the Commission on Accreditation of Dental and Dental Auxiliary Educational Programs be considered minimum satisfactory education for licensure by credentials. Further, it is recommended that licensure by credentials be available only to a candidate who:

(a) is currently licensed in another jurisdiction;

(b) has been in practice or full-time dental education for a minimum of five years immediately prior to applying;

(c) is endorsed by the state board of dentistry and the appropriate committee of the constituent society in the state of current practice;

(d) has not been the subject of final or pending disciplinary action in any state in which he is or has been licensed;

(e) has not failed the clinical examination of the state to which he is applying within the last three years.

Alternate ways that current theoretical knowledge might be documented follow. It is recommended that, for a candidate who meets eligibility requirements for licensure by credentials, any one of these be considered sufficient to waive the written examination requirement.

1. Successful completion of an accredited advanced dental education program in the last ten years.

2. A total of at least 180 hours of acceptable formal scientific continuing education in the last ten years, with a maximum credit of 60 hours for each two-year period.

3. Successful completion of a recognized specialty board examination in the last ten years.

4. Teaching experience of at least one day per week or its equivalent in an accredited dental education program for at least six of the last ten years.

Possible documentation for current clinical skill appears in the following list. Provided that eligibility requirements for licensure by credentials are met, it is recommended that any one of these be accepted in lieu of satisfactory performance on a clinical examination.

1. Successful completion of an accredited general practice residency or dental internship within the last ten years.

2. Successful completion of an accredited dental specialty education program in a clinical discipline within the last ten years.

3. A total of at least 180 hours of acceptable clinically oriented continuing education in the last ten years, with a maximum credit of 60 hours for each two-year period.

4. Clinical teaching of at least one day per week or its equivalent in an accredited dental education program, including a hospital-based advanced dental education program, for at least six of the last ten years.

5. Presenting case histories of patients treated by the candidate in the last five years, with preoperative and postoperative radiographs, covering procedures required on the state clinical examination, for discussion with the state board.

Bureau of Audiovisual Service

Miller, Daryl I., director
Deany, Charles E., assistant director

The Bureau of Audiovisual Service is responsible for the Association's audiovisual program, maintaining a film library as a service to the dental profession and providing audiovisual facilities and services in the headquarters building. The Bureau has a staff of eight persons.

Film Distribution: From May 1, 1975 to April 30, 1976, 9,858 films were scheduled for shipment and 10,710 were shipped. These figures include 2,497 free loan films and 1,172 films requested without charge for purchase preview and programming. The income from rentals was $20,905. Not included in these figures are 565 copies each of one 30-second and one 60-second color television spot announcements which were sent out in cooperation with the Bureau of Dental Health Education for the 1976 National Children's Dental Health Week programs. For the period covered by this report, 2,867 notices of unavailability were sent out for requests that could not be accommodated. The above figures do not include film activities reported under "sponsored distribution" and "international distribution and audience."

The Bureau converted to a computerized booking system in December 1975. It has proven to be very successful to date, and has resulted in faster and more accurate scheduling of films.

Sponsored Film Distribution: Summarized below is the report of free film distribution to schools, lay groups, and television audiences made possible by the Association through the services of Modern Talking Picture Service, Inc. Sponsored distribution of dental health education films continues to be a highly effective and economical means of reaching both nontheatrical and television audiences. The Association this year received an award signifying that the nontheatrical distribution program had reached more than ten million viewers in community audiences since the start of the program in 1961. This distribution program also makes it possible for the Association's film library to devote the major part of its time to the collection and distribution of films for professional audiences.

Modern Talking Picture Service, Inc.
(nontheatrical—schools and lay audiences)

Title	Bookings	Showings	*Audience
The Shaw That Almost Wasn't	1,567	2,854	136,969
The Beaver's Tale	927	1,922	86,426
Teeth (withdrawn December 1975)	288	684	27,538
Merlin's Magical Message	1,672	3,359	144,046
Dudley the Dragon	1,381	2,710	123,545
The Scanning Electron Microscope (withdrawn June, 1975)	858	2,541	93,370
Teeth Are for Keeping	1,367	3,288	136,810
The Munchers: A Fable	2,345	5,581	306,120
Doorway to Dental Health	2,199	5,794	214,289
Showdown at Sweet Rock Gulch	2,296	5,814	232,876
Fluoridation: A White Paper (added May, 1975)	2,327	5,560	211,122
The Haunted Mouth (added May, 1975)	2,503	6,643	277,035
Dentures and Your Health: A Report (added May, 1975)	1,586	3,034	106,349
Preventive Dentistry in B Sharp (added August, 1975)	1,208	3,005	112,738
Aprendamos A Cepillarnos Los Dientes	27	52	1,635
La Salud Dental Y La Escuela	12	21	705
Que Sabemos Sobre Los Dientes?	18	33	1,122
El Desafio De La Dentisteria	16	27	738

*The reported audience for all showings was 2,213,433.

Modern Talking Picture Service, Inc.
(television)

Title	Telecasts	Estimated Audience
A Report on Bootleg Dentistry (withdrawn June, 1975)	29	432,900
Pattern of a Profession	178	2,978,000
One in a Million (withdrawn June, 1975)	12	309,000
Maxwell, Boy Explorer	127	3,225,300
Teeth Are for Keeping	218	3,932,200
Dudley the Dragon	128	2,107,700
The Munchers: A Fable	105	2,469,400
Merlin's Magical Message	133	241,400
Fluoridation: A White Paper	213	9,231,500
The Haunted Mouth	129	241,500
Dentures and Your Health: A Report	165	6,597,600
Preventive Dentistry in B Sharp (added February, 1976)	55	101,500
Showdown at Sweet Rock Gulch (added February, 1976)	55	90,300
Total	1,647	32,048,300

It should be noted that for the period covered by this report there were an additional 15,190 requests for films in the nontheatrical sponsored distribution program that could not be filled. Budget limitations control the number of copies of each film that can be supplied to the distributor for use in the program. Although additional funds were allocated during the past two years, the number of requests that could not be accommodated increased by almost 10,000 during the current year. With the increasing awareness of dental health education, it is anticipated that there will be an even greater demand for these films in the future.

Audience: For the distribution reported from the Association's film library, 2,782 audiovisual materials were requested by dental societies, study groups, and individual dentists; 355 by dental schools; 337 by government agencies; 308 by dental auxiliaries; 1,526 by hospitals and miscellaneous professional groups; 4,359 by nonprofessional groups; 79 by commercial agencies, and 7 by television stations. In addition, the sponsored distribution of films amounted to a total of 22,597 (nontheatrical) bookings and 52,922 showings to an audience of 2,213,433, and 1,647 telecasts to an estimated audience of 32,048,300. These figures do not include the number of telecasts or audiences for the television spot announcements which were given to television stations and to local dental societies. Additionally, 105 films and slide sets were shipped to eight countries: Australia, Canada, Columbia, Iran, Italy, Jamaica, Lebanon, and Sweden.

Film Purchase and Inventory: Additions to the film library, either by donation or purchase, include 99 copies of 20 dental technical films, 51 copies of two dental health films, 83 copies of nine television spot announcements, 11 copies of two slide sets, and ten copies of one series of radio spots. The inventory of audiovisual materials now includes 2,592 copies of 438, 16-mm motion picture films; 687 copies of 78 slide sets; 1,633 copies of 119 dental health television spot announcements; 32 copies of 16, 35-mm dental health spot announcements; 22 copies of five filmstrips; 167 copies of 14 radio transcriptions, and one copy each of 598 audiovisuals in the historical and reference collection. Replacement sections were purchased for the repair of many films, yet it was necessary to retire all copies of some films because of extensive damage. A considerable amount of time and effort was spent in reviewing the older films in the library. As the figures indicate, a substantial number of 16-mm films were retired because of obsolescence. The retired films will be replaced with new productions as they become available and as budget permits their purchase.

Film Production: The Director serves as a member of the film committee and cooperates in all film productions, acting as technical consultant during the actual production procedures. Additional information on new films completed is included in the report of the Bureau of Dental Health Education.

The joint project of the Bureaus of Public Information, Dental Health Education, and Audiovisual Service of annually producing six public service television spot announcements successfully continued into its 14th year. Additional information on this project is included in the report of the Bureau of Public Information.

Patient Counseling Film Program: The ADA Patient Counseling Motion Picture Film Library, produced and distributed by Professional Research, Inc., Los Angeles, is now used in over 5,000 dental offices. Plans are now underway to revise two and possibly add one new film to the program during the coming year. Fifteen films are currently available in the program.

Continuing Education Films: This collection now includes 200 titles with a total of 759 copies. Production of approximately 30 new titles annually will complement the existing collection; however, a reduction in the 1976 capital film purchase budget will make it impossible to add all of the new films to the library during the current year.

Annual Session Motion Picture Program: Fifty-eight films were selected and shown on

the motion picture program as part of the 1975 scientific session. Eight speakers from the United States, Sweden, and England supplemented the presentations. The program opened on Sunday afternoon with a special two-hour motion picture symposium on wound healing presented by Harry Hayes, M.D. of the University of Arkansas School of Medicine.

Pathology Slide Sets: The oral pathology and histopathology slide collections continue to be in great demand. The oral pathology slide sets are particularly in demand by those preparing for national board examinations.

Previews and Reviews: Audiovisual materials are continually reviewed by the Bureau, other staff members and selected subject experts for selection of films to be included in the annual session motion picture program and for addition to the film library. The Audiovisual Committee of the American Society of Oral Surgeons has continued its film evaluating project with the Bureau. The Director serves as chairman for the dental and public health categories of the Committee on International Nontheatrical Events (CINE) and was also again named jury chairman in medicine and public health for the US Industrial Film Festival. The Assistant Director also served as jury chairman for the 1976 American Film Festival.

Publications: Special lists of films and slides on various subjects are continually revised for distribution. The complete catalog, *Audiovisual Materials in Dentistry,* is scheduled for publication late in 1976.

Participation in Meetings and Conferences: The Association was represented by the Director at the following meetings and conferences: the 17th Annual American Film Festival, the 46th Annual Meeting of the Biological Photographic Association, the 1976 meeting of the Association for Educational Communications and Technology (AECT), and the Council on International Nontheatrical Events (CINE) awards ceremonies and Board of Directors meetings. The Director also spoke at the "Leaders Luncheon" sponsored by Inforfilm, an international association of film distributors. The Director holds the following elected offices: Secretary and member of the Board of Directors, Council on International Nontheatrical Events (CINE); President emeritus (Chicago Chapter) and member of the House of Delegates, Biological Photographic Association; and member of the Board of Directors, Chicago Film Council. The Assistant Director served as President of the Audio-Visual Conference of Medical and Allied Sciences; attended the 1976 meeting of the Association for Educational Communications and Technology (AECT); represented the Association at the 1976 US Industrial Film Festival awards ceremonies and the Third Annual Midwest Seminar on Videotape and Film. The Assistant Director was reelected President of the Chicago Film Council and serves on the Board of Directors of the Chicago Society for Communicating Arts.

RESOLUTIONS

This report is informational in nature and no resolutions are presented.

Bureau of Convention Services

McCormick, William T., director
DePaolo, Jean M., assistant director

The Bureau of Convention Services is responsible for preparation and coordination of the annual session of the Association; for arranging the travel accommodations of those persons on official assignment for the Association; and for coordinating the use of meeting rooms in the Headquarters Building of the Association. The Bureau has a staff of four persons: director, assistant director, and two clerical personnel.

Annual Session: The Bureau is the liaison office between the Association and the Convention Bureau of the annual session site and the various hotels which have committed meeting space and hotel rooms for the use of the Association members. All meeting rooms for the Association and for approximately 32 allied dental groups meeting prior to the annual session are controlled by the Bureau for proper assignment and coordination. Public space for 20 alumni groups and fraternities is also assigned.

The Bureau works with the Convention Bureau in processing the hotel reservation requests for 10,000 hotel rooms used by the Association during the annual session. It secures the necessary rental equipment, tickets, and temporary personnel required throughout the annual session. Further, it coordinates and prepares copy for the official program.

After consultation with the General Chairman of the Committee on Local Arrangements, the Bureau submits suggestions to the Executive Director concerning the social events and general entertainment.

The Bureau conducts convention site surveys and prepares the staff report for the Board of Trustees consideration of future annual session sites of the Association.

The criteria for selection of an annual session site cover several requirements. The major points are as follows:

1. The city must commit approximately 9,500 first-class hotel rooms, within ten miles of the convention hall.
2. The convention hall must have 200,000 gross square feet to accommodate the scientific and technical exhibits, table clinics, and health screening pro-

grams. In addition, it must have sufficient space for meetings of the scientific session, and necessary offices.

3. A headquarters hotel with sufficient sleeping rooms to accommodate the Board of Trustees, delegates, and those persons authorized to be housed in the headquarters hotel; in addition, sufficient rooms in this hotel or an immediately adjacent hotel to house the alternate delegates. Total rooms required in the headquarters and co-headquarters hotels is 1,100. The headquarters hotel must also contain public space to accommodate the meetings of the Board, reference committee hearings, and other meetings and functions related to the annual session that are best held in the headquarters hotel.

4. All bids for annual session sites covering the above outlined facilities are based on existent properties so as to be viewed and deemed satisfactory.

The Board of Trustees has selected the following dates for future annual sessions:

1976	Las Vegas	November 14-18
1977	Miami Beach	October 9-13
1978	Anaheim	October 22-26
1979	Dallas	November 4-8
1980	New Orleans	October 12-16

In compliance with Resolution 13-1973-H (*Trans.* 1973:641), a critique form is furnished each delegate and alternate delegate covering accommodations, convention hall, city services, restaurants, etc. A compilation is submitted to the following Spring Board session and furnished to the headquarters hotel and Convention Bureau. Said critique will be continued for future annual sessions.

Headquarters Building Meeting Rooms: The Bureau receives and coordinates with the building staff all requests for meeting rooms within the Headquarters Building throughout the year. From June 1, 1975 to May 31, 1976, 301 meetings were held in the Headquarters Building. During this period the meeting rooms were used a total of 406 times for a total of 443 meeting days.

For the majority of scheduled conferences, the Bureau arranges for accommodations, at a special assigned rate, for those desiring housing for the period of the meetings and the Bureau acts as the liaison between the headquarters office and nearby hotels to continually secure appropriate rates for conferees.

Travel Arrangements: The Bureau arranges for transportation and accommodations for persons on official business of the Association. From June 1, 1975 to May 31, 1976, approximately 645 transportation arrangements were made.

RESOLUTIONS

This report is informational in nature and no resolutions are presented.

Bureau of Data Processing Services and Membership Records

Smith, Victor L., director
Speiser, James J., assistant director

The Bureau of Data Processing Services and Membership Records has a staff of 14 and utilizes a Honeywell 2030 computer system and various peripheral computer equipment.

Membership Records: Biographical and membership data are maintained for approximately 145,000 dentists and dental students in the United States.

All membership mailing requirements, including the mailing of *The Journal* and *ADA News* are processed through the computer as well as selective mailing label preparation for all agencies of the Association.

The preparation of all membership cards, dues remittance forms, the recording and reconciliation of all dues, is completely automated as is the processing of a variety of membership statistics. A summary of membership for the years 1973, 1974, and 1975 follows:

	Dec 31, 1973	Dec 31, 1974	Dec 31, 1975
Active Members	91,753	93,667	94,905
Life Members	11,214	11,817	12,325
Retired Members	11	16	24
Total Fully Privileged Members	102,978	105,500	107,254
Affiliate Members	647	612	633
Associate Members	69	72	82
Honorary Members	117	115	111
Student Members (Undergraduate and Graduate)	15,185	16,457	16,431
Total Membership	118,996	122,756	124,511

Membership recruitment materials are provided to all freshmen and senior dental students. Communications are maintained concerning all Association membership matters with individuals, and also state and local societies.

1976 "American Dental Directory": The 1976 edition of the *American Dental Direc-*

tory containing over 1,500 pages was compiled and published by the Bureau. The alphabetical and geographical sections contain all dentists in the United States.

Other Bureau Activities: The Association's payroll, general ledger, budget status reports, and various financial analyses are prepared by computer.

The tests administered by the Division of Educational Measurements of the Council on Dental Education and the Council of National Board of Dental Examiners are scored and test results prepared. Numerous surveys, statistical analyses, and reports are also processed for these two agencies.

In support of the activities of the Department of Sales and Advertising the Bureau provides circulation statistics of all publications, prepares circulation audit reports, and provides a product information referral system for advertisers in *The Journal.*

Some of the Bureau's many other activities include data processing support for the Bureau of Economic Research and Statistics and the processing of Relief Fund contributions.

Mailing label services are provided to dental schools, dental societies, and related dental organizations. Data processing services are also provided to related groups and unused computer time is sold to outside users. Gross income from these sources amounted to $108,000 in 1975.

RESOLUTION

This report is informational in nature and no resolutions are presented.

Bureau of Dental Health Education

Stauffer, Delmar J., director
Craig, Timothy T., assistant director
Rechner, Robert, special program coordinator
Oberg, S. William, materials development manager
Mortensen, Barbara, program specialist

The Bureau of Dental Health Education is responsible for developing health education materials for use in patient education, for school health programs, and for the general public. In addition to materials development and evaluation, the Bureau is responsible for: (1) the review of dental health education materials and programs developed by other agencies and organizations; (2) consultation on health education program development; and (3) permission to use the Association's statement of scientific accuracy.

Staff: The Bureau has a staff of eleven persons and one open position for a program specialist for school health to be filled July 1, 1976. Timothy T. Craig was appointed assistant director of the Bureau on July 1, 1975. Phillip J. Cozort left the employ of the Association on May 31, 1976 to resume graduate study in West Virginia.

Printed Materials Program: The following new materials were produced since June 1, 1975: *Nursing Bottle Mouth, Removable Partial Dentures, Smoking and Teeth?* (formerly *Smoking's Impact on Oral Health*), and *Your Dentist is Involved in the National High Blood Pressure Education Program.*

Revised materials completed since June 1, 1975 include: *Speaker's Guide for Dental Professionals, Ask Yourself, Your New Dentures, Parents Want to Help, Why Gold?, Your Teeth and What They Do, Space, Don't Do It Yourself, Immediate Dentures,* and *They're Your Teeth—You Can Keep Them.*

Forty-five items were reprinted and/or reordered without revision since June 1, 1975.

The response to new and revised materials continues to be reflected in the following income figures representing the sale of Bureau materials during the past five years: 1971 sales, $233,679; 1972 sales, $304,869; 1973 sales, $444,399; 1974 sales, $527,268; 1975 sales, $530,689.

Free Materials: Requests for free samples of Bureau materials for the past year totaled 23,192. This represents a decrease in requests from the previous year due to the fact that there were no television spot announcements for free sample materials during the reporting period.

Library Packet Program: In an effort to keep college and university libraries informed of the availability of Association health education literature and materials, the Bureau has established a free library packet of sample materials. A single copy of all pamphlets and brochures, descriptions of school program materials and teaching aids such as models, charts, and posters, and an Association publications catalog are included. Packets are sent upon request to dental school libraries as well as to schools offering programs for the training of dental auxiliaries, health educators, and classroom teachers. Four hundred and forty such schools now receive materials through the program and each school annually receives an updated collection of publications and descriptive materials.

Materials for the Blind: In cooperation with two outside agencies, a number of Association health education materials are now available in braille and audiocassette. The following materials are not directly from the Association but are listed in the back of the Association's publications catalog. *Cleaning Your Teeth and Gums, Your Child's Teeth, Orthodontics: Questions and Answers, Your Teeth Can Be Saved By Endodontic Treatment, Casper and Space-Age Dentistry,* and *Casper the Friendly Cub Scout* are all distributed by the Braille Volunteers of Huntington, PO Box 9422, Huntington, West Virginia 25704.

The State of Iowa Commission for the Blind, 4th and Keosauqua Way, Des Moines, Iowa 50309 has audiocassettes of *Cleaning Your Teeth and Gums, Your Child's Teeth, Orthodontics: Questions and Answers,* and has the following four pamphlets recorded on one cassette, *Your Teeth Can Be Saved By Endodontic Treatment, Prophylaxis, They're Your Teeth—You Can Keep Them,* and *Break the Chain of Tooth Decay.*

Exhibit Program: Forty exhibits were scheduled for one hundred and seven meetings since June 1, 1975. These meetings included component and/or constituent society-sponsored meetings, state and local health fairs, school health and career day affairs, hospital displays, teachers' meetings, and national school-related conventions. Ten exhibits were retired from circulation during this reporting period and need to be replaced. It has been impossible to fill all requests for exhibit loans. Thirty-four requests were denied because specific exhibits requested were unavailable for the dates desired during 1975.

School Nutrition Exhibit: The 1975 House of Delegates adopted a resolution directing the Bureau to (1) construct a traveling exhibit and develop descriptive literature explaining the rationale for removing sugar-rich foods from school food facilities, and to (2) rent space and staff the exhibit at the national conventions of the American Association of School Administrators and the National School Boards Association (Trans. 1975:681).

The exhibit has been developed for the specific conventions named above and will be available for additional meetings under the Association's traveling exhibit program. The first description and promotion of the exhibit will be published in the 1976-77 Association's publications catalog.

Audiovisual Materials: The Bureau, in cooperation with the Association Film Committee, completed the production of five films and one slide set during the past year. *Preventive Dentistry in B Sharp,* developed under a grant from Pro Brush, Division

of Vistron Corporation, was designed to carry the preventive dentistry message to junior high and high school students via an informative, entertaining performance by comedian, Avery Schreiber. *What It Means To Be a Dentist,* financed through a grant from Arm and Hammer Baking Soda, Division of Church Dwight, was developed as a documentary film reporting on the numerous career opportunities open to dental school graduates. A slide set and film, *The Senior Smile,* were produced as educational tools for dentists to use in training nursing home personnel in oral health care for geriatric patients. Two short films (5 minutes each), *Clean, Cleaner, Cleanest: Brushing* and *Clean, Cleaner, Cleanest: Flossing* were developed to explain current plaque removal techniques and are intended to be used for patient education and school based health education programs.

The Film Committee's one continuing project is the development of a cartoon film for elementary school children.

Association Film Awards: The following Association productions have won awards in film competition during the reporting period.

> *The Haunted Mouth*—Golden Eagle Award, 1975, Council on International Nontheatrical Events.
>
> *Preventive Dentistry in B Sharp*—Gold Cindy, 1975, Information Film Producers Association Festival of Hollywood; Gold Plaque, 1975, Chicago International Film Festival; Golden Image Award, 1975, Long Island International Film Festival.

Women's Auxiliary to the American Dental Association: The Bureau director serves as liaison representative to the Women's Auxiliary to the American Dental Association, providing Auxiliary officers and members with information on health education materials and programs.

In a cooperative effort to promote dental health education, the Bureau and the Auxiliary initiated a program to reward newly formed component and constituent WAADA chapters with a credit for health education materials. Credit for materials was awarded to the following: $50—Bay County (Florida) Dental Auxiliary, St. Joseph County (Indiana) Dental Auxiliary, Southeastern (Kentucky) Dental Auxiliary, Women's Auxiliary to the North District Dental Association (Nebraska), Central District (Oklahoma) Dental Auxiliary, Grant County (Washington) Dental Auxiliary, North Central (Washington) Dental Auxiliary, Weld County (Colorado) Dental Auxiliary, Auxiliary to the Pinellas County (Florida) Dental Society; $100—Women's Auxiliary to the Oklahoma Dental Association; $200—Women's Auxiliary to the South Carolina Dental Association.

The Bureau and Auxiliary have agreed to continue this program as a method to promote health education and as an incentive to membership drives within the Auxiliary.

In the past year, Bureau staff members have participated in the two WAADA Regional Conferences in Boston, Massachusetts and Louisville, Kentucky. Bureau staff act as consultants and provide routine office services for Auxiliary programs.

National Children's Dental Health Week, 1976: In the spirit of the bicentennial, the Bureau chose "Smile America" as the theme for the annual observance of National Children's Dental Health Week. Cartoon artwork featuring a caricature of "Yankee

Doodle" was developed for all printed and audiovisual material used to promote the dental health of children.

A complete report of the week's activities was published in the July issue of *The Journal of the American Dental Association*.

The colonial theme and materials were very well received by local dental societies, in part, because the observance was easily coordinated with other bicentennial activities planned for local communities. The bicentennial television and radio spot announcements received good media coverage during National Children's Dental Health Week with 1,300 television broadcasts and 4,350 radio broadcasts. The vast majority of the stations reported that they intended to use the dental health announcements at other times throughout the year. These public service announcements have been added to the Association's audiovisual library for regular circulation.

For the 1976 observance, the Bureau distributed 930,000 standard posters, 6,000 program planning kits, 1,200 television public service announcements, 1,907 recorded spot announcements for radio, 800 slides for television, and 8,400 citations. In addition to these free materials, orders were received for approximately 2 million miniature posters, 52,000 calendars, 20,000 car cards, and 900 outdoor billboard posters. A total of 66 television stations and 147 radio stations had their requests for the public service materials denied because the demand was greater than the supply.

National Children's Dental Health Week, 1977: In reporting their activities for the 1976 National Children's Dental Health Week, chairmen from constituent dental societies were asked to comment on the possible retention of the "Smile America" theme for 1977. In the previous year, a similar survey of chairmen indicated their desire to retain a dental health week theme for longer than one year to provide greater recognition and recall. The results of the 1976 survey indicate that the chairmen wish the "Smile America" theme to be retained but with a change in artwork. Program planning kits will be ready for distribution in September and will include the announcements of the 1977 materials and the scheduling dates for ordering supplies.

National Rural Health Week, 1976: In liaison activities with the American Medical Association and a number of other national health-related organizations, the Bureau and the Council on Dental Health assisted the medical association in the observance of the first National Rural Health Week, April 4-10, 1976. The Association's participation included helping staff the steering committee which planned the week's activities and assisting in the compilation of program planning kits which were mailed to the membership of each participating group. The Bureau prepared 30,000 copies of a publication which included a description of dental programs suggested for rural areas. Within the dental profession, 800 kits with special dental materials were sent to all state and local dental societies, state dental directors, and dental schools.

In a separate activity during National Rural Health Week, a Bureau staff member and a member of the Council on Dental Health represented the Association at the 29th National Conference on Rural Health held in Phoenix, Arizona.

National Symposium on Dental Health Education: During the 1975 Association annual session in Chicago, the Bureau sponsored a national symposium on school-based dental health education programs. Sponsoring agencies of national, state, and local com-

munity dental health education programs were convened to present the details of philosophy and logistics of programs currently available to elementary and secondary schools. The second day of the symposium was divided between a special session on critical evaluation of school programs and a session devoted to a review of audio-visual materials provided specifically for school dental health education programs. Symposium participants were also invited to display their program materials in an exhibit area adjacent to the symposium meeting room. Seventeen such exhibits were available and manned throughout the conference. Proceedings of the symposium are available from the Bureau. In an effort to help the profession provide leadership in the expanding area of school health education, the Bureau plans to hold a second symposium during the 1977 annual session.

Education Materials for Fully and/or Partially Edentulous Patients: In response to directives from the Board of Trustees and the Special Study Commission on the Care of Fully and/or Partially Edentulous Patients, the Bureau is engaged in the development of a number of materials to educate the public about the profession's responsibility for complete denture care. The plans include an after-care program kit for dentists to use in patient education, public service announcements for radio and television and a motion picture on after-care of edentulous patients. Plans also include an educational packet for legislators and a separate effort to inform nondental agencies and organizations about the consequences of oral health neglect by denture wearers.

School Program: "Learning About Your Oral Health" designed for grades kindergarten through twelve, continues to be one of the Bureau's most successful programs with over 80,000 program kits distributed. The prevention-oriented teaching guides and supplementary materials have been well received by both educators and dental professionals. The Bureau continues to assist state and local societies with program implementation and evaluations. Formal evaluations of the Association's school program have been developed and are being used to revise and/or develop new materials for elementary and secondary school dental health education programs. The greatest amount of program activity continues to be in grades kindergarten through six.

Patient Education/School Program Workshops: The Bureau staff presented workshops and seminars to promote dental health education to three target groups: elementary and secondary schools, local communities, and the private dental office. The seminars are conducted to promote health education and to discuss the role of the profession in patient education and the use of appropriate methods and materials in the dental office. School program workshops are conducted to promote the development of comprehensive school health education. Bureau staff participated in the following conferences: Colorado State Department of Health and Colorado Dental Association, Denver, Colorado; New York State Association of Health, Physical Education and Recreation, Lake George, New York; Maine Department of Health and Welfare and Maine Dental Association, Bangor, Maine; Dental Health Workshop, Charleston, West Virginia; State Conference on Health Education, Liberty, New York; Women's Auxiliary to the American Dental Association Conference 18, Boston, Massachusetts; Western Ohio Dental Society, Troy, Ohio; Women's Auxiliary to the American Dental Association Regional Conference, Louisville, Kentucky; Dental Health Workshop, San Francisco, California.

Geriatric Oral Health Nursing Home Program: On June 30, 1975, the American Society for Geriatric Dentistry in cooperation with the Association entered into an 18-month contract with the Division of Long Term Care, US Department of Health, Education, and Welfare, to develop a seminar program to educate dentists and dental auxiliary personnel of the dental needs particular to nursing home residents, and to educate nursing home personnel with respect to the regular oral health care for geriatric patients.

The improvement in dental service and the establishment of procedures for regular oral health care are the primary objectives and are to be achieved with the cooperation and guidance of a national advisory committee. Tasks of the program include:

1. developing a curriculum guide with specific and separate considerations for the dental team, the administrators, and the nursing staff;
2. planning and staging ten seminars, one in each HEW region;
3. arranging liaison meetings with representatives of national and state associations concerned with the health of geriatric patients;
4. promoting the concept of a state dental caucus to facilitate the development of a permanent state organization to deal with oral health care of nursing home residents;
5. developing possible courses of action to alleviate problems confronting dental advisors and nursing home personnel;
6. evaluating the seminar program to determine its effectiveness.

The first seminar was held in HEW Region V, May 13-14, 1976 at Lake Geneva, Wisconsin. The following nine additional seminars have been scheduled:

Oct 22-23,	1976	Farmington, Connecticut—Region 1 –Dr. S. Rafal
Nov 7-8,	1976	New Hyde Park, N.Y.—Region 2—Dr. S. Kamen
Dec	1976	Colorado—Region 8—Dr. O. Wright/Dr. A. Shaver
Jan	1977	Louisiana—Region 6—Dr. Radke
Jan	1977	Missouri—Region 7—Dr. P. Needham/Dr. G. Schmidt
Feb	1977	California –Region 9—Dr. S. Epstein/Dr. J. Campbell
March	1977	Washington—Region 10—Dr. Lukens/Dr. Swoope
March	1977	Pennsylvania—Region 3—Dr. Soricelli/Dr. Shipman
April	1977	Florida—Region 4- Dr. S. Lotzkar

Routine Activities: Among the services the Bureau is regularly called upon to offer are consultations concerning dental health education program development, permission to use photographs and copyrighted Association educational materials, and permission to use the Association's statement of scientific accuracy. All submitted materials are reviewed by staff and consultants in an attempt to influence the quality of dental health education materials published in health textbooks and other publications. Overall 52 reviews were completed on 43 different projects. Of the 23 manuscripts submitted for the Association's statement of scientific accuracy, 10 were accepted. Twenty-one reviews were completed on manuscripts submitted with requests to use copyrighted materials; 14 manuscripts were accepted for copyright release.

Conference and Meetings: Another service of the Bureau staff is liaison with other

health agencies. A staff member attends as a speaker, consultant, or general participant primarily to promote greater interest in and understanding of dental health education. Bureau staff participated in the following meetings: National Interagency Council on Smoking & Health, New York City and Washington, D.C.; American Public Health Association Annual Meeting, Chicago; American Brush Manufacturers Association Annual Meeting, Boca Raton, Florida; American College Health Association Annual Meeting, Denver; Chicago Dental Society Mid-Winter Meeting; American School Health Association Annual Meeting, Denver; American Dental Association and American Pharmaceutical Association Liaison Committee Meeting, Chicago; American Dental Association and Public Health Service Fluoridation Liaison Committee Meeting, Chicago; Third World Conference on Smoking & Health, New York City; 15th National Conference on Physicians, Schools & Communities, Chicago; American Health Care Association Convention, Houston; American Association for Health, Physical Education, and Recreation Annual Meeting, Milwaukee; 29th Conference on Rural Health, Phoenix, Arizona; Symposium on Dental Needs of the Developmentally Disabled, Springfield, Illinois; National Institute of Dental Research, Bethesda; American Legion, Indianapolis, Indiana.

RESOLUTIONS

This report is informational in nature and no resolutions are presented.

Bureau of Dental Society Services

Caldwell, J. Robert, director

The Bureau of Dental Society Services is responsible for developing, maintaining, coordinating, and disseminating information and for providing services related to the administrative and program activities of constituent, component and other dental societies, and organizations composed of members of dental auxiliaries. The Bureau has a full-time staff of a director and three clerical persons.

Liaison with National Dental Organizations: The Third Conference of National Dental Organizations will be held in the Association's Headquarters Building on August 9-10. Invitations to this Conference have been sent to presidents, secretaries, and executive directors of each of the 99 national dental organizations carried on the American Dental Association's "List of National Dental Organizations." The purpose of the Conference is to improve communications and liaison between the American Dental Association and other related organizations. It is designed to provide an opportunity for meaningful dialogue on legal, legislative, and other problems of mutual concern and to coordinate a concentrated approach to these problems. The two previous conferences of national dental organizations were held in 1970 and 1972, respectively. The Bureau, also, provides day-to-day liaison with these national dental organizations in much the same manner as it serves as a coordinating, referral, and service agency for constituent and component societies.

Regional Conferences: The Bureau serves as coordinating and planning agency for the Regional Conferences of the Association. The last three conferences of the second series include: the Sixteenth Regional Conference in Hartford, Connecticut, March 26-27, for Trustee District 1; the Seventeenth Regional Conference in Louisville, Kentucky, June 25-26, for Trustee Districts 6 and 7; the Eighteenth Regional Conference in Milwaukee, Wisconsin on July 30-31, for Trustee Districts 8 and 9. Regional Conferences are presented to improve communications within the profession, particularly from the local and state level to the national level and to assist the Association and its constituent and component societies to fulfill their obligation to the profession and the public.

Management Conference: The 27th Annual Management Conference was held in the Association's Headquarters Building, June 7-9. Emphasis was given to topics of particular interest to administrators; to the practical application of policy in program planning. Mr. Thomas H. Lawrence, president, Lawrence-Leiter and Company, management consultants and past president, Association of Consulting Management Engineers, presented a keynote program, *Communications and Teamwork: The Key to Results.* Participating were more than 100 secretaries, executive directors, and other officials of constituent societies, executive secretaries of component societies, and representatives of the Canadian Dental Association, American Student Dental Association and related dental organizations.

State Society Officers Conference: The 1976 Conference of State Society Officers will be held in Las Vegas, November 13. The program is being developed by Dr. William J. Greek, president, Mr. Rex T. Butler, vice-president, and Dr. William T. Strahan, secretary, in consultation with the Bureau director.

Administrative Orientation Program: The Bureau serves as planning and coordinating agency for the intensive five-day administrative orientation program for dental society executives. The fourth Administrative Orientation Program was held March 1-5 and the fifth is scheduled for September 26-October 1. Six constituent and component society executives and a mentor participate in each of these programs. The program was developed to introduce selected administrative officials of constituent and component societies to the American Dental Association, its Headquarters functions, resources and staff, and the operation of the Board of Trustees and the House of Delegates as they relate to the Association's 54 constituents and 485 component societies. In addition, the program is intended to present some of the fundamental procedures of effective management, such as administrative function and structure, collection of dues, handling of membership problems, operation of the relief fund, organization of delegate caucuses and public and professional relations.

President-Elect's Day: The Bureau coordinated and planned the first President-Elect's Day, held in the Headquarters Building, February 9. The concept of this conference, for individuals soon to assume the responsibilities of chief elected officer of their constituent societies, grew out of recommendations of participants in the Presidents' Program held in conjunction with the 26th Annual Management Conference in 1975. The program included the presentation and discussion of topics of direct interest and concern to constituent society presidents-elect.

Continuing Education Registry: The Continuing Education Registry serves as a mechanism to record the continuing education activities of individual dentists and hygienists in participating states. The Registry program was developed to assist constituent societies and state dental boards in implementing their continuing education programs, whether mandatory or voluntary. Costs of the program are shared by the Association and participating states. The Registry has as full-time staff, a project director and two clerical staff members.

States currently utilizing the Registry service include Minnesota, Iowa, and Wisconsin. Minnesota requires continuing education participation for licensure renewal by both dentists and hygienists. The Iowa Dental Association and the Wisconsin Dental Association have established voluntary continuing education reporting programs for

their members and offer recognition for those dentists who voluntarily meet a high standard of participation. North Dakota and South Dakota, which both require continuing education for license renewal of dentists and hygienists, will initiate the Registry service in July 1976.

The Veterans Administration Dental Service also will implement the Registry recording system for VA-employed dentists during the summer of 1976. VA dentists who meet a standard of continuing education participation will become eligible for an increment in pay under the 1975 Veterans Administration Physicians and Dentists Pay Comparability Act.

Discussions are being held with the New England Foundation for Continuing Dental Education, a consortium of the six constituent societies and four dental schools in the New England region. The New England Foundation has proposed development of a voluntary continuing education program for the six New England states (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont) utilizing the Continuing Education Registry as the record-keeping mechanism. Several other constituent societies and state dental boards have indicated interest in the Registry program, including Nebraska, Oklahoma, New Jersey, Michigan, and Illinois. The Registry service is available to any constituent society or state dental board.

The project director met with each of the 1976 Administrative Orientation Program groups, addressed the Annual Management Conference and participated in the programs of several national dental organizations. Registry staff is responsible for the list of continuing education courses published in *The Journal*. Staff, also, has cooperated with the Council on Dental Education on several projects related to continuing education, such as the proposed national continuing education approval program and annual surveys of dental schools' and constituent societies' continuing education activities.

The Registry, which functioned under the Bureau, has been assigned by administrative decision to the Council on Dental Education.

RESOLUTIONS

This report is informational in nature and no resolutions are presented.

Bureau of Economic Research and Statistics

Gift, Helen C., director

The Bureu of Economic Reserch and Statistics is responsible for collecting, compiling, analyzing, and disseminating data and statistics that concern the dental profession.

Price Index on the Cost of Conducting a Dental Practice: In June 1976 the Bureau completed the comprehensive price index and its component parts. The index was developed in response to an action of the 1973 House of Delegates (*Trans.* 1973: 675) concerning the cost of running a dental practice and further action by the 1974 House of Delegates (*Trans.* 1974:656). The index is based on data gathered from a special version of the 1975 Survey of Dental Practice which provided information on the costs of running a dental practice over a period of five years.

The index is designed to show changes in unit prices of materials and services purchased by dentists for the operation of a dental practice from the base year, 1970, through 1974. The data utilized reflect national measurements, with selected state and regional data for comparison.

The index consists of one comprehensive index of all operating costs, which is comprised of subindices of major expenditure items. For analytical purposes, the index provides trend data on dentists' operating costs as a whole, and subsidiary trend data on the costs of significant expense components of dental practice.

Major expense categories were determined from past surveys of dental practice. The major expense items included in the index are: monthly office rent or equivalent mortgage payment, and utilities cost; monthly salary or commission for full-time employees; monthly salary for part-time employees; yearly depreciation of dental office equipment; taxes on business and business property; cost of repairs; insurance related to dental practice; legal and professional fees related to dental practice; employee benefits (not included in salaries); interest on business indebtedness; bad debts arising from services; expenses for travel to professional meetings, society dues, license fees, etc.; commercial dental laboratory charges; expenses for drugs; expenses for office supplies; expenses for dental materials; and all other minor costs associated with dental practice.

Three major areas were identified as needing further breakdown for cost analysis.

These three component indices were the Dental Supplies Price Index, the Dental Equipment Price Index and the Dental Laboratory Procedures Price Index. The supply and equipment indices show price changes between 1970 and 1975 for 34 expendable dental supply items and 19 equipment items. National sales volume was the main determinant for items selected and assignment of their relative importance in the index. The data sources were mid-year price lists obtained directly from manufacturers. The Laboratory Procedures Index shows price changes from 1970 to 1974 of 20 frequently used dental laboratory procedures based on laboratory industry survey data.

A further report on the Index on the Cost of Conducting a Dental Practice, which will be an example of the index based on recent survey data, will be in the *Supplement to Annual Reports and Resolutions, 1976*.

Survey of Dental Practice, 1975: The questionnaire, redesigned from previous years for The Survey of Dental Practice, 1975, was mailed in May 1975 to two samples of dentists. Follow-up was used to increase the response rate. The survey was conducted in two parts: one sample was requested to supply information on dental practice for the past year; a second sample was asked to supply information on the costs of conducting a dental practice for each of the past five years. Information from the five-year survey was used to obtain needed information for constructing the Price Index on the Cost of Conducting a Dental Practice. The one-year survey had an adjusted response rate of 70 percent; the five-year survey had an adjusted response rate of 44 percent. These represent substantially higher response rates than had been achieved in previous years.

The results of this survey have been analyzed and will be used to update descriptions of dental practice.

Fee Survey, 1975: In accord with a resolution adopted by the 1973 House of Delegates (*Trans.* 1973:521), a dental fee survey was performed in the fall of 1975. With follow-up, an adjusted response rate of 55 percent was obtained. The analysis is completed and stored on computer tape, but as noted below is embargoed.

Distribution of Reports on Dental Fees and Overhead Costs: In response to the House directive (*Trans.* 1972:679), requests for information on office overhead costs are currently being forwarded to the constituent societies so that distribution decisions can be handled by them. The results from the 1975 Survey of Dental Practice will be published in sections so that distribution of general information requests can easily be made from the Association. Requests for overhead information will be referred to constituents in accord with House directives.

On the basis of current legal opinion, particularly in light of the 1975 decision of the United States Supreme Court in the case of *Lewis H. Goldfarb, et al, vs Virginia State Bar, et al* [in which the United States Supreme Court found that the publication of a professional minimum fee schedule, when coupled with the power to enforce its use as a fee floor, constitutes anticompetitive conduct within the reach of the prohibitions of the Sherman (Antitrust) Act] and other pending litigation, the Board of Trustees of the American Dental Association decided at its March 1976 session that the 1975 Survey of Dental Fees should not be published. This prohibition will remain in effect either until dental fee surveys no longer present a "substantial, potential risk or until the 1976 House of Delegates, fully aware of the potential legal risks, formulates clear and concise direction." In the interim, the Bureau will not engage in any further activity concerning dental fee surveys.

Distribution of Dentists, 1976: The Bureau prepares the Distribution of Dentists every three years. In the past, the information was obtained directly from the membership file. Due to the increased importance of accurate manpower figures for planning, the 1976 project was conducted as a postcard survey to all dentists on record. Members and nonmembers were included in order to determine location and activity status. By the end of May approximately 108,000 cards had been returned, approximately 2,000 were notifications of deaths and 12,000 were address unknown which are still being traced. Follow-up activities in the summer of 1976 will be a major effort of the Bureau to ensure that the final publication is as accurate a representation of dental manpower as possible. Data from this survey will become available to state societies by late 1976. The completed analysis will be published in a monograph at the end of the year.

Redistribution of Dentists: The Bureau is undertaking an investigation to determine the impact of the redistribution of dentists which would result from a system of national reciprocity (*Trans.* 1975:720). The analysis at this point has involved investigating the movement of dentists between states in the last five years and comparing the net gains and losses among states which have few, if any, mobility barriers with those that are more restrictive. These comparisons will provide a better understanding of what potential effect reciprocity might have at the regional level.

Dental Manpower Information System (ADA Manpower Research Project): In response to House of Delegates resolutions (*Trans.* 1972:686, 687, 689 and *Trans.* 1973:662) the American Dental Association contracted with the Leonard Davis Institute of Health Economics of the University of Pennsylvania (LDI) to develop a data gathering mechanism and an analytic procedure to be used at the local, state, and national levels in order to provide more reliable information for making decisions in such areas as expansion of dental schools, use of auxiliaries, and placement of dentists in scarcity areas.

The analytic procedures to be developed were a production function and a demand index. This third progress report is presented on behalf of the three co-sponsoring agencies: Council on Dental Education, Council on Dental Health and Bureau of Economic Research and Statistics. The contract with the LDI ended on January 31, 1976. The final meeting of the Manpower Project Advisory Committee was held on February 2-3, 1976. The purpose of the meeting was the final oral report on the dental planning information system presented by Leonard Davis Institute staff.

The final report of the project included the following: (1) the measurement instruments to be used for gathering information from dentists as edited at the February 2-3, 1976 Advisory Committee meeting; (2) a comprehensive written technical description of the modeling for both the production and demand functions; (3) the computer software delivered and set up on a local university computer; (4) the data from the pretest states (Indiana, Louisiana, Pennsylvania, North Carolina, and Massachusetts); (5) a comprehensive written computer program operations manual; (6) a listing of the states requesting participation in the program; and (7) a written operations manual outlining all activities for states wishing to participate in the project.

It is organized dentistry's continuing advantage to make the fullest possible use of the dental information planning system and to conduct a full complement of state surveys over a relatively limited period of time. This was recognized by the 1975 House of Delegates (*Trans.* 1975:673).

The data resulting from state surveys would allow some judgments to be drawn by the Association on the overall dental productivity, as well as the total demand for dental needs in the United States. The Association would then have a sound data base for testimony in Congress on the capacity of the dental delivery system, on dental manpower, and on educational needs.

The Association is making necessary arrangements for ongoing use of the information system. With the Bureau's assistance, the system will be implemented in additional states (during 1976) and eventually on a national scale. With advances in dental technology or new experiences concerning dental demand, relevant indices will be adjusted.

After reviewing the progress of the Manpower Project to date, the Advisory Committee made the following recommendations to the Board of Trustees in March 1976: (1) efforts to seek outside funding for various portions of the LDI project should be continued; (2) since the operating success of this project is completely dependent upon sophisticated computer facilities, the Association's present facilities are inadequate. Since it is inefficient to have staff out of the office at other computer facilities, the Committee recommends the upgrading of the Association's facilities or the placement of remote terminals in the Bureau of Economic Research and Statistics for this as well as other analysis activities of the Bureau.

By July 1976, selected states indicating an interest in the manpower study will participate in the continuation of the project. Following up on House of Delegates action (*Trans.* 1975:673) and the recommendation of the committee to the Board of Trustees, Bureau staff consulted with several funding sources in February 1976.

The requests for supplemental funding are being prepared for submission to selected agencies. The current allocation of funds for 1976, which is a combination of monies in the Bureau's budget and a grant from the American Dental Association Health Foundation, is approximately $130,000. Without further financial assistance, it is anticipated that the project can continue and that the available funds will be used during the 1976-1977 budget years. (The Leonard Davis Institute demonstrated the computer software to the Bureau staff and documentation of this has been received.)

Aside from the Association's commitment to take on the implementation of the system, the major responsibility for making it work falls on the constituent societies. Every state has much to be gained in self-assessment by conducting the survey and, additionally, each state can provide input into the national data base.

While the ultimate decisions at the local level regarding the adequacy of manpower supply may be different, the tools to determine this are not unique. With limited resources, this project seems to be a most pragmatic way to join efforts to investigate manpower through research that will provide information of use at all levels of organized dentistry.

Economic Barriers to Dental Care: At the request of the House of Delegates (*Trans.* 1975:674), the Bureau is investigating the feasibility of conducting a study concerning what effect elimination of economic barriers would have on the demand for dental care.

The Bureau, working with the Council on Dental Care Programs, is conducting a literature search as well as a review of ongoing research projects that have investigated the economics of health care delivery. Several major studies that have been conducted are being considered in greater detail to determine if they meet the re-

quirements for necessary data, thereby removing the necessity from the Association for performing such an investigation. These major studies include the national utilization study by the National Opinion Research Center in 1965, the Feldstein model regarding the effects of costs, the Rand Health Experiment, the United Auto Workers study being conducted by the Department of Health, Education, and Welfare, an investigation begun by American Telephone and Telegraph, and various other models designed to determine the relationship between costs, prices, and utilization of dental services.

A commentary on the adequacy of these data and models for studying the effects of the removal of the economic barrier is being prepared. A study protocol and funding proposal are also being prepared as alternatives should none of the above studies--alone or in combination--appear appropriate. A report of these investigations and recommendations will be made to the August 1976 session of the Board of Trustees.

Dental Manpower Policy Model: The results of the Dental Manpower Planning System, as well as results from other studies performed by the Department of Health, Education, and Welfare, have indicated the need for improved measures in dental delivery system planning. The Bureau is engaged in activities that are an outgrowth of several of its routine projects such as the *Survey of Dental Practice,* the *Distribution of Dentists,* and the *Dental Manpower Planning System* which are leading toward the development of a dental manpower policy model as an alternative to the dentist/population ratio (*Trans.* 1975:675).

Work on these alternative measures has included investigation of supply and demand indices, use of adjusted dentist/population ratios (using a specified subpopulation of dentists and geographic regions other than counties). These alternatives are being presented along with the traditional dentist/population ratios in preparation of testimony for legislation and in presentations involving manpower issues. The Bureau has been working closely with the Division of Dentistry of the Department of Health, Education, and Welfare to insure that the progress they are making in improving their analysis is consistent with that of the Association.

Facts About States, 1976: This publication is prepared every three years by the Bureau to provide dental students and dentists with information on practice locations. The most recent edition will be distributed in the summer of 1976.

Survey of Public Attitudes on Dental Prosthetic Care: Begun in April 1975, the project's prime objective was to provide basic descriptive data on persons with prosthetic appliances. The survey was conducted under contract to the Association by National Family Opinion, Inc., using a panel of 20,000 households closely matched to the general population. From the original sample of 20,000 households, 2,000 individuals were randomly selected for more in-depth study regarding their experiences in obtaining dentures and their attitudes regarding dentures and denture care.

Results and analyses have been made available to the Special Study Commission on the Care of Fully and/or Partially Edentulous Patients and other agencies of the Association. The tables on the final report, which provide information on the number and distribution of denture wearers, are being distributed. The final descriptive results, including tables, will be presented in Association publications during 1976.

Survey of Dentists: Due to the many issues of concern to the profession, the *1975 Sur-*

vey of Dentists (opinion) had to be divided into two questionnaires. Two samples (3,200 each) of practicing dentists received these questionnaires in the fall of 1975 and both questionnaires were sent to all elected officials of state organizations. A response rate of 70 percent was obtained on these surveys. The topics covered in the questionnaires included continuing education, illegal dental practice, drugs and dental materials, peer review, dental prepayment, auxiliaries, national dental health insurance, and evaluation of American Dental Association services.

The data from these surveys have been analyzed and results are being prepared for presentation in ADA publications. In the interim, tabular results have been sent to Councils for their use. The Council on Dental Care Programs has reviewed the results on prepayment and peer review, and the Council on Dental Education has reviewed the results on attitudes toward and use of dental auxiliaries, and expansion of duties for consideration in preparing their reports. Another survey of dentists' opinion will be performed in the fall of 1976.

Evaluation of the Association's Annual Session: The Bureau performed two surveys for the Special Committee to Study the Association's Annual Session. One survey was included in the *ADA News,* to assess plans for attending the annual session. The second was a more lengthy questionnaire, distributed at the annual session, to determine attitudes toward portions of the meetings. The results were presented to the Special Committee and are available for distribution.

In conjunction with these evaluations, Bureau staff assisted the *Fédération Dentaire Internationale* (FDI) by evaluating the scientific sessions of these meetings. The results of these analyses are being submitted to the Commission on the Scientific Session of the FDI for their review.

Assistance to Constituent and Component Societies and Councils: One of the major functions of the Bureau is to assist other agencies of the Association and its constituents in research-related activities. Some of the activities in which the Bureau has been involved include: preparation of salary and related statistics for the committee appointed to study the structure of the Association; preparation of resource material for the Council on Legislation's committee on emergency dental care; preparation of data for documentation of Public Education Programs' presentations; research design and analysis assistance to the Council on Dental Care Programs for a survey of dentists regarding the United Auto Workers prepayment plan.

Assistance to constituents and other organizations include: review of research design for the Pennsylvania Society of Periodontics; review of research design and assistance with sampling on productivity of group practices for the Research Triangle Institute; preparation of tables for studies of migration of dentists for Fairleigh Dickinson Dental School and Ohio State Dental School; preparation of tables for manpower analysis for the California Post Secondary Education Commission; preparation of tables of demographic data for the University of Florida Dental School, and Harvard Medical School and Duke University; review of research design and assistance with sampling on dentists' delivery of care to the handicapped for J. Robb Associates; preparation of exhibits for testimony before the House Subcommittee on Health for the Louisiana Dental Association; and review of research design and assistance in survey activities related to attitudes toward the illegal practice of dentistry for the Oregon Dental Association.

Consumer Price Index: With greater media coverage being given to the inflationary impact of health care costs, misleading reports about dental fees have appeared on several occasions. The Bureau is attempting to refute such misinformation with reference to the Consumer Price Index, which showed that dentists' fees in the 1970's have increased at about the same rate as average prices in the economy. The Bureau has prepared statistical tables and graphs derived from the Consumer Price Index on the trend of dental fees compared with other health care services and other prices in the economy. A comprehensive report of this has been developed jointly with the Bureau of Public Information and is scheduled to be published in the July 1976 issue of *The Journal.*

Federal Legislation: Costs estimates and other exhibits for legislative testimony have been prepared by the Bureau.

1. Testimony before the House Subcommittee on Health was prepared which included: (a) estimated cost of an emergency dental care program; (b) estimated cost of a comprehensive dental care program with varied deductibles and co-payment; (c) estimated cost of adding comprehensive dental care to Medicare Part B; and (d) national expenditures for dental and health care, 1950-1975.
2. An estimate of the cost of denture services under Medicare Part B, HR 11740 was prepared in connection with HR 11740.
3. The proposed Physician Fee Index Reform Act, S. 2560 was reviewed with respect to impact on dentistry.

Reports: The following reports were issued in 1975.

Patterns of Dental Practice in the United States: Solo vs Group Practice, *JADA* July 1975.

Inventory of Dentists, 1975.

Research as the Basis for Policy Decisions: The Role of the Constituent and Component Societies—Manpower, Economics, *Attitudes* June 1975.

The Role of the Practicing Dentist in the Delivery of Caries Prevention, Final Analytic Report December 1975.

The Role of the Practicing Dentist in the Delivery of Caries Prevention, Final Summary Report December 1975.

The Role of Parents in the Oral Health Habits of Their Children, Final Report May 1976.

Publications:

Gift, H. C., Frew, R., and Hefferren, J. J.: Attitudes Toward and Use of Pit and Fissure Sealants, *Journal of Dentistry for Children,* 1975.

Gift, H. C., and Milton, B. B.: Comparison of Two Dental Preventive Dentistry Surveys: 1957 and 1974, *Journal of Preventive Dentistry,* 1975.

Notice of available publications and information are printed in Association publications.

RESOLUTIONS

This report is informational in nature and no resolutions are presented.

BUREAU OF ECONOMIC RESEARCH AND STATISTICS: SUPPLEMENTAL REPORT 1

Price Index of Cost of Conducting a Dental Practice: The *Index of Cost of Conducting a Dental Practice* was prepared by the Bureau in accordance with directives from the House of Delegates.

House Resolution 60, adopted in 1972 (*Trans.* 1972:679), and Resolutions 273 and 277, adopted in 1973 (*Trans.* 1973:611, 612), were the most pertinent to development of the *Index*. Resolution 60 required that a fee and overhead cost survey be conducted every two years. Previously, overhead costs were surveyed every three years as part of the Survey of Dental Practice and fee surveys were not conducted on a regular basis. Resolution 277 in 1973 reaffirmed this House action, instructing the Bureau to ". . . conduct a survey of dental practice, including overhead costs, at least every second year. . . ." These resolutions provided for a continuous flow of input to the *Index*. Resolution 273 instructed the Bureau to establish seven separate indices for the past five years and for each future year, to be used individually and also collectively when weighted according to percentage of expense for their respective importance to produce an *Index*.

The first three indices specified in Resolution 273 were Expendable Dental Supplies, consisting of 25 to 30 most basic and frequently used supplies; Dental Equipment, consisting of depreciable dental and office equipment; and Laboratory Procedures, consisting of 10 to 20 basic and most used procedures. These indices were prepared in 1974 and updated in the following years (*Trans.* 1975:207).

The remaining four indices specified in Resolution 273 were Rent or its equivalent with self-owned property; Employee Compensation, including fringe benefits; Utilities, and other items which fluctuate with the economy; and Taxes (local, state and federal). Data for the preceding indices were to be collected from new surveys or from surveys already completed.

These specific indices have been developed and all seven have been combined into one measurement, *The Index of the Cost of Conducting a Dental Practice.*

The *Index* is a statistical time series measure designed to show changes in the cost of materials and services purchased in order to operate a dental practice. It measures changes in prices and in dentists' expenses for items that are the most important current cause of changes in the cost of conducting a dental practice.

The *Index* is conceived as a functional tool, a statistical description of the economic structure of private dental practice and an indicator of cost trends in dentistry. By means of a comprehensive, continuous data series, it is a factual demonstration of dentistry's position in the American economy. Its overall purpose is to provide information. In this capacity, it is directed to several publics: the dental profession, leaders of public opinion and policy, and the public at large.

The *Index* is a precise instrument for demonstrating cost information. It is needed because of the increasing use of indices in formulating and evaluating economic programs and policies. If equitable decisions are to be made, the dental profession cannot rely on general indices to represent accurately conditions in dentistry. The dental fee index of the Consumer Price Index, for example, does not consider the cost of conducting a practice and its indices of health care costs are weighted toward physicians' services and toward hospital care. To serve the needs of the dental profession, there must be indices specifically applying to and representative of private dental practice.

Indices of dental practice are most urgently needed for documentation of positions serving the interests of the dental health of the public and of the dental profession. The most immediate need is for valid documentation before legislative and regulatory bodies.

All of these purposes are closely interrelated. They underscore the profession's need for an accurate, continuous instrument for documentation of the trend of dental fees, other costs in the economy, public opinion of dentists and the political and socio-economic climate affecting the dental profession. The media have tended to reinforce unsupported notions of high dental fees or dental fees as part of a "spiraling complex of health care costs." It is not improbable that many dentists are influenced by this, and so reinforce a negative self-image. But, by comparison with the Consumer Price Index, it is demonstrated that the trend of dentists' fees in the last decade, and over a longer period of time, are not out of line with the general price rise in the economy. Dentist fee increases have, in fact, tended to lag behind in the cost of other health services and of services in general.

An index documenting the cost of operating a dental practice will not in itself change popular notions. But it can be highly effective when used strategically to combat misinformation. It can be channeled into the legislative and judicial process as evidence bearing on economic and regulatory proposals. It must be competent as an instrument for combating adverse statistical presentations.

Methodology: Expenditure data used in the *Index* were collected in *The 1975 Survey of Dental Practice*–Special Version, in which a 6 percent sample of all active dentists were asked to report their itemized expenses for the years 1970 through 1974. Supplementary data were collected in the regular one-year version of *The 1975 Survey of Dental Practice*. Only dentists with financial responsibility reporting expenditures were used as the basis for the *Index*. The methodology in these surveys is presented in *The 1975 Survey of Dental Practice*.

The items of the *Index* for each year, 1970 through 1974, are listed in Table 1. Average annual expenditures by item, total average annual expenditures (all items), and annual percentage distribution of expenditures by item are shown in Tables 2 and 3.

The percentage distribution of total expenditures by item for 1970 was assigned as the weight or relative value for each item in the *Index*, and it can be seen from Table 3 that year-to-year variations in the percentage distributions were relatively minor.

The average dollar amount of expenses by item for each year is shown in Table 2. During the four year period, respondents' average expenses increased from $35,672 to $54,448. Of this total, average salary expense accounted for $13,054 to $20,832 of the increases.

Table 3 shows, for each year, the percentage of total expense accounted for by each item. Among the major items, salaries increased over the four years 36.6 percent to 38.3 percent of total expenses. The other major items declined as follows: commercial laboratory charges from 16.5 percent to 16.0 percent, drugs, dental materials and office supplies from 15.2 percent to 14.7 percent, and rent or mortgage and utilities from 11.4 percent to 9.9 percent.

Table 3 also shows that employee benefits increased from 1.8 percent to 2.8 percent of total expenses over the four-year period.

Respondents reporting zero expenditures were included in the calculation of each

average on all items except salaries, but the respondent was omitted if an item was left blank.

To develop a price index it is necessary to convert the actual expenditures to allow for realistic comparisons. Measurement units convert expenditures for a given item to price per standard item. Each item in the *Index* is a major type of expenditure.

Measurement may be expressed in units of space, time, expenditures per employee, per patient visit, or per operatory or expenditures as a percentage of gross income, whichever is most appropriate to each item. The unit of measurement and weight assigned to each are shown in Table 1.

Four units were selected on the basis of their sensitivity with respect to items in the *Index*: (1) square feet of office space for items such as rent, utilities and repairs; (2) number of employees for salaries and fringe benefits; (3) expenses as a percentage of constant-dollar gross income for taxes and bad debts; and (4) special measurements for other expenditures as shown in Table 1. Relative weights were not assigned to items the cost of which are not directly influenced by practice size– such as travel expenses, dental society dues or license fees– but, instead, dollars per year were used.

The item "utilities" required special treatment because it did not appear on the Special Version questionnaire. This item refers to expenditures for telephone service, gas, electricity and water. The item, however, was included in the regular one-year *1975 Survey of Dental Practice* questionnaire, making available 1974 data on utilities expense. The weight assigned to utilities was based on the 1974 ratio of utilities expense to rent or equivalent mortgage expense, which was 42.0 percent. In determining this ratio, only respondents reporting cost of utilities not included in rent were used, to allow for comparison of actual utilities expense and actual rent (excluding utilities). Among the returns, about 95 percent of respondents reported their utilities expenses separately from rent or mortgage payment. To account for the relative price of utilities over this five-year period, the Consumer Price Index for utilities was used.

The values of laboratory procedures, supplies and equipment were developed as previously described (*Trans.* 1975:207) and as shown in Table 1. After determination of the values, weighted aggregate and weighted average expenditures were calculated for each item in the *Index*. In any given year the *Index* is equal to the sum of the weighted price indices of all component items.

The *Index* is designed for the purpose of measuring changes in operating costs from what they were in 1970; that is, changes in the cost of goods and services *purchased in 1970*. To do this, the assumption is made that the structure of the average dental practice is unchanged, and that only operating costs (prices) have changed. The bulk of the available data indicate this to be an appropriate assumption.

The *Index* as developed and presented here is a time series measuring price changes in 1971 to 1974 from a 1970 base. Results for this period are shown in Table 4. As shown in Tables 1 and 4, the *Index* is comprised of 14 items. Depending upon the item, the data used are either prices paid by dentists, such as in monthly salaries or are dentists' expenditures for items, such as taxes or drug charges. These have been converted to unit cost, as explained above, so that, in effect, the *Index* measures price changes. It is planned to update and refine the *Index* continuously by means of additional analysis and use future surveys to be conducted at a minimum of every two years.

Results: Between 1970 and 1974, the *Index* recorded a 36.3 percent increase in the cost of conducting a dental practice. The annual rate of increase was 8.0 percent.

However, year-to-year increases varied between 6.8 percent and 10.9 percent as shown below:

	Annual percentage increase in index
1971	6.8
1972	7.5
1973	7.1
1974	10.9

As shown in Table 4, four major categories account for about 80 percent of dentists' costs. These are salaries, commercial laboratory expenses, drugs, dental materials and office supplies, rent or mortgage, and utilities. Most of these items of major importance increased less than the *Index* as a whole during the four-year period. Salaries increased 28.8 percent; commercial dental laboratory charges, 30.8 percent; office rent or equivalent mortgage payment, 13.7 percent; and drugs, dental materials and office supplies, 22.9 percent. The last two items had the smallest increases of any items in the *Index*.

By far the largest percentage increase for any item was a 152 percent increase in employee benefit cost, or a 26 percent annual rate of increase.

Among items of lesser importance to total cost, the smallest increase was reported for depreciation, 24.5 percent. All other minor items increased at a faster rate than the *Index* as a whole. These were: interest up 51.3 percent in the four-year period; insurance, 68.3 percent; bad debts, 72.2 percent; repairs, 72.8 percent; travel, dues, and license fees, 76.9 percent; taxes, 81.4 percent; legal fees, 111.5 percent; and, as mentioned, employee benefits, 152.0 percent.

Table 5 shows annual percentage increases by item and the rate of percentage increase for each item over the four-year period. In 1974, the *Index* as a whole increased 10.9 percent compared with an average 7.1 percent increase in the preceding three years. For nearly all items in the *Index,* the largest annual increase over the four-year period occurred in 1974. Among items with comparatively large increases in 1974 over preceding years were utilities, drugs, dental materials and office supplies, employee benefits, and bad debts.

Table 6 shows a comparison between the *Index of the Cost of Conducting a Dental Practice* and the Consumer Price Index for all items and for dentists' fees, converted to a 1970 base year. This comparison shows that dentists' fee increases did not keep pace with the increased cost of practice. In the four-year period, the cost of conducting a dental practice increased 36.3 percent, whereas dentists' fees increased only 22.9 percent and prices in the economy as a whole increased 27.0 percent.

A more detailed explanation of the methodology results are in Appendix A.

Potential Uses of the "Index": Revisions and refinements are a necessary part of the construction and use of any index. As technology and productivity advances are made and become factors in changing dentists' spending patterns,* quantitative asso-

*Inflationary price increases also affect spending patterns differently. Productivity improvements shift demand toward greater cost efficiency, whereas inflation may distort demand toward less cost efficiency. Deflation, similarly, may be distorting in terms of personnel to capital imbalance. The optimum condition is a stable price level with an economic climate conducive to stimulating productivity advances.

ciations in the *Index* no longer reflect base year conditions and cannot be compared with them. For example, improvement in the quality of care resulting from technical advances may induce significant changes in method of performing dental procedures. This can give rise to a different mix, within total expenditures, of the expenditures for supplies, equipment, auxiliaries or amount of office space.

Obsolete practice methods and equipment then drop out of the *Index* and are replaced by items (or sub-items) reflecting this improved technology. If changes are confined to a small sector of the *Index,* the base year can be retained with changes in the relative value of the items. When, in time, limited changes accumulate, the base year expenditure pattern will become obsolete and need to be changed. It is anticipated that changes in weights involving some items will be made over a period of several years. Changes in weights will be more frequent than revision of the base year. A change in the base year is undesirable except when absolutely essential because the purpose of the *Index* is to measure changes from an historical base and historical analysis of trends is more complex with frequent changes of base year.

In addition to the continuous refinement and updating of the *Index* which the Bureau will perform, data generated from the *Index* and dental practice surveys offer wide opportunities for sophisticated statistical analyses. Examples of such studies, which would produce valuable input in serving the information needs of the dental profession, are:

1. Simulation or Model Building

   a. Index on minimum cost of running a practice, providing data on operating a solo practice with no auxiliaries;

   b. Models of cost and productivity indices built on the index of solo practice, adding variable numbers of operatories and types of auxiliaries; and

   c. Combination studies of economies of scale and hypothetical models of optimum practice size under varied conditions.

2. Trend Analysis

   a. Analysis of each expense category to predict trend of future cost. This involves projection of historic data from past surveys and data developed from the *Index;*

   b. Trend line analyses of ratios of expenditures and unit cost of each item to total expenditures, net income and gross receipts. For example, projection of trends, 1960 through 1990;

   c. Trend line analyses of annual percentage changes in cost, by item;

   d. Analysis of item expense ratios of total expenditures, net and gross income, at varied levels of gross receipts. This will contribute to studies of economies of scale and optimum practice size;

   e. Analyses of cost per square foot in relation to expenditure level, gross and net income, also in relation to studies of economies of scale and optimum practice size;

   f. Examination of association between population surrounding practice location and number of patient visits by dentists' age and type of practice; and

   g. Comparison of *Index of the Cost of Conducting a Dental Practice* with

Consumer Price Index for dentists' fees, physicians' fees, hospital charges, medical care, services and all items and projection of historical trends, 1960 through 1990. This study can show inter-relationships between practice operating costs and dental fees and between dental fees, other health care costs and the economy as a whole. It will provide a factual basis for evaluation of dental fees as a factor in inflation within the health care sector and within the economy as a whole.

3. Productivity and Cost Effectiveness

a. Calculation of elasticities of demand for each item in conjunction with developing models of optimum cost effectiveness of a practice under varied conditions;

b. Extension of other analysis to examine relationships between demand for each item and its contribution to dentists' productivity. Identification of factors contributing to greater productivity and measurement of contribution under varied practice conditions can be considered. This study will also differentiate between cost increases incurred by dentists that are inflationary from cost increases that contribute to increased productivity of a dental practice. An example is measurement of association between auxiliaries' salaries and their contribution to increased productivity;

c. Comparisons of cost efficiency of dentists by age group, type of practice, population characteristics and other practice variables; and

d. Study of trends in dentists' productivity and cost effectiveness over time.

The size and scope of the above studies are large, indicating needs for feasibility studies with respect to projects that could be performed by the Bureau itself, or be performed cooperatively with other agencies including the Department of Health, Education, and Welfare, state societies, dental schools, and other research organizations who would be given authorization to utilize data developed in connection with the *Index on Cost of Conducting a Dental Practice.*

Continued refinement and investigation of the feasibility of additional analyses will be major activities of the Bureau during the coming year.

Summary: Expenditures associated with operating a dental practice have been used as a basis for the development of the *Price Index of Cost of Conducting a Dental Practice.*

Using 1970 as a base year, a sample of dentists reported expenditures over a five-year period through 1974. These expenditures were used as the basis for establishing relative weight or value for each item contributing to total expenditures. The *Index* was established by setting 1970 as a base year and applying the relative weights and measurement by cost per unit in each subsequent year. Thus the *Index,* insofar as possible, shows changes in price, rather than expenditures over the five-year period. Previous indices developed by the Bureau have been comparisons of average expenditures not adjusted for quantity of items purchased (*JADA,* July 1976:129). Additionally, by not providing weights for the items, changes reflected in the expenditure index might have reflected changes in size of practices or number of auxiliaries rather than real changes in cost per unit. The *Index* developed and reported here should

be interpreted based on its added sophistication and only highly selective comparisons should be made with the previously reported figures since the statistical methods involved make them basically incompatible.

Total expenditures have risen 53 percent between 1970 and 1974 from an average of $35,672 to $54,448 per year. Of the total expenditure, the percentage accounted for by each of the items has changed little. For example, repairs accounted for 1.1 percent of the total in 1970 and 1.1 percent in 1974. While none of the proportions of total expenditures change significantly, the largest changes are seen in increased proportions accounted for by salaries, benefits, and in decreased proportion accounted for by rent or mortgage.

When the *Index* has been established by applying the relative weights to items, holding 1970 constant as the base year for comparison, the real changes in total costs and item costs can be seen as they have been converted to per unit costs.

The four major total costs to dentists are salaries; commercial dental laboratory charges; drugs, dental materials and office supplies; and office rent or equivalent mortgage payment. Consideration of the *Index,* however, does not indicate that these are where the major changes in costs have occurred. Major increases are employee benefits, 152 percent; legal and professional fees, 111 percent; followed by taxes, 81 percent; repairs, 73 percent; bad debts, 72 percent; and dental society dues and licenses, 77 percent. Thus it can be seen that none of the major cost items have contributed as much to the rising cost of conducting a dental practice when compared to a 1970 base and per unit costs. The enormous increase in employee benefits can best be explained by more incorporated practices and changes in the Keogh plan, increasing the number of employees covered. Other major changes in items may reflect changes in the nature of the business operation of the dental office, requiring more need for legal services and changes in the dynamics of the dental profession, expecting more continuing education, thus more professional travel.

By comparing two price indices—*Cost of Conducting a Dental Practice* and the Consumer Price Index—it is apparent that dental costs have risen more than dental fees during the period from 1970 to 1974, a difference of 36 percent and 23 percent. This difference is not as great as has been apparent in other comparisons which compared expenditures with fees, but is more realistic since they are basically the same type of index.

The *Index* has great value in expressing dentistry's concern for health care costs in a statistical method. Further refinements will be made as the sophistication of the data provided from dental offices improves.

RESOLUTIONS

This report is informational in nature and no resolutions are presented.

Table 1

Expense Items and Measurement Units

Item	Unit of Measurement	Relative Importance (percent)	
1. Office rent or equivalent mortgage payment	per square foot	8.0	
2. Utilities	(see note 1)	3.4	
3. Salaries or commissions of full-time employees	per full-time employee	31.6	
(salary or commission of full-time hygienists)	per full-time hygienist		(5.4)
(salary or commission of full-time laboratory technicians)	per full-time laboratory technician		(1.7)
(salary of full-time dental assistants)	per full-time assistant		(15.3)
(salary of full-time secretary/receptionists)	per full-time secretary/receptionist		(7.7)
(salary or commission of full-time dentists)	per full-time dentist		(1.5)
4. Other salaries	per part-time employee	5.0	
5. Employee benefits not included in salaries	per full-time employee	1.8	
6. Depreciation of dental and office equipment	per square foot	4.6	
7. Insurance related to dental practice	per square foot	1.7	
8. Taxes on business and business property	percentage of gross receipts	3.0	
9. Repairs	per square foot	1.1	
10. Legal and professional fees	(see note 2)	1.1	
11. Interest on business indebtedness	(see note 2)	1.5	
12. Bad debts arising from services	percentage of gross receipts	3.3	
13. Travel to dental meetings, society dues, license fees, etc.	(see note 2)	2.2	
14. Commercial dental laboratory charges	(see note 3)	16.5	
15. Drugs, dental materials and office supplies	(see notes 4 and 5)	15.2	
Drugs	(see note 4)		(2.84)
Dental materials	(see note 5)		(9.12)
Office supplies	(see note 4)		(3.24)
All items		100.0	

Notes:

1. Utilities index was derived from Consumer Price Index for utilities.
2. Dollar amount of expenditures is the unit of measurement.
3. Index derived from Laboratory Procedures Price Index described in *Transactions, 1975,* p. 207, based on surveys of the National Association of Dental Laboratories.
4. Indices for drugs and office supplies derived from Wholesale Price Index, Bureau of Labor Statistics.
5. Index for dental materials derived from Dental Supplies Price Index, described in *Transactions, 1975,* p. 207.

Table 2

Average Expenses by Item

	Item	1970	1971	1972	1973	1974
1.	Office rent or equivalent mortgage payment and utilities	$ 4,076	$ 4,263	$ 4,591	$ 4,976	$ 5,367
2.	Salaries or cammission paid to employees	13,054	14,063	16,129	18,336	20,832
3.	Employee benefits (not included in solaries)	625	797	1,035	1,367	1,514
4.	Insurance related to dental practice	594	658	753	818	917
5.	Depreciation of dental and office equipment	1,650	1,667	1,832	1,945	2,214
6.	Taxes on business and business property	1,071	1,154	1,292	1,364	1,546
7.	Interest on business indebtedness	535	591	732	869	1,069
8.	Repairs	383	402	476	510	583
9.	Legal and professional fees	409	462	592	689	775
10.	Bad debts arising from services	1,197	1,256	1,327	1,477	1,708
11.	Travel to dental meetings, society dues, license fees, etc.	787	902	981	1,055	1,169
12.	Commercial dental laboratory charges	5,875	6,328	7,024	7,756	8,736
13.	Drugs, dental materials and office supplies	5,416	5,792	6,408	7,012	8,018
	Total	$35,672	$38,335	$43,172	$48,174	$54,448

Table 3

Item Expenses as Percentage of Total Expenses

	Item	1970	1971	1972	1973	1974
1.	Office rent or equivalent mortgage payment and utilities	11.4	11.1	10.6	10.3	9.9
2.	Salaries or cammissions paid to employees	36.6	36.7	37.4	38.1	38.3
3.	Employee benefits (not included in salaries)	1.8	2.1	2.4	2.8	2.8
4.	Insurance related to dental practice	1.7	1.7	1.7	1.7	1.7
5.	Depreciation of dental and office equipment	4.6	4.4	4.2	4.0	4.1
6.	Taxes on business and business property	3.0	3.0	3.0	2.8	2.8
7.	Interest on business indebtedness	1.5	1.5	1.7	1.8	2.0
8.	Repairs	1.1	1.0	1.1	1.1	1.1
9.	Legal and professional fees	1.1	1.2	1.4	1.4	1.4
10.	Bad debts arising from services	3.3	3.3	3.1	3.1	3.1
11.	Travel to dental meetings, society dues, license fees, etc.	2.2	2.4	2.3	2.2	2.1
12.	Commercial dental laboratory charges	16.5	16.5	16.3	16.1	16.0
13.	Drugs, dental materials and office supplies	15.2	15.1	14.8	14.6	14.7
	Total	100.0	100.0	100.0	100.0	100.0

Table 4

Price Index of Cost of Conducting a Dental Practice, 1970-1974

	Item	Relative Importance (percent)	Index (1970 = 100)				
			1970	1971	1972	1973	1974
1.	Office rent or equivalent mortgage payment	8.0	100.0	101.5	104.6	109.3	113.7
2.	Utilities	3.4	100.0	106.9	111.6	117.9	139.6
3.	Salaries or commissions paid to employees	36.6	100.0	105.3	112.7	120.3	128.8
4.	Employee benefits (not included in salaries)	1.8	100.0	117.1	157.6	186.8	252.0
5.	Insurance related to dental practice	1.7	100.0	118.6	132.8	153.3	168.3
6.	Depreciation of dental and office equipment	4.6	100.0	108.0	115.5	116.6	124.5
7.	Taxes on business and business property	3.0	100.0	120.2	138.2	153.1	181.4
8.	Interest on business indebtedness	1.5	100.0	104.5	124.9	135.9	151.3
9.	Repairs	1.1	100.0	114.3	139.2	145.0	172.8
10.	Legal and professional fees	1.1	100.0	126.4	145.4	175.4	211.5
11.	Bad debts arising from services	3.3	100.0	113.7	126.8	139.3	172.2
12.	Travel to dental meetings, society dues, license fees, etc.	2.2	100.0	120.9	144.9	158.1	176.9
13.	Commercial dental laboratory charges	16.5	100.0	106.0	111.9	118.2	130.8
14.	Drugs, dental materials and office supplies	15.2	100.0	102.3	104.3	108.7	122.9
	All items	100.0	100.0	106.8	114.8	122.9	136.3

Table 5

Annual Percentage Increases and Average Rate of Increase in Cost of Items

	Item	Annual Rate of Increase 1970-1974 (percent)	Percentage Increase from Previous Year			
			1971	1972	1973	1974
1.	Office rent or equivalent mortgoge payment	3.3	1.5	3.1	4.5	4.0
2.	Utilities	8.7	6.9	4.4	5.6	18.4
3.	Salaries or commissions paid to employees	6.5	5.3	7.0	6.7	7.1
4.	Employee benefits (not included in salaries)	26.0	17.1	34.6	18.5	34.9
5.	Insurance related to dental practice	13.9	18.6	11.2	15.4	9.8
6.	Depreciation of dental affice equipment	5.6	8.6	6.9	1.0	6.8
7.	Taxes an business and business property	16.1	20.2	15.0	10.8	18.5
8.	Interest on business indebtedness	10.9	4.5	19.5	8.8	11.3
9.	Repairs	14.7	14.3	21.8	4.2	19.2
10.	Legal and prafessional fees	20.6	26.4	15.0	20.6	20.6
11.	Bad debts arising from services	14.6	13.7	11.5	9.9	23.6
12.	Travel ta dental meetings, society dues, license fees, etc.	15.3	20.9	19.9	9.1	11.9
13.	Commercial dental laboratory charges	7.0	6.0	5.6	5.6	10.7
14.	Drugs, dental materials and office supplies	5.3	2.3	2.0	4.2	13.1
	All items	8.0	6.8	7.5	7.1	10.9

Table 6

Comparison of Index of Cost of Conducting a Dental Practice and Consumer Price Index for Dentists' Fees and All Items

Year	Index of Cost of Conducting a Dental Practice (1970 = 100)	Consumer Price Index (1970 = 100)*	
		Dentists' Fees	All Items
1970	100.0	100.0	100.0
1971	106.8	106.4	104.3
1972	114.8	110.8	107.7
1973	122.9	114.2	114.4
1974	136.3	122.9	127.0

*Source: Bureau of Labor Statistics, US Department of Labor.

APPENDIX A

INDEX OF COST OF CONDUCTING A DENTAL PRACTICE

Technically, the *Index* may be described as a weighted aggregative index number with fixed or constant annual weights. "Weighted aggregative" means the *Index* consists of weighted subindices for each item, such as rent, salaries, etc. The *Index of Cost of Conducting a Dental Practice* equals the sum of all subindices. But the subindices also are independent of the total index and annual percentage change in the price of each item can be calculated from them.

Reported items in the *Index* are measured from the base year 1970, for which the total value of all items is set equal to 100. Each item has a relative value or weight based on the percent of the total expenditures that item represents. Thus, if average rental expenses were $3,000 and total expenses were $30,000, the fixed weight assigned to rental expenses is 10, since it is 10% of the total expense.

The conversion to expenditures per unit makes possible a time series comparison of the prices of items purchased in the base year. Measurement is made of the increase in the cost of each item without regard to the expected growth of practice size. While it is recognized that, every year, some dentists will be increasing the size and scale of their practice, the structure of the average practice has remained essentially the same during a five-year period. Therefore, unit cost in the time series is affected only to some extent by economies of growth in scale (availability of quantity discounts, more efficient deployment of resources).

Explanation of the Index Formula: The statistical method employed in constructing the *Index* is similar to that used in the Consumer Price Index and other economic indices. In the absence of major weight revisions, the *Index* formula is most simply expressed as:

$$I_{i:0} = \frac{\sum_{j=1}^{n} (q_{0j}p_{ij})}{\sum_{j=1}^{n} (q_{0j}p_{0j})} \times 100 \qquad (1)$$

Definition of symbols in the above equation are:

$I_{i:0}$ = index number in period i based on weights of the base year

q_{0j} = amount of item j consumed in the base year

p_{ij} = price of item j in period i

o = the base year.

In the base year $p_i = p_o$, therefore

$$I = 100$$

In equation 1, if we fix the base year price of all items at 100, we can rewrite it as follows:

$$I_{i:o} = \frac{\sum_{j}^{n} q_{oj}p_{ij}}{\sum q_{oj}} = \sum_{j=1}^{n} (W_{oj}p_{ij}) \qquad (2)$$

where

$$W_{oj} = \frac{q_{oj}}{\sum q_{oj}} \text{ and } \sum_{j=1}^{n} W_{oj} = 1$$

W_{oj} = the weight of item j in the base year o

p_j = the relative price of item j.

According to equation 2, the total cost index in year i is the sum of the weighted relative price of all items; the relative price is now used instead of the absolute price because of the decision to fix the price in the base year to 100. This affords the advantage of having, as results, an index of individual items as well as an *Index* of total cost.

When dentists' expenditure patterns change significantly, a change in weighing structure seems needed; the *Index* can be calculated using the following formula:

$$I_{i:o} = \frac{\sum p_o p_{i-s}}{\sum q_o p_o} \times \frac{\sum q_a p_i}{\sum q_a p'_{i-s}} \times 100 \quad \text{or}$$

$$I_{i:o} = \frac{I_{i-s:o} \times I_{i:i-s}}{100}$$

where

$i - s$ = the period where the weight revision occurs

q_{aj} = the revised weight of item j

p, p' = the average price of each item, the subscript indicates that these prices are not necessarily derived from the same sample

$I_{i:i-s}$ = calculated as the sum of weighted relative price of all items, the weights being the new weights and the relative price is calculated based on price in period i - s equal 100.

Supplemental Results: The major results are presented in the text. These results are presented as alternate methods of considering the results and as an in depth examination of subindices.

Table A-1 shows the percentage of average expense for each item in each year from 1970 through 1974. For example, a set of quantity of repairs which "costs" 1.1 in 1970 will cost 1.26 in 1971. The same quantity, valued at 100 in 1970, will "cost" 106.9 in 1971.

Table A-2 shows the salary index by type of employee. Salary increases for various categories of auxiliaries varied between 25.3 percent and 31.0 percent over the four-year period, with the largest increase reported for laboratory technicians. Salaries paid to dentists employed by other dentists registered a cumulative four year increase of 50.6 percent.

Table A-3 shows the percentage increase in each year for each salary category for those dentists who pay employees, and Table A-4 shows the amount a dentist would have to pay for the same quantity of employee in each year.

Table A-5 shows a breakdown of the three separate subindices that comprise the items "drugs, dental materials and office supplies," which as a whole, increased 22.9 percent between 1970 and 1974. Separately, the subindices for these items increased as follows: drugs, 11.4 percent; dental materials, 22.9 percent; and office supplies, 33.1 percent.

Table A-6 shows the percentage increase for each item of the drugs, dental materials, and office supplies; Table A-7 shows the value of the same quantity of these items in each of the years.

Table A-1

Value of Component Items

Item	Relative Importance (percent)	1970	1971	1972	1973	1974
1. Office rent or equivalent mortgage	8.0	8.00	8.12	8.37	8.74	9.10
2. Utilities	3.4	3.40	3.63	3.79	4.00	4.75
3. Salaries or commissions paid to employees	36.6	36.60	38.69	41.43	44.54	47.49
4. Employee benefits (not included in salaries)	1.8	1.80	2.10	2.84	3.36	4.53
5. Insurance related to dental practice	1.7	1.70	2.03	2.26	2.61	2.87
6. Depreciation of dental and office equipment	4.6	4.60	4.96	5.31	5.36	5.73
7. Taxes on business and business property	3.0	3.00	3.61	4.15	4.59	5.44
8. Interest on business indebtedness	1.5	1.50	1.57	1.87	2.04	2.27
9. Repairs	1.1	1.10	1.26	1.53	1.60	1.90
10. Legal and professional fees	1.1	1.10	1.39	1.60	1.93	2.33
11. Bad debts arising from services	3.3	3.30	3.75	4.18	4.60	5.68
12. Travel to dental meetings, society dues, license fees, etc.	2.2	2.20	2.65	3.19	3.48	3.89
13. Commercial dental laboratory charges	16.5	16.50	17.49	18.46	19.49	21.58
14. Drugs, dental materials and office supplies	15.2	15.20	15.55	15.86	16.53	18.69
All items	100.0	100.00	106.80	114.84	122.87	136.25

Table A-2

Index of Salaries or Commissions Paid to Employees, by Type of Employee

Item	Relative Importance (percent)	Index (1970 = 100)				
		1970	1971	1972	1973	1974
All salaries or commissions paid to employees	36.6	100.0	105.3	112.7	120.3	128.8
Salaries or commissions of full-time employees:						
Dentists	1.5	100.0	108.2	120.8	135.2	150.6
Hygienists	5.4	100.0	104.6	112.0	117.5	125.9
Dental assistants	15.3	100.0	105.1	111.8	119.6	128.1
Laboratory technicians	1.7	100.0	105.1	113.4	121.7	131.0
Secretary/receptionists	7.7	100.0	104.9	111.8	119.1	128.1
Other salaries	5.0	100.0	111.7	118.6	132.8	135.1

Table A-3

Annual Percentage Increases of Salaries or Commissions Paid to Employees, by Type of Employee

Item	Annual Rate of Increase 1970-1974 (percent)	Percentage Increase from Previous Year			
		1971	1972	1973	1974
All salaries or commissions paid to employees	6.5	5.3	7.0	6.7	7.1
Salaries or commissions of full-time employees:					
Dentists	10.8	8.2	11.6	11.9	11.3
Hygienists	5.9	4.6	7.1	4.9	7.1
Dental assistants	6.4	5.1	6.4	7.0	7.1
Laboratory technicians	7.0	5.1	7.9	7.3	7.6
Secretary/receptionists	6.4	4.9	6.6	6.5	7.6
Other salaries	7.8	11.7	6.1	12.0	1.7

Table A-4

Value of Component Salary Items, by Type of Employee

Item	Relative Importance (percent)	1970	1971	1972	1973	1974
All salaries or commissions paid to employees	36.6	36.60	38.67	41.43	44.54	47.49
Salaries or commissions of full-time emplayees:						
Dentists	1.5	1.50	1.62	1.81	2.03	2.24
Hygienists	5.4	5.40	5.53	6.05	6.34	6.80
Dental assistants	15.3	15.30	16.08	17.10	18.30	19.59
Laboratory technicians	1.7	1.70	1.79	1.93	2.07	2.23
Secretary/receptionists	7.7	7.70	8.07	8.61	9.17	9.87
Other salaries	5.0	5.00	5.58	5.93	6.63	6.76

Table A-5

Index of Drugs, Dental Materials and Office Supplies

Item	Relative Importance (percent)	Index (1970 = 100)				
		1970	1971	1972	1973	1974
All drugs, dental materials and office supplies	15.20	100.0	102.3	104.3	108.7	122.9
Drugs	2.84	100.0	101.2	101.8	103.1	111.4
Dental materials	9.12	100.0	102.4	104.9	108.9	122.9
Office supplies	3.24	100.0	103.1	105.0	113.0	133.1

Table A-6

Annual Percentage Increases of Drugs, Dental Materials and Office Supplies

Item	Annual Rate of Increase 1970-1974 (percent)	Percentage Increase from Previous Year			
		1971	1972	1973	1974
All drugs, dental materials and office supplies	5.3	2.3	2.0	4.2	13.1
Drugs	2.7	1.2	0.6	1.3	8.1
Dental materials	5.3	2.4	2.4	3.8	12.9
Office supplies	7.4	3.1	1.8	7.6	17.8

Table A-7

Value of Component Items: Drugs, Dental Materials and Office Supplies

Item	Relative Importance (percent)	1970	1971	1972	1973	1974
All drugs, dental materials and office supplies	15.2	15.20	15.55	15.86	16.53	18.69
Drugs	2.8	2.80	2.89	2.91	2.95	3.18
Dental materials	9.1	9.10	9.30	9.53	9.89	11.17
Office supplies	3.3	3.30	3.36	3.42	3.69	4.34

BUREAU OF ECONOMIC RESEARCH AND STATISTICS: SUPPLEMENTAL REPORT 2

Effect on Dental Distribution of Total Reciprocity: Pursuant to Resolution 104 (*Trans.* 1975:720 and *Reports* 1976:198) adopted by the House of Delegates, the Bureau of Economic Research and Statistics was asked to conduct a comprehensive study of all aspects of the potential impact of a redistribution of dentists that would result from a system of national reciprocity. The Resolution further asks that the study include consideration of the ramifications of existing and pending federal legislation affecting dentistry and that special emphasis be placed on input to the study from the American Association of Dental Examiners and constituent societies of the American Dental Association.

Objectives of this Study: It is assumed that the intent of Resolution 104 is to: (1) assess conditions likely to prevail if there is enactment of national reciprocity and, in so doing, to identify and assess the impact of various socioeconomic factors on private decisions to relocate; (2) forecast what the resulting pattern of redistribution will be; and (3) assess the impact of the resulting redistribution on the dental profession and private practice.

It should be noted that, in a nation where professional licensure has been historically linked to state jurisdiction, there is no available mechanism that could predict with certainty what the precise effects will be of new, more nationally oriented licensure arrangements.

The patterns of the past, however, can provide significant information on what has happened under the existing situation. This information could, employed with due caution, be of use in judging whether those discernible trends of the past would be intensified, diminished or unchanged in the future if new conditions of licensure are postulated.

In order to implement the objectives of this study, the trend of interstate dentist movement in the past was analyzed and is presented in this report as a basis for exploring the validity of forecasting future trends under a system of national reciprocity. Further data on motivation and behavior with respect to choice of a practice location would need to be developed in regard to dentists as a group in conjunction with cost data on relocating a dental practice, if comprehensive comments are to be made. The next step should be obtaining the response of dentists to opportunities for relocation when they are presented with data on the cost of relocation. With these or similar data bases, a projection of probable dentist movement under national reciprocity could be developed for five, ten and possibly twenty years into the future.

Concept of National Reciprocity: For purposes of this study, national reciprocity is defined in the most extreme fashion without having numerous conditions attached to it. The definition used in this study is: that the laws permit complete freedom of movement across state lines to all dentists licensed to practice by any state or regional authority. Initially, no other qualifying conditions are considered.

Existing and pending legislation affecting reciprocity will be summarized later in this report. Forecasts under the above definition should be modified to show expectations under those provisions more likely to be approved by Congress, if any are enacted at all.

The above definition does not go beyond the concept of voluntary relocation. It does not consider the implications of explicitly coercive measures. To do so would require a study of much broader scope. However, it is recognized that implicit coercion can be present to varied degrees in any legislation, depending on how the laws are shaped and implemented.

Trend of Population and Dentist Interstate Moves Since 1950: Over a long period of time, the redistribution of dentists among the states has followed, to some extent, trends in the redistribution of the general population. Table 1 examines the operation of this concept over the past quarter century. This table shows percentage increases in the population, by state, from 1950 to 1975 and percentage increases in the number of living dentists, by state, from 1952 to 1976[1]. In both instances, the population of living dentists was compared, as listed by state, in the Association's Directory. The number of living dentists was used instead of the number of practicing dentists, since at the time of the study it was a more reliable measure.

The most important shift in the distribution of the general population since 1950 has been movement from eastern and middle western states to the so-called "sun belt".[2] Certain, though not all, sun belt states have experienced impressive population gains since 1950. The total population of California, Arizona, Arkansas and Florida increased between 100 and 202 percent while the national average increase in total population over this period was 40 percent. Only two states outside the sun belt, Nevada and Alaska, equalled or surpassed the growth rate of the above four states.

Some parallels with the general population can be drawn from the dentist data in Table 1. The largest percentage increases in the number of dentists between 1952 and 1976 were in Arizona, 337%; Nevada, 262%; Florida, 257%; South Carolina, 172%; New Mexico, 134%; Maryland, 130%; Virginia, 125%; Georgia, 120%; and Texas, 105%. In many states the dentist gain, expressed by percentage, exceeded the population gain, thus improving the dentist-population ratio. In some states- including California, Oregon, Wyoming and Arkansas—the opposite effect has occurred. Other states—including Iowa, Missouri, Illinois and Nebraska—had fewer dentists in 1976 than they did in 1952.

Interstate Relocation of Dentists Between 1971 and 1975: In presenting this study as part of a comprehensive study on the future distribution of dentists under changed conditions, it is recognized that past experience may offer only limited guidance in this task. However, if complete reciprocity should occur or, as seems more likely, reciprocity with specific conditions attached, some conclusions drawn from past experience can be expected to retain their validity.

Even with complete freedom to relocate, the following conditions are considered virtually axiomatic with respect to the overall behavior of dentists: (1) a location must reasonably satisfy the dentist's practice and income objectives; (2) the community environment must reasonably satisfy the dentist's personal and family needs for educational, recreational, cultural and social participation or expression. However, a limited percentage may be willing to sacrifice these objectives for other advantages

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[1]The years are not identical because of the lack of availability of the interstate distribution of dentists for 1950, but the comparison is valid enough to show redistribution trends over the past quarter century.

[2]In this report, the "sun belt" is defined as the following fourteen states: Virginia, North Carolina, South Carolina, Georgia, Florida, Alabama, Mississippi, Louisiana, Arkansas, Texas, New Mexico, Arizona, California and Hawaii.

(including personal work satisfaction), at least temporarily; (3) once an independent practice is established, there are cost barriers as well as familial and social ties restraining mobility for a community.[3] However, this factor must be weighed against mobility tendencies of the general population, particularly the continued trend of population movement to the South and Southwest regions of the country, and it must be weighed as well against the continuing process of community change (aspects of which are urban neighborhood change and growth of suburbs); (4) keeping in mind the preceding mobility tendencies, dentists maintaining successful established practices would not be motivated to utilize mobility opportunities in substantial numbers while conditions in their communities remain stable or are improved, and while their personal goals are unaltered. In all instances, the significant costs a dentist would encounter in closing a practice in one location and beginning one elsewhere must be kept in mind.

Description of Data: Data on all known interstate moves by dentists during the years 1971 through 1975 were supplied by the Association's Bureau of Data Processing and Membership Records. The following types of dentists were included in the study: those in private practice, either general practice or as one of the following specialists—oral surgeon, orthodontist, endodontist, periodontist, pedodontist and prosthodontist—who remained in their particular status of practice for a full calendar year during the period studied, 1971 through 1975.

The last condition stated above was important in order to assure that: (1) individuals transferring from student to professional status and, (2) those transferring from active to retired dentist during a calendar year were not counted in the study. The following were excluded from the study: (1) dentists in the federal services; (2) retired, life, associate, honorary, graduate, resident, intern and student members of the Association; (3) full time faculty of dental schools, dentists in state public health programs, administrators and dentists known to be retired from active practice (not included above) and those engaged in other occupations; and (4) oral pathologists and public health dentists, because of their small number and the possibility of relocation due to transfer within public employment or change of status from public employment to private practice.

The source of the data utilized was the Association's name and address file, which contains entries on all known living dentists and is updated at least once a month. The following data were collected on dentists included in the study, on whom an address change to another state was reported in the file (either by the dentist, post office, etc): the dentist's age; the state from which the dentist moved; the state to which the dentist moved; and the calendar year in which the move occurred. Collection of these data took place in February 1976.[4]

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[3] It appears that studies documenting this point are not available. However, the costs connected with disposal of an established practice and acquisition of a practice at a new location are important determinants of decisions to relocate. Later in this report it is suggested that such cost studies be made to provide data for a comprehensive understanding of mobility.

[4] Although the data source was the best available, it should be noted that the Association's name and address file did not distinguish practicing from nonpracticing dentists or between practice and home address. It does so only for dentists who have notified the Association of such changes. The data in the study are therefore overstated to some extent because of the inclusion of some retired dentists. While the use of age data partially compensates for this limitation, the problem will be resolved only with completion of the 1976 Survey of the Distribution of Dentists.

Results: A total of 7,089 interstate moves of dentists over the five-year period, 1971 to 1975 inclusive, were identified as meeting the criteria of the study. Of these, approximately 98% were moves between the fifty states. The remaining 2% were moves between states and US territories or possessions or foreign countries. The number of interstate moves averaged 1,418 per year, which amounts to an interstate relocation rate annually of 1.4% of the dentist population assumed to be engaged in private practice.[5]

Table 2 shows the annual number of moves into and out of each state and census region, and the net gain or loss resulting from interstate moves. Table 3 shows the ratio of dentists gained to those lost in interstate moves by state and region over the five-year period. The regional ranking by this ratio is as follows:

Census Region	Number of Dentists Gained in Interstate Moves 1971–1975	Number of Dentists Lost in Interstate Moves 1971–1975	Ratio of Dentists Gained to Lost in Interstate Moves 1971–1975
Mountain	659	321	2.1 to 1
South Atlantic	1,750	1,080	1.6 to 1
New England	655	457	1.4 to 1
West South Central	503	423	1.2 to 1
Pacific	865	744	1.2 to 1
West North Central	493	698	0.7 to 1
East South Central	304	422	0.7 to 1
Middle Atlantic	1,078	1,696	0.6 to 1
East North Central	625	1,076	0.6 to 1

This means that the states within the Mountain region gained two dentists for every one lost through interstate moves. The data by state was more revealing. States with the highest ratios were New Hampshire (4.4 to 1), Florida (4.1 to 1), Arizona (4.0 to 1) and Arkansas (3.0 to 1); and with the lowest Illinois (0.4 to 1), New York (0.5 to 1), Nebraska (0.5 to 1) and District of Columbia (0.5 to 1). In Table 4, the states were ranked by size of net gain or loss during the five-year period. For most states, the magnitude of net gains or losses was between 0 and 50 dentists. Florida had by far the largest net gain, with 678 dentists over the five-year period. It is followed by Arizona with a net gain of 163. Colorado, California and Arkansas each had a net gain of 50 to 100 dentists.

In the middle range, 24 states each had a net gain of 0 to 49 dentists. Thirteen states each had a net loss of 1 to 50 dentists. New York had the largest net loss, 553 dentists, and was followed by Illinois with 241.

The data by age group (Table 5) give a more definitive answer to the question of which dentists are relocating across state lines. The percentage distribution by age group of all interstate moves in the study was:

Age Group	Percentage of All Interstate Moves 1971–1975
Under 40	72%
40 to 55	15%
Over 55	13%

This indicates that the dentists most inclined to move to another state tend to be

[5]Since it is known that the data include some retired dentists, the 1.4% annual relocation rate may overstate the percentage of practicing dentists annually involved in interstate moves between 1971 and 1975.

those who are younger and less established in practice. Other studies indicate that many of these dentists may be salaried and/or recent graduates with little or no investment in an independent practice. Recent graduates also would have experienced less difficulty in meeting licensure requirements. Some moves may reflect dentists moving from temporary positions to a permanently established practice. Many states also accept licenses from other states if the dentist has five years of qualified experience. Many dentists in this age category fit this condition.

The data by age group also indicate the extent to which states with dental schools are supplying dentists to states without schools. Recent graduates may enter practice in the state where they received training, remain for a few years and then settle into permanent practice in another state. This pattern is undoubtedly present among the under-40 age group, constituting 72% of interstate moves. This is a necessary pattern to some extent since 33 states with dental schools are supplying dentists to all 50 states. It helps explain why New York, Pennsylvania, Illinois, Ohio, Missouri and certain other states with several dental schools are losing young dentists.[6] However, California, with an enrollment of nearly 2,000 dental students in 1975, had a net gain of younger dentists moving into the state during the period studied.[7]

Data on the over-55 age group show that a relatively small percentage is making interstate moves prior to full retirement. To some extent, this may be due to the difficulty of examinations and other procedures necessary for licensure in another state. It is suggested that this problem and the extent to which it exists be documented by further study.

Table 6 shows the ratio of dentist gains to losses by region and state for the over-55 age group. It is noted that there are some extreme ratios in this table because of the small number of moves recorded. It is evident, even from the small amount of data, that dentists over 55 are following the trend of population movement into the "sun belt" states. For example, Arizona gained 20 dentists in this age group for every one lost; Arkansas, 13; Florida, 9; Idaho, 8; Nevada, 7; and Mississippi, 5. By contrast, New York and Illinois lost 10 dentists over the age of 55 for every one gained, and Ohio lost 5, while Michigan, Minnesota, Nebraska, South Dakota and West Virginia each lost 3. There were no recorded moves of dentists over 55 to Wyoming or Alaska.

Table 7 shows the number of moves by dentists into and out of each state, by origin and destination of move, over the five year period. It restates in greater detail data in preceding tables. It shows, for example, that 315 dentists moved from New York to Florida and that many relocations are between neighboring states. These detailed statistics show the varied directions in which dentist relocations have been taking place.

Table 8 is an analysis of data on the state of Missouri as an example of how Table 7 may be used. The analysis traces the destination of 241 moves out of the state and the origin of 144 moves into the state, with the other states classified as "adjacent", "sun belt" and "other".

Review of Existing Reciprocity Mechanisms: Under present state laws, recognition of licenses granted by other states is accomplished through one or a combination of the following mechanisms:

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[6]These states are examples of states with more than one dental school that experienced a net loss of dentists under 40 through interstate moves between 1971 and 1975.

[7]The Council on Dental Education comments that California, as do other states with multiple dental schools, supplies numerous California trained dentists under 40 to other states, but at the same time California has gained many dentists under 40 from other states.

(1) Criteria approval—License is granted to a previously licensed dentist without complete examination based on the discretionary acceptance of specific credentials. Typically these are: (a) clearance from state board that granted previous license; (b) recommendation of local dental society in former practice location; and (c) personal interview by state board having jurisdiction in the applicant's new practice location.

(2) Licensure by credentials- License is granted on the basis of performance record in place of examinations. The procedure *may* include any of the above discretionary criteria in addition to requiring that: (a) the applicant has been in practice or full-time dental education for a minimum of a specified number of years immediately prior to applying; (b) is endorsed by the state board and appropriate committee of the constituent society in the state of current practice; (c) is not the subject of final or pending disciplinary action; or (d) has not failed the clinical examination of the state to which he is applying in the last three years.

(3) Licensure by examination -In addition to requiring some of the criteria specified in items 1 and 2 above, license is granted on the basis of performance in clinical and/or written reexamination. Certain states waive retaking of portions successfully completed within a specified number of years. Most states accept successful completion of National Board examinations and regional clusters of states accept results of examinations given by the North East Regional Board, Central Regional Testing Service and the recently inaugurated Southern Regional Testing Service.

Appendix I, obtained from the American Association of Dental Examiners, lists the states that have provisions for recognizing licenses obtained from other states.[8] It is apparent from the language in Appendix I and from the above mechanisms that interstate recognition of licenses is not an automatic procedure. On the contrary, authority to review and approve applications is vested in the state boards. Under national reciprocity, functions of the state boards, which are essentially to insure that qualified individuals are licensed to provide dental care, would presumably be assigned to other agencies or to a single agency or altered in other ways. Old restraints to mobility could reemerge in different guises and new restraints could be imposed arising from administrative problems in maintaining professional quality standards. The Association's Commission on Licensure, consisting of representatives from each Trustee District, has the responsibility for recommending improved licensure guidelines. It is noteworthy that the Commission reviewed House disposition in 1975 of resolutions related to the freedom of interstate movement for licensed dentists and considered Resolution 104 in particular. The Commission's observations are presented in Appendix II. To summarize briefly, the Commission noted that the matter of distribution or potential redistribution of dentists should not be linked to any system of licensure. A study by the AADE was also cited, which found that dentists relocate more frequently than pharmacists, even though pharmacy has greater flexibility in recognizing licenses issued in other states.

[8]It is noted that in some states where reciprocal recognition of licensure agreements is in effect, it is no more difficult for dentists from states not included in such agreements to obtain licensure, than it is for dentists from states included in such agreements. In no cases do states having reciprocal agreements with other states *automatically* recognize licences from those states. Applicants seeking to be licensed in states that have reciprocal agreements with the applicant's state of origin must follow some of the procedures specified above in licensure by criteria approval, credentials or examination.

Federal Legislation Affecting the Distribution of Dentists: The following information on the status of federal legislation as of October, 1976 was obtained from Mr. Bernard J. Conway, Assistant Executive Director: Legislation and Legal Affairs, and from the Association's Washington Office.

Neither existing nor pending legislation, as of October, 1976, would have effect on licensing procedures administered by state boards of dentistry. Indirectly, the National Health Service Corps program does have an impact on assignment of dentists to federally designated shortage areas. There are currently 746 such areas in the United States as determined by the Department of Health, Education, and Welfare.

On October 13, 1976, President Ford signed into law the Health Professions Education Assistance Act. The law is a compromise measure which received final approval after a House-Senate Conference Committee agreed to delete or modify most of the provisions that were opposed by the Association and other major health groups. Among the deleted provisions were those authorizing the HEW secretary to develop national licensure and relicensure standards for dentistry and medicine, including standards for professional examinations. There are no provisions in the present law related to reciprocity or any other aspect of dental licensure.

Funds to considerably increase the National Health Service Corps (NHSC) scholarship program are included in this new law. It authorizes $140 million for the scholarship program in Fiscal Year 1977 and $200 million in Fiscal Year 1978, of which 90% is authorized for scholarships in medicine, osteopathy and dentistry. The dental portion of these funds will be not less than 10% of the authorization to the above three professions. This amounts to a minimum of $12.6 million authorized for NHSC scholarships to dentists in the fiscal year ending September 30, 1977. The new law also requires that the HEW Department complete a revised designation of shortage areas by May, 1977. The new law lessens the role of the local dental society with respect to placement of a NHSC dentist. Previously, if the dental society disapproved of a placement, the Secretary could overrule such a veto only on a formal review basis. Now, the Secretary is required only to consult with the society.

It can be expected that many dental students will consider these scholarships highly desirable since they provide a stipend for living costs as well as coverage of tuition and other costs of education. In two or three years, this could result in the production of far more graduates committed to National Health Service Corps. If that occurs, there is then the possibility that HEW would designate additional shortage areas by liberalizing present criteria. This has already been foreshadowed by HEW statements concerning the need to examine sections of urban centers as potential shortage areas as well as rural, isolated communities.

Additional Information Needed for Projecting Future Distribution of Dentists: To provide an adequate basis for forecasting a redistribution of dentists under a system of national reciprocity, the preliminary steps outlined below must be taken. The most useful type of forecasts would be those allowing for variable definitions of reciprocity, variable assumptions of population distribution, and variable assumptions about dentists' responses to mobility opportunities. Assumptions on population variables would utilize projections developed by the Bureau of the Census. Data on potential dentists' response to reciprocity could be developed in the following way:

(1) An in-depth study of a dentist sample would be made, selected by age and geographic location, consisting entirely of dentists who relocated their practices

within the last five years. The study should provide an in-depth probe of reasons for relocation and the extent to which expectations were realized.

(2) Participants in the above study would be asked to furnish economic and cost data relating to their moves. These would provide "before and after" data on variables such as: (a) income; (b) cost of disposing of established practice at previous location; (c) method or sequential steps taken in doing so; (d) cost of establishing or acquiring a practice at new location and steps taken in doing so, including data on indebtedness accrued, capital outlays, and operating expenses.

The above study would provide useful information of a descriptive nature, but it should be carefully noted that the results still would be highly speculative about movement that might occur under national reciprocity and would have these important limitations regarding its usefulness in predicting future movement: (1) a study of past moves would not provide data on dentists who considered, but decided against relocating under the present system of restrictions. If national reciprocity were to be enacted, data about this group would be of great significance; (2) a study of past moves very likely would not give adequate consideration to caess where relocation was tried and did not prove to be feasible for the dentist. Analysis of such cases are essential to a soundly conceived forecast of movement under conditions of national reciprocity, since it is expected that such cases would increase under national reciprocity.

A study of past experience would enable us to understand more about the interstate movement of dentists, but it would not provide data on all measurable parameters needed for a projection of future movement under national reciprocity. *At best, the possible projections that could be made, supported by preliminary studies of past experience under the present system, would have a low level of confidence as a predictor of the probable movement of dentists under national reciprocity.*

The cost of a retrospective, descriptive study as outlined above is estimated to be about $10,000 if performed by the Bureau. While this study would provide considerable information about dentist movement, in our judgment it is not a feasible basis for projecting future movement under a system of national reciprocity. Staffing, in addition to project costs, are a limitation due to previously scheduled projects for 1977.

Summary Findings of This Study: Evidence from legislative review does not indicate that a system of national reciprocity is likely in the foreseeable future. Thus, these summary findings are made prior to a determination of what system of reciprocity has the best probability of being enacted; they tend to sum up what might be learned from past experience covered in this report: (1) the overall pattern of movement by dentists would tend to follow that of the general population, but would be subject to important considerations suggested below; (2) an extreme system that maximizes mobility possibilities will tend to accelerate movement to "attractive" practice locations in terms of such considerations as practice characteristics, income potential, climate, and educational and cultural advantages. A sequel to this could possibly be shortages in "less attractive" areas where it is difficult to practice preferred type of dentistry and obtain an income, leading to a potentially greater increase in federal intervention.

Projection of relocation of dentists in the future with only the barrier of licensure removed would be speculative at best since information on dentists' mobility, on

population trends and dental health needs in addition to any new data needed regarding cost of relocation and attitudinal factors affecting mobility, all of which affect dentists' relocation, are lacking.

The Bureau recommends obtaining more descriptive information on factors associated with mobility, but does not feel a comprehensive study projecting future conditions under national reciprocity is feasible.

APPENDIX I:

Recognition of Licenses

The following table lists the states which report some provision for recognizing licenses granted by other states, or for recognizing results of examinations administered by a regional clinical testing service.

State Board	Recognizes Licenses from
Arkansas	Will accept Southern Regional Testing Agency results as a clinical performance test.
Colorado	Will accept Central Regional Dental Testing Service results as a clinical performance test.
Connecticut	Will accept North East Regional Board results as a clinical performance test.
Delaware	Qualified applicants from other states if they meet specified endorsement requirements of state, including five years of continuous practice prior to application.
District of Columbia	Will accept North East Regional Board results as a clinical performance test.
Illinois	Iowa, Massachusetts, North Dakota, Pennsylvania, Rhode Island, West Virginia and New Jersey by reciprocal contract. Will accept North East Regional Board results as a clinical performance test.
Indiana	Qualified applicants from other states if they meet specified endorsement requirements of state, including five years of continuous practice prior to application.
Iowa	Illinois. Will accept Central Regional Dental Testing Service results as a clinical performance test.
Kansas	Missouri, Oklahoma, South Dakota, Nebraska, Iowa, Minnesota, North Dakota, Wisconsin and Wyoming. Will accept Central Regional Dental Testing Service results as a clinical performance test.
Kentucky	Will accept Southern Regional Testing Agency results as a clinical performance test.
Maine	Will accept North East Regional Board results as a clinical performance test.
Maryland	Will accept North East Regional Board results with application, plus exam on Maryland dental laws.
Massachusetts	The board will accept candidates by criteria approval from States that will accept Massachusetts dentists and hygienists. Will accept North East Regional Board results as a clinical performance test.
Michigan	Will accept North East Regional Board results as a clinical performance test.
Minnesota	By criteria approval. Will accept Central Regional Testing Service results as a clinical performance test.
Missouri	Licensure by credentials. Will accept Central Regional Dental Testing Service results as a clinical performance test.
Nebraska	Will accept Central Regional Dental Testing Service results as a clinical performance test.
New Hampshire	Will accept North East Regional Board results as a clinical performance test.
New Jersey	Illinois, Ohio, Pennsylvania. Will accept North East Regional Board results as a clinical performance test.
New York	All other states (endorsement of licenses is subject to specific legal and regulatory qualifications). Will accept North East Regional Board results as a clinical performance test.
North Carolina	Subject to its Rules and Regulations, the North Carolina State Board of Dental Examiners may issue a provisional license to dentists licensed no less than two years in jurisdictions imposing requirements for licensure no less exacting than those of North Carolina. License valid until date of announcement of the results of the next Board Examination.
North Dakota	Illinois, Iowa, Minnesota (partial), Missouri (partial), South Dakota (partial). Will accept Central Regional Dental Testing Service results as a clinical performance test.
Ohio	Qualified applicants from other states desiring to practice in Ohio and subject to regulatory requirements including five years of practice. Will accept North East Regional Board results as a clinical performance test.

Oklahoma	Qualified applicants from other states desiring to practice in Oklahoma and subject to regulatory requirements, including five years of practice. Will accept Central Regional Dental Testing Service results as a clinical performance test.
Pennsylvania	Illinois, Indiana, Iowa, Kansas, Massachusetts, New Jersey, Ohio, West Virginia. In addition to the states already listed, at the discretion of the Board, an applicant with five or more years of practice may be licensed. Will accept North East Regional Board results as a clinical performance test.
Rhode Island	Qualified applicants from other states if they meet specific endorsement requirements of state. Will accept North East Regional Board results as a clinical performance test.
South Dakota	Qualified applicants from other states if they meet specified endorsement requirements of state. Applicant must hold license in state where the examination shall be considered by the state board to be equivalent to the South Dakota examination. Will accept Central Regional Dental Testing Service results as a clinical performance test.
Tennessee	Considers other states' licenses with five years of practice history. Will accept Southern Regional Testing Agency results as a clinical performance test.
Vermont	Will accept North East Regional Board results as a clinical performance test.
Virginia	Will accept Southern Regional Testing Agency as a clinical performance test.
West Virginia	Will accept North East Regional Board results as a clinical performance test.
Wisconsin	Will accept Central Regional Dental Testing Service results as a clinical performance test.
Wyoming	Will accept Central Regional Dental Testing Service results as a clinical performance test.
Guam	Qualified applicants from all states.
Puerto Rico	Ohio.

Source: American Association of Dental Examiners.

APPENDIX II

(Minutes of Commission on Licensure Meeting, November 1975, Pertaining to House of Delegates Disposition of Resolutions Related to the Freedom of Interstate Movement for Licensed Dentists)

Mobility Resolutions: The Commission reviewed House disposition of seven resolutions related to the freedom of interstate movement for licensed dentists and expressed satisfaction with the California resolution, substituted for the other six, then amended and adopted.

Though not directly related to the seven mobility resolutions, the Commission considered Resolution 104 which was referred to the Board of Trustees for study and report to the 1976 House of Delegates.

> **Resolved,** that the appropriate agency of the American Dental Association as identified by the Board of Trustees conduct a comprehensive study of all aspects of the potential impact of redistribution of dentists which would result from a system of national reciprocity, and be it further
>
> **Resolved,** that this study shall include consideration of the ramifications of existing and pending federal legislation affecting dentistry, and be it further
>
> **Resolved,** that special emphasis should be placed on input to the study from the American Association of Dental Examiners and constituent societies of the American Dental Association.

The Commission discussed the above resolution and the propriety of making any response since the resolution had been referred to the Board of Trustees. It was decided that a comment to the Board would be in order because of the sequence of meetings.

After extended discussion, the Commission asked that a statement incorporating all of the objections discussed be prepared for consideration the following day. This pattern was followed and the following revised statement approved on November 20, 1975.

> **Comment:** At its November 19-20, 1975 meeting, the Commission on Licensure considered Resolution 104 as referred to the Board of Trustees for study and report to the 1976 House of Delegates. The Commission offers the following observations for the Board's consideration.
>
> 1. The Commission continues to feel that the matter of distribution or potential redistribution of dentists should not be linked to any system of licensure. The 1975

House of Delegates supported this view in adopting the amended *Position Statement on Federal Intervention in Licensure* (*Trans.* 1975:187).

2. The Commission reiterates its position that licensure is for the protection of the public, and for no other purpose. It is not for the protection of the profession. It is not to control the distribution of dentists (*Trans.* 1975:182).

3. Definition of "a system of national reciprocity" is obscure. Even if this were not so, the proposed study seems impossible of accomplishment. A survey could be undertaken to determine how many dentists think they might move if licensure were not a consideration, and, if so, when and to where. Results of such an opinion survey might then be used to speculate on what impact such a potential redistribution might have. Such an expensive, speculative dissertation, particularly if it were possible to "include consideration of the ramifications of existing and pending federal legislation affecting dentistry" might be expected to consume the time and resources of various Association agencies, at the expense of potentially more productive activities.

4. As another possibility, mobility of dentists might be compared with that of other professional or occupational groups not subject to state licensure. The AADE did a mini study of this sort and found that in the year of the study more dentists moved than did pharmacists, even though pharmacy has greater flexibility in recognizing licenses issued in other states. Such an approach could be expanded into a full-blown study, but then one would be hard pressed to say how experience in one profession could be projected to another profession taking into account all variables between the two professions. Results of such a study would be speculative at best. There really is not a laboratory in which to test this sort of thing.

5. The current manpower study may provide some information that would bear upon this problem.

6. If the Board of Trustees is obliged to come up with a cost estimate for what the Commission considers an ill-advised proposal, those involved in manpower studies may be able to project costs. The Commission does not seem the appropriate agency to do so.

Table 1

Percentage Increase in Number of Dentists, by Region and State, 1952–1976; and Percentage Increase in Population by Region and State, 1950–1975

Region and State	Percent Increase		Region and State	Percent Increase	
	Dentists	Population		Dentists	Population
NEW ENGLAND			W. N. CENTRAL		
Connecticut	45.1	54.2	Iowa	−12.5	9.5
Maine	14.9	15.9	Kansas	12.8	19.0
Massachusetts	23.5	24.2	Minnesota	16.8	31.7
New Hampshire	68.8	53.5	Missouri	−5.7	20.4
Rhode Island	1.4	17.1	Nebraska	−1.3	16.6
Vermont	60.0	24.6	N. Dakota	3.6	2.4
MIDDLE ATLANTIC			S. Dakota	2.7	4.6
New Jersey	43.2	51.1	W. S. CENTRAL		
New York	4.1	22.2	Arkansas	58.5	172.9
Pennsylvania	2.3	12.7	Louisiana	47.4	41.2
SOUTH ATLANTIC			Oklahoma	37.4	21.5
Delaware	8.2	82.1	Texas	105.0	58.7
Dist. of Columbia	—17.0	—10.7	MOUNTAIN		
Florida	257.5	201.6	Arizona	337.4	196.5
Georgia	120.4	43.0	Colorado	96.4	91.9
Maryland	130.0	74.9	Idaho	69.5	39.2
N. Carolina	90.0	34.2	Montana	33.8	26.6
S. Carolina	171.8	33.1	Nevada	261.6	270.0
Virginia	124.7	49.7	New Mexico	134.2	68.4
W. Virginia	4.1	−10.1	Utah	97.8	75.0
E. S. CENTRAL			Wyoming	20.1	28.5
Alabama	59.0	18.0	PACIFIC		
Kentucky	45.0	15.3	Alaska	n.a.	172.9
Mississippi	41.5	8.5	California	91.5	100.1
Tennessee	72.0	27.2	Hawaii	n.a.	73.0
E. N. CENTRAL			Oregon	48.5	50.4
Illinois	−3.3	27.9	Washington	62.1	49.0
Indiana	12.3	35.0	UNITED STATES	38.7	40.1
Michigan	41.5	43.7			
Ohio	21.4	35.4			
Wisconsin	7.5	34.1			

Sources: Dentist column is based on the percentage increase in the number of dentists listed by state in the 1953 (1952 data) and 1976 American Dental Directory.
Population increases based on US Bureau of the Census data.

Table 2

Relocation of Dentists, by State, 1971–1975

Region and State	1971			1972			1973			1974			1975			Total 1971–75		
	Moves		Net	Moves		Net	Moves		Net	Moves		Net	Moves		Net	Moves		Net
	In	Out	Gain	In	Out	Gain	In	Out	Gain	In	Out	Gain	In	Out	Gain	In	Out	Gain
NEW ENGLAND	133	80	53	115	102	13	107	73	34	154	110	44	146	92	54	655	457	198
Connecticut	43	21	22	33	27	6	28	17	11	31	36	−5	39	25	14	174	126	48
Maine	12	4	8	14	2	12	9	5	4	10	6	4	11	3	8	56	20	36
Massachusetts	51	47	4	42	68	−26	47	42	5	79	57	22	63	54	9	282	268	14
New Hampshire	10	3	7	15	2	13	10	2	8	16	4	12	11	3	8	62	14	48
Rhode Island	8	5	3	3	2	1	7	4	3	8	4	4	10	3	7	36	18	18
Vermont	9	0	9	8	1	7	6	3	3	10	3	7	12	4	8	45	11	34
MIDDLE ATLANTIC	213	327	−114	197	302	−105	216	355	−139	232	357	−125	220	355	−135	1078	1696	−618
New Jersey	53	63	−10	55	45	10	73	67	6	75	53	22	74	63	11	330	291	39
New York	111	203	−92	102	200	−98	96	228	−132	116	235	−119	103	215	−112	528	1081	−553
Pennsylvania	49	61	−12	40	57	−17	47	60	−13	41	69	−28	43	77	−34	220	324	−104
EAST NORTH CENTRAL	141	217	−76	122	222	−100	109	188	−79	138	243	−105	115	206	−91	625	1076	−451
Illinois	41	74	−33	29	86	−57	27	62	−35	34	110	−76	30	70	−40	161	402	−241
Indiana	16	34	−18	14	16	−2	10	27	−17	14	23	−9	13	18	−5	67	118	−51
Michigan	31	48	−17	26	45	−19	27	42	−15	33	44	−11	24	47	−23	141	226	−85
Ohio	29	38	−9	32	56	−24	28	44	−16	37	48	−11	27	57	30	153	243	−90
Wisconsin	24	23	1	21	19	2	17	13	4	20	18	2	21	14	7	103	87	16
WEST NORTH CENTRAL	93	159	−66	109	138	−29	105	117	−12	99	156	−57	87	128	−41	493	698	−205
Iowa	10	21	−11	16	13	3	19	7	12	14	19	−5	12	12	0	71	72	−1
Kansas	19	23	−4	17	21	−4	15	21	−6	23	20	3	17	15	2	91	100	−9
Minnesota	22	24	−2	31	25	6	17	28	−11	20	19	1	16	31	−15	106	127	−21
Missouri	24	48	−24	33	50	−17	35	42	−7	27	67	−40	25	39	−14	144	246	−102
Nebraska	10	21	−11	9	19	−10	10	13	−3	6	19	−13	9	21	−12	44	93	−49
North Dakota	5	11	−6	2	7	−5	4	4	0	3	5	−2	6	5	1	20	32	−12
South Dakota	3	11	−8	1	3	−2	5	2	3	6	7	−1	2	5	−3	17	28	−11
SOUTH ATLANTIC	409	226	183	306	194	112	342	214	128	360	228	132	333	218	115	1750	1080	670
Delaware	3	9	−6	7	4	3	2	5	−3	2	4	−2	1	1	0	15	23	−8
Dist. of Columbia	11	29	−18	12	24	−12	6	26	−20	14	29	−15	12	12	0	55	120	−65
Florida	198	48	150	165	37	128	178	35	143	171	51	120	183	46	137	895	217	678
Georgia	45	24	21	17	14	3	29	22	7	29	18	11	20	28	−8	140	106	34
Maryland	58	39	19	39	39	0	47	44	3	57	35	22	40	40	0	241	197	44
North Carolina	20	13	7	18	16	2	23	19	4	33	20	13	22	18	4	116	86	30
South Carolina	19	18	1	13	8	5	13	14	−1	13	15	−2	14	14	0	72	69	3
Virginia	46	34	12	26	37	−11	33	40	−7	35	39	−4	28	48	−20	168	198	−30
West Virginia	9	12	−3	9	15	−6	11	9	2	6	17	−11	13	11	2	48	64	−16

Table 2 (cont'd)

Relocation of Dentists, by State, 1971–1975

Region and State	1971			1972			1973			1974			1975			Total 1971–75		
	Moves In	Moves Out	Net Gain	Moves In	Moves Out	Net Gain	Moves In	Moves Out	Net Gain	Moves In	Moves Out	Net Gain	Moves In	Moves Out	Net Gain	Moves In	Moves Out	Net Gain
EAST SOUTH CENTRAL	59	84	−25	63	87	−24	58	86	−28	63	88	−25	61	77	−16	304	422	−118
Alabama	13	16	−3	11	19	−8	12	16	−4	11	9	2	9	13	−4	56	73	−17
Kentucky	21	29	−8	19	30	−11	15	20	−5	19	32	−13	16	22	−6	90	133	−43
Mississippi	9	13	−4	11	6	5	10	7	3	16	8	8	16	12	4	62	46	16
Tennessee	16	26	−10	22	32	−10	21	43	−22	17	39	−22	20	30	−10	96	170	−74
WEST SOUTH CENTRAL	110	115	−5	106	75	31	104	84	20	84	78	6	99	71	28	503	423	80
Arkansas	10	5	5	14	5	9	18	5	13	13	5	8	20	5	15	75	25	50
Louisiana	18	17	1	13	15	−2	15	12	3	11	15	−4	13	16	−3	70	75	−5
Oklahoma	20	15	5	27	10	17	20	9	11	21	16	5	18	12	6	106	62	44
Texas	62	78	−16	52	45	7	51	58	−7	39	42	−3	48	38	10	252	261	−9
MOUNTAIN	123	73	50	115	54	61	123	68	55	145	50	95	153	76	77	659	321	338
Arizona	38	11	27	42	9	33	35	11	24	53	7	46	49	16	33	217	54	163
Colorado	22	21	1	26	11	15	41	15	26	34	16	18	37	23	14	160	86	74
Idaho	10	4	6	6	1	5	7	5	2	7	3	4	10	5	5	40	18	22
Montana	9	5	4	8	1	7	7	7	0	9	5	4	8	5	3	41	23	18
Nevada	10	4	6	4	11	−7	10	6	4	10	7	3	12	2	10	46	30	16
New Mexico	12	16	−4	12	10	2	8	11	−3	9	4	5	12	10	2	53	51	2
Utah	19	8	11	14	8	6	12	7	5	18	5	13	19	13	6	82	41	41
Wyoming	3	4	−1	3	3	0	3	6	−3	5	3	2	6	2	4	20	18	2
PACIFIC	204	191	13	184	147	37	143	126	17	166	136	30	168	144	24	865	744	121
Alaska	7	7	0	4	5	−1	5	2	3	1	1	0	4	4	0	21	19	2
California	134	134	0	132	103	29	109	85	24	107	102	5	105	99	6	587	523	64
Hawaii	10	4	6	10	3	7	7	6	1	11	4	7	12	3	9	50	20	30
Oregon	22	19	3	15	17	−2	10	12	−2	12	9	3	23	12	11	82	69	13
Washington	31	27	4	23	19	4	12	21	−9	35	20	15	24	26	−2	125	113	12

Note: For the years 1971 through 1975, total moves into states was 6,932; total moves out of states was 6,917.
The difference consists of dentists who moved to and from U.S. territories and possessions and foreign countries.

Table 3

Ratio of Dentists Gained to Lost by Region and State, 1971–1975

Region and State	Ratio of Dentists Gained to Lost	Region and State	Ratio of Dentists Gained to Lost
NEW ENGLAND	1.4 to 1	W. N. CENTRAL	0.7 to 1
Connecticut	1.4 to 1	Iowa	1.0 to 1
Maine	2.8 to 1	Kansas	0.9 to 1
Massachusetts	1.1 to 1	Minnesota	0.8 to 1
New Hampshire	4.4 to 1	Missouri	0.6 to 1
Rhode Island	2.0 to 1	Nebraska	0.5 to 1
Vermont	4.1 to 1	N. Dakota	0.6 to 1
MIDDLE ATLANTIC	0.6 to 1	S. Dakota	0.6 to 1
New Jersey	1.1 to 1	W. S. CENTRAL	1.2 to 1
New York	0.5 to 1	Arkansas	3.0 to 1
Pennsylvania	0.7 to 1	Louisiana	0.9 to 1
SOUTH ATLANTIC	1.6 to 1	Oklahoma	1.7 to 1
Delaware	0.7 to 1	Texas	1.0 to 1
Dist. of Columbia	0.5 to 1	MOUNTAIN	2.1 to 1
Florida	4.1 to 1	Arizona	4.0 to 1
Georgia	1.3 to 1	Colorado	1.9 to 1
Maryland	1.2 to 1	Idaho	2.2 to 1
N. Carolina	1.3 to 1	Montana	1.8 to 1
S. Carolina	1.0 to 1	Nevada	1.5 to 1
Virginia	0.8 to 1	New Mexico	1.0 to 1
W. Virginia	0.8 to 1	Utah	2.0 to 1
E. S. CENTRAL	0.7 to 1	Wyoming	1.1 to 1
Alabama	0.8 to 1	PACIFIC	1.2 to 1
Kentucky	0.7 to 1	Alaska	1.1 to 1
Mississippi	1.3 to 1	California	1.1 to 1
Tennessee	0.6 to 1	Hawaii	2.5 to 1
E. N. CENTRAL	0.6 to 1	Oregon	1.2 to 1
Illinois	0.4 to 1	Washington	1.1 to 1
Indiana	0.6 to 1		
Michigan	0.6 to 1		
Ohio	0.7 to 1		
Wisconsin	1.2 to 1		

Table 4

Relocation of Dentists by State, 1971–1975

Ranking by Size of Net Gain or Loss

States with Net Gain of More than 100 Dentists	
Florida	+678
Arizona	+163
States with Net Gain of of 50 to 100 Dentists	
Colorado	+74
California	+64
Arkansas	+50
States with Net Gain of 1 to 49 Dentists	
Connecticut	+48
New Hampshire	+48
Maryland	+44
Oklahoma	+44
Utah	+41
New Jersey	+39
Maine	+36
Vermont	+34
Geargio	+34
Hawaii	+30
North Carolina	+30
Idaho	+22
Montana	+18
Rhode Island	+18
Mississippi	+16
Nevada	+16
Wisconsin	+16
Massachusetts	+14
Oregon	+13
Washington	+12
South Carolina	+ 3
Alaska	+ 2
New Mexico	+ 2
Wyoming	+ 2

States with Net Loss of 1 to 50 Dentists	
Iowa	−1
Louisiona	−5
Delaware	−8
Kansas	−9
Texas	−9
South Dakota	−11
North Dakota	−12
West Virginia	−16
Alabama	−17
Minnesota	−21
Virginia	−30
Kentucky	−43
Nebraska	−49
States with Net Loss of 51 to 100 Dentists	
Indiana	−51
Tennessee	−74
Dist. of Columbia	−65
Michigan	−85
Ohio	−90
States with Net Loss of Over 100 Dentists	
Missouri	−102
Pennsylvania	−104
Illinois	−241
New York	−553

Table 5

Relocation of Dentists by State and Age Group, 1971–1975

Region and State	Moves to State by Age Group				Moves from State by Age Group				Net Moves by Age Group			
	Under 40	40–55	Over 55	Total	Under 40	40–55	Over 55	Total	Under 40	40–55	Over 55	Total
NEW ENGLAND	537	62	56	655	323	71	63	457	214	−9	−7	198
Connecticut	138	15	21	174	70	26	30	126	68	−11	−9	48
Maine	35	11	10	56	15	4	1	20	20	7	9	36
Massachusetts	246	24	12	282	208	34	26	268	38	−10	−14	14
New Hampshire	46	6	10	62	11	0	3	14	35	6	7	48
Rhode Island	33	2	1	36	11	5	2	18	22	−3	−1	18
Vermont	39	4	2	45	8	2	1	11	31	2	1	34
MIDDLE ATLANTIC	860	125	93	1,078	1,104	204	388	1,696	−244	−79	−295	−618
New Jersey	250	39	41	330	200	34	57	291	50	5	−16	39
New York	433	60	35	528	665	128	288	1,081	−232	−68	−253	−553
Pennsylvania	177	26	17	220	239	42	43	324	−62	−16	−26	−104
EAST NORTH CENTRAL	499	86	40	625	746	159	171	1,076	−247	−73	−131	−451
Illinois	121	29	11	161	269	57	76	402	−148	−28	−65	−241
Indiana	49	12	6	67	86	17	15	118	−37	−5	−9	−51
Michigan	115	17	9	141	153	38	35	226	−38	−21	−26	−85
Ohio	129	17	7	153	178	32	33	243	−49	−15	−26	−90
Wisconsin	85	11	7	103	60	15	12	87	25	−4	−5	16
WEST NORTH CENTRAL	385	76	32	493	507	115	76	698	−122	−39	−44	−205
Iowa	53	11	7	71	42	18	12	72	11	−7	−5	−1
Kansas	71	13	7	91	72	16	12	100	−1	−3	−5	−9
Minnesota	85	16	5	106	91	16	20	127	−6	0	−15	−21
Missouri	113	22	9	144	180	46	20	246	−67	−24	−11	−102
Nebraska	31	11	2	44	75	11	7	93	−44	0	−5	−49
North Dakota	19	0	1	20	27	3	2	32	−8	−3	−1	−12
South Dakota	13	3	1	17	20	5	3	28	−7	−2	−2	−11
SOUTH ATLANTIC	1,030	283	437	1,750	804	178	98	1,080	226	105	339	670
Delaware	12	1	2	15	22	0	1	23	−10	1	1	−8
Dist. of Columbia	41	9	5	55	79	31	10	120	−38	−22	−5	−65
Florida	375	131	389	895	131	42	44	217	244	89	345	678
Georgia	115	19	6	140	77	22	7	106	38	−3	−1	34

Table 5 (cont'd)

Relocation of Dentists by State and Age Group, 1971–1975

Region and State	Moves to State by Age Group				Moves from State by Age Group				Net Moves by Age Group			
	Under 40	40–55	Over 55	Total	Under 40	40–55	Over 55	Total	Under 40	40–55	Over 55	Total
Maryland	184	42	15	241	153	27	17	197	31	15	−2	44
North Carolina	87	23	6	116	72	11	3	86	15	12	3	30
South Carolina	52	17	3	72	58	9	2	69	−6	8	1	3
Virginia	133	26	9	168	163	28	7	198	−30	−2	2	−30
West Virginia	31	15	2	48	49	8	7	64	−18	7	−5	−16
EAST SOUTH CENTRAL	217	67	20	304	345	62	15	422	−128	5	5	−118
Alabama	40	13	3	56	50	16	7	73	−10	−3	−4	−17
Kentucky	72	15	3	90	105	25	3	133	−33	−10	0	−43
Mississippi	45	12	5	62	42	3	1	46	3	9	4	16
Tennessee	60	27	9	96	148	18	4	170	−88	9	5	−74
WEST SOUTH CENTRAL	354	103	46	503	351	54	18	423	3	49	28	80
Arkansas	55	7	13	75	21	3	1	25	34	4	12	50
Louisiana	44	23	3	70	61	10	4	75	−17	13	−1	−5
Oklahoma	87	14	5	106	48	9	5	62	39	5	0	44
Texas	168	59	25	252	221	32	8	261	−53	27	17	−9
MOUNTAIN	466	89	104	659	252	49	20	321	214	40	84	338
Arizona	129	28	60	217	46	5	3	54	83	23	57	163
Colorado	135	13	12	160	71	10	5	86	64	3	7	74
Idaho	22	10	8	40	14	3	1	18	8	7	7	22
Montana	33	6	2	41	18	4	1	23	15	2	1	18
Nevada	27	12	7	46	22	7	1	30	5	5	6	16
New Mexico	33	9	11	53	37	11	3	51	−4	−2	8	2
Utah	71	7	4	82	34	7	0	41	37	0	4	41
Wyoming	16	4	0	20	10	2	6	18	6	2	−6	2
PACIFIC	661	118	86	865	545	141	58	744	116	−23	28	121
Alaska	18	3	0	21	16	2	1	19	2	1	−1	2
California	438	81	68	587	378	100	45	523	60	−19	23	64
Hawaii	42	4	4	50	13	5	2	20	29	−1	2	30
Oregon	57	17	8	82	49	16	4	69	8	1	4	13
Washington	106	13	6	125	89	18	6	113	17	−5	0	12

Table 6

Over 55 Age Group:

Ratio of Dentists Gained to Lost by Region and State, 1971–1975

Region and State	Ratio of Dentists Gained to Lost Over Age 55	Region and State	Ratio of Dentists Gained to Lost Over Age 55
NEW ENGLAND	0.9 to 1	W. N. CENTRAL	0.4 to 1
Connecticut	0.7 to 1	Iowa	0.6 to 1
Maine	0.5 to 1	Kansas	0.6 to 1
Massachusetts	0.5 to 1	Minnesota	0.3 to 1
New Hampshire	3.3 to 1	Missouri	0.5 to 1
Rhode Island	0.5 to 1	Nebraska	0.3 to 1
Vermont	2.0 to 1	N. Dakota	0.5 to 1
MIDDLE ATLANTIC	0.2 to 1	S. Dakota	0.3 to 1
New Jersey	0.7 to 1	W. S. CENTRAL	2.6 to 1
New York	0.1 to 1	Arkansas	13.0 to 1
Pennsylvania	0.4 to 1	Louisiana	0.8 to 1
SOUTH ATLANTIC	4.5 to 1	Oklahama	1.0 to 1
Delaware	2.0 to 1	Texas	3.1 to 1
Dist. of Columbia	0.5 to 1	MOUNTAIN	5.2 to 1
Florida	8.8 to 1	Arizona	20.0 to 1
Georgia	0.9 to 1	Colorado	2.4 to 1
Moryland	0.9 to 1	Idaho	8.0 to 1
N. Carolina	2.0 to 1	Montana	2.0 to 1
S. Carolina	1.5 to 1	Nevada	7.0 to 1
Virginia	1.3 to 1	New Mexico	3.7 to 1
W. Virginia	0.3 to 1	Utah	+*
E. S. CENTRAL	1.3 to 1	Wyoming	—*
Alabama	0.4 to 1	PACIFIC	1.5 to 1
Kentucky	1.0 to 1	Alaska	—*
Mississippi	5.0 to 1	California	1.5 to 1
Tennessee	2.3 to 1	Hawaii	2.0 to 1
E. N. CENTRAL	0.2 to 1	Oregon	2.0 to 1
Illinois	0.1 to 1	Washington	1.0 to 1
Indiana	0.4 to 1		
Michigan	0.3 to 1		
Ohio	0.2 to 1		
Wisconsin	0.6 to 1		

*+ indicates no dentists lost; — indicates no dentists gained.

Table 8

Interstate Moves of Dentists to and from Missouri, by State of Origin and Destination, 1971–1975

Region and State	Number of Moves from Missouri	Number of Moves to Missouri	Missouri's Net Gain of Dentists from Interstate Moves
STATES ADJOINING MISSOURI	92	63	−29
Arkansas	5	4	−1
Illinois	6	15	9
Iowa	3	3	0
Konsas	55	26	−29
Nebraska	2	3	1
Oklahoma	13	6	−7
Tennessee	6	4	−2
Kentucky	2	2	0
"SUN BELT" STATES	85	35	−50
Alabama	4	0	−4
Arizona	11	1	−10
California	21	12	−9
Florida	12	2	−10
Georgia	2	1	−1
Hawaii	1	0	−1
Mississippi	1	1	0
New Mexico	4	3	−1
North Carolina	1	1	0
South Carolina	2	0	−2
Texas	20	9	−11
Louisiana	4	2	−2
Virginia	2	3	1
OTHER STATES	64	46	−18
MIDDLE WEST	8	13	5
Indiana	2	0	−2
Michigan	0	3	3
Minnesota	2	3	1
North Dakota	1	0	−1
Ohio	2	6	4
Wisconsin	1	1	0
NEW ENG. & MID. ATLANTIC	27	24	−3
Connecticut	2	1	−1
Dist. of Columbia	1	1	0
Maryland	6	5	−1
Massachusetts	4	2	−2
Maine	2	0	−2
New Jersey	5	3	−2
New York	4	5	1
Pennsylvania	1	7	6
West Virginia	2	0	−2
MOUNTAIN & NORTHWEST	29	9	−20
Alaska	1	0	−1
Colorado	11	4	−7
Idaho	1	0	−1
Montana	2	0	−2
Nevada	4	1	−3
Oregon	3	0	−3
Utah	7	2	−5
Washington	0	2	2
Total	241	144	−97

TABLE 7: Relocation of

Moved to → / Moved from ↓	Alabama	Alaska	Arizona	Arkansas	California	Colorado	Connecticut	Delaware	Dist. of Columbia	Florida	Georgia	Hawaii	Idaho
Alabama				1	4	3	1			10	10		
Alaska			1		2	1							
Arizona					12	1	1			3			1
Arkansas	1	1	3							2	2		
Colifarnia	5	2	37	5		14	5		1	16	12	23	15
Colarado	1		6		18					1	1		1
Cannecticut	1				2	2		1		26	1	1	
Delaware							1			3			
Dist. of Columbia					5		1			6	5		
Florida	6		1	2	12	1	3		2		9		1
Georgia	6			1	5	1	5			22			
Hawaii					7	1							
Idaho					6								
Illinois	1	1	29	7	66	23	2		1	57	3	2	4
Indiana			10	1	8	1	2			22	4	3	1
Iowa			4		6	6			1	3	3		
Kansas			4	3	1	2				4	3		1
Kentucky	4		1	2	7	1			2	23	5		1
Louisiana			1	1	6	4	1			5	3		
Maine							1						
Maryland	1				10		5	2	25	14	1		
Massachusetts		1	2		25	2	14		4	29	2	4	1
Michigon			10		36	8	2			45	1	3	1
Minnesota			9	1	11	7			1	9	1		
Mississippi	2			2	2					4	3		
Missouri	4	1	11	5	21	11	2		1	12	2	1	1
Montana		1			3						1		2
Nebraska			3		15	11	1			2		2	1
Nevada			2		9	1					1		
New Hampshire					1					1	1		
New Jersey			1		6	3	11			63	3		
New Mexico			3	1	8	3				1	1		1
New Yark		1	15		78	11	84	3	5	315	10	3	
North Carolina	3			2	5		1		1	10	3		1
North Dakota			2		4	1				1			
Ohio			7	2	21	6	2			43	7		
Oklahoma	2		5		2	1				4	3	1	
Oregon		4	2		21							2	2
Pennsylvania	2		5		16	3	11	6	1	51	3	1	
Rhode Island					1			1		1			
South Carolina	2		1	1	2				1	6	7		
South Dakota			3		3	1				1			1
Tennessee	5		2	25	10		3		1	11	13		
Texas	7		10	8	20	14	3	2	1	13	3		1
Utah			3		3	2	1				2		
Vermont	1				1					2			
Virginia	1		2	2	14	2	4		7	17	5		
Washington	1	8	9	1	24	3				1	3	3	3
West Virginia			2			3	2			10			
Wisconsin		1	5	1	10	3	2			12			
Wyoming			3		3	1							
US Passessions ar Other			3	1	25	2	3			14	3	1	
Total Moves to Each State	56	21	217	75	587	160	174	15	55	895	140	50	40
Net Gain far Each State	—17	2	163	50	64	74	48	—8	—65	678	34	30	22

Dentists by State, 1971—1975

Illinois	Indiana	Iowa	Kansas	Kentucky	Louisiana	Maine	Maryland	Massachusetts	Michigan	Minnesota	Mississippi	Missouri	
2	3				3		1	2	2		6		Alabama
		1						3		1			Alasko
					1		1	1	2	1		1	Arizona
				1				1				4	Arkansas
18	8	8		8	3	1	6	10	13	11	1	12	California
		5	5	1	2	1			1	1		4	Colorado
2	1		1	1	2	1	4	10		1	3	1	Connecticut
1							2		2	1			Delaware
							56	8	2	1	1	1	Dist. of Columbia
11	5	1	1	5	3		7	10	8	1	1	2	Florida
3	1			1	1	2	3	1	1		1	1	Georgia
2	1	1						1	2	2			Hawaii
1	1												Idaho
	7	3	2	3	1		8	9	13	7	2	15	Illinois
8		1	2	7	1		4	1	2	3			Indiana
4			2	2			3	2		3		3	Iowa
2	1	2		3	1		1	1		2		26	Konsas
2	8	2	1					3	2		4	2	Kentucky
1	1	2		1			3	1			2	2	Louisiano
								6		1			Maine
3	1	1	1			2		9	5	3		5	Maryland
3	1			4	2	21	9		4	4	3	2	Massachusetts
8	5	3		1	1	2	8	11		1		3	Michigan
5	1	2			1		2	1	3		4	3	Minnesota
2		1	2		3		1	5				1	Mississippi
6	2	3	55	2	4		6	4	6	2	1		Missouri
1									1	1			Montono
2		7		1	1		1	1	2	2		3	Nebraska
	1			1								1	Nevada
						1	1	3					New Hampshire
4	1	3	1	3	2	4	6	16	3	4	1	3	New Jersey
1	1		1		1			2	1	1		3	New Mexico
13	2	4	2	3	4	9	37	66	9	5	1	5	New York
1		4	1	5		1	1	4	1	1	3	1	North Carolino
1			1							9			North Dakota
8	8		1	6	2	3	5	15	11	2	1	6	Ohio
3		1	1	1	4		2		1	1	2	6	Oklahoma
2			1				1	1	3	1			Oregon
4		2	2	4	1	5	18	23	5	3		7	Pennsylvonia
		1				1		7					Rhode Island
1	2	1		7	2	1		1	2		2		South Carolina
3		2						1	1	2			South Dokoto
6	2			6	3		5	4	4	3	17	4	Tennessee
4	1	3	5	2	11		8	5	7	4	3	9	Texas
1			1	1			1		1		1	2	Utah
							1	2					Vermont
4		3		8	3	1	16	14	2	3	2	3	Virginia
3			1		4			4	1	8		1	Washington
2				1			4	3	3				West Virginia
8	1	2			2		2	1	7	7			Wisconsin
1							1		1	1			Wyoming
4	1	2	1	1	1		6	9	7	2		2	US Possessions or Other
161	67	71	91	90	70	56	241	282	141	106	62	144	
—241	—51	—1	—9	—43	—5	36	44	14	—85	—21	16	—102	

TABLE 7

Moved to → / Moved from ↓	Montana	Nebraska	Nevada	New Hampshire	New Jersey	New Mexico	New York	North Carolina	North Dakota	Ohio	Oklahoma	Oregon	Pennsylvania
Alabama			1				2	4			1		2
Alaska							1			2		2	
Arizona	1	1	1			2	4			1	1	6	
Arkansas							1	1					
California	4	8	15	1	4	5	43	4	3	14	9	17	20
Colorado		2	1		2	1	4		2	4	2	1	
Connecticut				2	7		34	3		1			3
Delaware							3	2			1		4
Dist. of Columbia			1	1	1		7	4		3	1		3
Florida		3		3	11		37	10		11	1	3	9
Georgia			1		4		4	4		4	1		6
Hawaii							1						
Idaho	1				1							1	
Illinois	4	5	2	1	4	5	16	3	2	5	3	2	5
Indiana		1	1		3		6	4	1	2		1	1
Iowa	1	4			1		1			1	2	2	
Kansas	1	1				1	6			1	12	1	1
Kentucky			1	2	2		4	4		12	5		4
Louisiana		2			1		3	3		1	5		3
Maine				2	1		4	1		2			
Maryland	1	1		1	10		28	4		4	3		6
Massachusetts				19	2		38	3		7			12
Michigan	4		1	1	5	3	14	5		9	1	3	2
Minnesota	6	1			1	1	5	1	7	2	1	1	4
Mississippi					1		3			2			
Missouri	2	2	4		5	4	4	1	1	2	13	3	1
Montana			1				3					2	
Nebraska			3			2	4		1		1	1	2
Nevada	1						1			1		1	1
New Hampshire					2	1	2						1
New Jersey				5		1	96	1		6		1	26
New Mexico			1				2			3	1	1	3
New York		2	3	14	189	4		14		12	3	3	43
North Carolina	1				1		3			4			
North Dakota		3	1	1			2					1	1
Ohio	4				5	2	12	6			3	4	13
Oklahoma	1					3		1		2		2	3
Oregon			2		1	3	2			1	1		
Pennsylvania	2	1	2	4	35	2	52	6	1	9	4	2	
Rhode Island				1	1		1						2
South Carolina					4		3	2				1	3
South Dakota		1				1	1		1				1
Tennessee					3		8	3		4	7		
Texas	2		2		9	9	22	4		5	18	5	6
Utah			1			1					1	1	
Vermont							3						1
Virginia		2		2	4		17	10		4	2		13
Washington	1	2		1	1		1		1	2	1	8	1
West Virginia					3		5	3		3	1		9
Wisconsin	1		1	1	1	1	1	1		3		1	
Wyoming		1					2			1			
US Possessions or Other	3	1			5	1	12	4		3	1	5	5
Total Moves to Each State	41	44	46	62	330	53	528	116	20	153	106	82	220
Net Gain for Each State	18	—49	16	48	39	2	—553	30	—12	—90	44	13	—104

(Continued)

Rhode Island	South Carolina	South Dakota	Tennessee	Texas	Utah	Vermont	Virginia	Washington	West Virginia	Wisconsin	Wyoming	US Possessions or Other	Total Moves from Each State	
1	3		1	6			2	1				1	73	Alabama
	1			1				3				1	19	Alaska
			2	2			1	3	1	1	1	1	54	Arizona
			7					1					25	Arkansas
1	5		6	31	26	2	10	33	2	6		20	523	California
				7	1		2	6		1		2	86	Colorado
1			1	1		4	4		1	1		2	126	Connecticut
							1		2				23	Delaware
	1					1	10	1					120	Dist. of Columbia
	3		6	5	1	1	11	1	1	2		6	217	Florida
	5		9	4	1		4	1	2	1			106	Georgia
				1								1	20	Hawaii
				1	2			3			1		18	Idaho
	1	3	3	12	15		5	5	1	29	1	4	402	Illinois
	3		2	1	1			4	1	3		2	118	Indiana
	2			6	1		1	1	1	2	1	3	72	Iowa
			1	11	1		1	1		3		1	100	Kansas
	4		5	5	2		9	2	2	1			133	Kentucky
	1		1	9	3		2	2	1	3		1	75	Louisiana
							1					1	20	Maine
1	2		3	6		1	23	2	3	3		7	197	Maryland
13	2		2	7	2	6	6	1	1	3		7	268	Massachusetts
2	1		4	5		2	1	1	2	5		6	226	Michigan
		5	1	5	1	1	3	2	1	15	1	1	127	Minnesota
	2		4	2			2		2				46	Mississippi
	2		6	20	7		2		2	1		1	246	Missauri
				2				2			1	2	23	Montono
	1	3		1	5	2	1	4		3	3	1	93	Nebraska
			1	2	3		1	1		1			30	Nevada
													14	New Hampshire
2	2					7	2	2	1			1	291	New Jersey
		1		6			1			2		1	51	New Mexico
10	7	2	3	17		13	17	6	2	3		29	1,081	New York
	7		6	8			3	1	1			2	86	North Carolina
		1		1				1		1			32	North Dakota
	2	1	1	14	1	1	5	5	3	2		3	243	Ohia
			1	8			1			1			62	Oklahoma
				2	2			10				5	69	Oregon
3	2			6		2	8	1	4			5	324	Pennsylvania
												1	18	Rhode Island
			2	6			5		1			3	69	Sauth Carolina
				2	1		2						28	South Dakota
	2			7			7	1	2		1	1	170	Tennessee
	2		8		1	1	4	4	1	5	1	8	261	Texas
								2			5	1	41	Utah
												1	11	Vermont
	6		7	6	3			1	4	1		3	198	Virginia
		1	1	5	1		3		2	1	1	1	113	Washington
1	2			1		1	5						64	West Virginia
			1	2				4			2	3	87	Wiscansin
			1	1						1			18	Wyoming
1	1			7	1		2	6	1	2	1	18	172	US Possessions or Other
36	72	17	96	252	82	45	168	125	48	103	20	157	7,089	
18	3	—11	—74	—9	41	34	—30	12	—16	16	2	—15		

Bureau of Library Services

Washburn, Donald A., director and librarian
Kowitz, Aletha A., assistant director

The Bureau of Library Services has responsibility for providing library services to Association members, for indexing the dental literature, for nomenclature, for the Association archives, and for collecting historical material. The Bureau has a staff of 19 persons full-time and three part-time. On March 8, Dr. John Cedrins, assistant director, died. He had been with the Association for 20 years. Miss Aletha Kowitz was named assistant director. Miss Lea Weber resigned as indexer of *Oral Research Abstracts*. Miss Karen Sorensen resigned as indexer of the *Index to Dental Literature* and was replaced by Mrs. Carol D. Strauss.

To provide library and indexing services, the Bureau staff collects dental literature comprehensively through purchase, exchange, and gifts. All materials are cataloged, indexed, bound, and otherwise processed for ready availability. They are used for general circulation, the package library service, for reference use, for the indexing programs and for the archival and historical collections. In addition to the membership, both licensed and student, library services are provided to hygienists, assistants, technicians, physicians, nurses, and others in the health field and Headquarters Building staff. Books are also purchased for individual members, dental associations and dental schools. Large numbers of individual articles are also supplied. These activities have been summarized by the use of tables whenever possible.

Service Activities: The general service activities of the Bureau are shown in Table 1.

Table 1

Comparison of 1974-75 and 1975-76 Circulation Figures, Service Fees and Book Sales

		1974-1975	1975-1976			1974-1975	1975-1976
Books:	Mail	3,679	3,560	Microfilm:	Mail	0	3
	Local	2,770	3,073		Local	0	3
Journals:	Mail	1,897	1,222	Renewals:	Books	1,650	1,453
	Local	2,433	2,720		Journals	415	342
					Packages	469	589
Package libraries:	Mail	1,821	2,114	Reserves:	Books	1,436	1,238
	Local	310	574		Journals	56	21
	Complimentary	449	466		Packages	0	0
Interlibrary loan:	Books	225	182	Overdues:	Books	5,002	4,917
(Outgoing)	Journals	2,203[1]	1,292[3]		Journals	1,315	1,322
					Packages	2,554	3,093
Interlibrary loan:	Books	100	55	Xerox sales:	Mail	1,904	1,712
(Incoming)	Journals	173[2]	65[4]		Local	615	409
Service fees:		$5,229	$7,317				
Book sales:		$3,975	$3,863				

[1]Includes 409 free copies (1,863 pages).
[2]Includes 51 free copies (408 pages).
[3]Includes 408 free copies (1,935 pages).
[4]Includes 21 free copies (151 pages).

Bureau Collections:

Present holdings	17,661	books
	9,473	bound journals
	27,134	accessioned items
	105	items cataloged for other departments
Volumes added during year Including 399 volumes on gift or exchange	745	
Volumes withdrawn	185	
Titles published outside US	72	
Catalog cards typed	3,531	
Binding volumes commercially bound	608	
Vertical file	550	folders
Journals received	912	titles
Newsletters included	53	titles
Subscriptions purchased	213	
Dental journals published abroad, 54 countries	268	

Interlibrary Projects: The Bureau continues to participate in the Midwest Union Catalog of Medical Books maintained at the John Crerar Library in Chicago to which 538 main entry cards of new Bureau additions were forwarded.

Book Lists: The annual edition of *Books and Package Libraries for Dentists* was released during the first month of 1976. It includes 900 books in English issued between January 1972 and December 1975. The subject index of this guide covering

60 topics illustrates the depth of the collection and the current trends in dental publishing and research.

Twelve monthly book lists of new additions were prepared for *The Journal of the American Dental Association.*

Since June 1, 1975, 272 specific requests for 348 copies of *Books and Package Libraries for Dentists* were received and processed.

Package Libraries: Staff members are still searching for very specific rather than broad, general topics. More and more requests are for subjects which cannot be adequately searched through either regular printed indexes or on-line computer indexes, but can be searched only by reading the articles themselves. The MEDLARS (Medical Literature Analysis and Retrieval System) data base (used via the terminal at Northwestern University Dental Library) is primarily useful for current awareness type material.

The library is able to supply most information within a 48-hour period generally except when there is a large number of package library requests for the same subject.

Indexing Services: The indexes prepared included: *Index to Dental Literature* (45th in the series and containing 12,799 entries), *The Journal of the American Dental Association, Dental Abstracts, Journal of Dental Research, Journal of Endodontics,* and *Transactions.* A special feature of the 1975 volume of the *Index* is a section, "Subject Headings Changes, 1965 to 1964," which was prepared to enable users to locate material by subject in the years immediately preceding the adoption of *Medical subject Headings* of the National Library of Medicine as the authority list.

Oral Research Abstracts: The index issue of volume 10 was completed. A two-year compilation of abstracts, the second *Advances in Sociodental Research* was published. Abstracts were selected and categorized for five *Advances.* They are *Advances in Orthodontics, Advances in Pedodontics, Advances in Periodontics, Advances in Prosthodontics,* and *Advances in Oral Surgery.*

Translation Services: Some 257 pieces of correspondence were translated as a routine service to Association staff members.

Gift and Exchange Program: The Bureau has continued its gift and exchange program. Shipments of dental literature abroad included 1,456 books and periodicals sent to Argentina, Belgium, Brazil, Mexico, Philippines, Thailand, and Uruguay. The Bureau received 58 gift items from 12 foreign countries, and 601 from 45 individuals and organizations in the United States. Items that cannot be used in the Bureau's collection are donated to other libraries.

The Bureau is also a member of the Medical Library Association Exchange of duplicate materials. Numerous needed items were received from this source during the past 12 months. During the same time, under this program the Bureau sent 3,071 duplicate items of books and journals to other related institutions.

Basic Dental Reference Works: A new reference work, *Basic Dental Reference Works,* was prepared by the assistant director. A first revision has already been made in response to numerous requests for the work.

Other Staff Activities: Staff members have attended national and local meetings of the Medical Library Association, the Special Libraries Association and the International Association for Dental Research. The Assistant Director taught a one-day class in Literature of Dentistry for the Medical Library Association in June 1975 and a two-hour class for graduate students at the University of Illinois and has served as president of the Chicago Chapter of the American Society of Indexers and as chairman of the Society's annual meeting in Chicago in May 1976. As a new staff indexer, Mrs. Strauss attended the index training course at the National Library of Medicine. She also served as moderator of a workshop for the Midwest Regional Group of the Medical Library Association and as chairman for the 1976 spring meeting of the same group.

Staff has also demonstrated the operation of the Bureau to groups of library students from the University of Chicago, the University of Illinois, and Rosary College and classes of dental hygienists from Northwestern University, dental assistants from Illinois Valley Community College, and dental students from the University of Iowa.

Since June 1, 1975, 970 persons who visited the Bureau signed the guest register. These included visitors from the United States as well as from the following countries: Argentina, Australia, Austria, Bolivia, Brazil, Canada, Denmark, Ecuador, Egypt, Ethiopia, France, Germany, Greece, Iceland, India, Iran, Israel, Hungary, Italy, Japan, Lebanon, Mexico, the Netherlands, Philippines, South Africa, Spain, Sweden, Taiwan, Thailand, United Kingdom.

Bureau of Public Information

Goulding, Peter C., director
Leahigh, Alan K., associate director
Borger, Jean, manager of officer services
Joseph, Lou, manager of media relations

The Bureau of Public Information is responsible for developing and maintaining the Association's public relations program and for disseminating information and publicity about dentistry. The Bureau has a staff of nine persons.

Television-Radio: During 1975-76, Association dental health public service messages were broadcast on all three major television networks, and a new spot was distributed on film every second month to 541 individual television stations. The Bureau surveys the stations once a year to determine usage of spots. This information and "paid" invoices received from the stations make it possible to estimate that the Association is receiving about $10 million in TV public service time each year.

The Bureau continued to work with radio and television station program managers and news directors on an individual basis. This cooperation included the development of new public service message scripts for radio announcers and cooperation with television program production. Once a year a Bureau staff member meets in New York with TV network executives.

Newspapers, Magazines, and Syndicates: The Bureau continued to increase its work with national publications to gain expanded coverage of dental topics. Three times a year, a staff member goes to New York to meet individually with science and medical editors of major magazines, wire services, and news feature syndicates. The purpose of these trips is twofold: first, to maintain contact so that the magazine editors will call the Bureau when they are developing a dental article and second, to plant story ideas. As a result of these trips in the magazine field, a number of major dental articles were published during the last half of 1975 and the first six months of 1976. Publications with major dental articles during this period included *McCalls, Parents, Boy's Life, Good Housekeeping, Redbook's Be Beautiful, Sky Magazine, Caring, Changing Times, Homemakers Magazine, Family Health, Today's Health, Newsweek, U.S. News & World Report, National Observer,* and *Girl Scout Leader.*

For the seventh year, the July issue of *Pharmacy Times* will be devoted entirely to cooperation between dentistry and pharmacy.

Bureau staff supplied assistance and consultation to the following magazines and pub-

lications: *Dental Management, TIC, Consumers Complaint Guide, Mini Page, SMASH, Viva, Sphere, Sprint, Woman's Day, Woman's Life, Family Circle, Co-Ed, Time, Good Housekeeping, Better Homes & Gardens, Dental Student, New Times, Moneysworth, Everybody's Money, Lady's Circle, Parade, Family Weekly,* and *Consumer News.*

Several articles on which the Bureau provided consultation will appear in the near future in the following publications: *Parents, Town & Country, McCalls, Ladies Home Journal, Glamour, Redbook's Be Beautiful, Harper's Bazaar, Woman's Life, Better Homes & Gardens, Woman's Day,* and *Family Health.*

Expanded coverage also resulted from closer contacts with a number of nationally syndicated columnists. The expansion of dental insurance was reported in a column by John Cunniff, Associated Press business analyst, which was published in over 600 newspapers. Patricia McCormack, family health editor of United Press International, wrote a three-part series on consumer, preventive, and research aspects of dentistry which was carried by over 800 newspapers. Increased coverage included an article by Ann McFeatters of the Scripps Howard News Service on the use of sealant techniques and a story discussing the myth of "detergent foods" in oral health by Gene McDaniel, Chicago-based AP science writer, which was published in 500 newspapers. Bureau staff also worked closely with other syndicated columnists including David Hendin, medical consumer columnist for Newspaper Enterprise Association, Marion Wells of Copley News Service, Charles Schrager of Medill News Service, Arthur Snider of Chicago Daily News Syndicate, Ruth Winter medical columnist, Ronald Kotulak of the Chicago Tribune News Syndicate, Mary Lou McKenna, beauty columnist, Dolores Katz of the Knight Newspaper Syndicate, and Dr. F. J. L. Blasingame, health economics columnist.

In addition, the Bureau continued its distribution of a series of illustrated newspaper features on dental consumerism.

Because of the sale of *Today's Health,* the American Medical Association's consumer publication, to *Family Health* magazine, the Bureau plans to increase its close cooperation with *Family Health.* For the last four years, *Today's Health* had published a monthly dental column and several major dental articles each year. In the future, the Bureau hopes to strengthen its good relations with *Family Health,* which has been running a monthly dental column since January 1974 as well as a number of dental features.

Annual Session Publicity: News coverage for the 116th ADA annual session held in conjunction with the 63rd World Dental Congress of the *Fédération Dentaire Internationale* in Chicago was probably the most extensive for any annual session in recent years. Locally, the *Chicago Tribune, Chicago Daily News,* and *Chicago Sun-Times* ran almost daily major stories on the meeting and a number of scientific stories were moved across the country by the Associated Press, United Press International, Knight News Service, and the Chicago Daily News Syndicate. A press conference featuring experts in forensic dentistry also contributed measurably to the expanded coverage.

In addition to the three Chicago newspapers and the Associated Press, the session was also covered by the following news media: ABC-News, British Broadcasting Corporation, *Caring, Chemistry & Engineering News, Dental Economics, Dental Management, Dental Products Report, Dental Student, Dental Survey, Eurowatch, Green Bay Press-Gazette, Helsingsborgs Dagblad,* Ketterer Publications, La Prensa International News, *Medical World News, Minneapolis Tribune,* National Business Jour-

nals, *National Enquirer,* NBC-News, *Oral Health, Photo Market Magazine, Quintessence,* and *Zoom-Up.*

Stories receiving the greatest coverage included a report that sugar consumption can be harmful to the body as well as the teeth, a suggestion that breastfeeding can help prevent tooth decay, a paper that more adults are seeking orthodontic treatment, a warning that heavy smoking may interfere with healing of gum tissues after tooth extraction, and a proposal for an international identification system for dentures.

The Bureau is also responsible for publishing the *Daily Bulletin* on five days of the annual session.

Public Relations Assistance to Dental Societies: One of the primary functions of the Bureau is assisting state and local dental societies in establishing and improving their public information programs. For a number of years the Bureau has distributed the "PR Library" which is an extensive compilation of information materials to state and local public information chairmen. The Bureau also provides guidance to societies planning to hire public relations counsel.

In addition, Bureau staff members assist several state societies each year in planning publicity programs for their annual sessions and in operating a pressroom during the meeting. This assistance is provided only once to a society, and in 1976 state societies in Hawaii, Iowa, Kansas-Missouri, and Vermont received this assistance. In 1977, Florida, Georgia, and South Dakota are scheduled to be aided. The long-range purpose of this assistance is to set a pattern which a society can follow in future years. Thus far, 30 state societies have received this help. State societies—especially smaller ones—wishing to receive this service should contact the Bureau director.

During the past year, Bureau staff members spoke at dental meetings in Oregon and Tennessee.

Dental Mechanics' Activities: The Bureau provided staffing throughout the year to the Board of Trustees-appointed Special Study Commission on the Care of Fully and/or Partially Edentulous Patients. In response to a Board directive to develop a public relations plan for matters related to the delivery of denture care, the Bureau and the Council on Dental Laboratory Relations retained an outside public relations firm to assist in designing a state-level demonstration project. The two-year plan was underway in March in cooperation with the Oregon Dental Association.

The Bureau continues to provide assistance to constituent dental societies in their efforts to respond to the dental mechanics' manipulation of mass media and public opinion.

Dental Participation in the Bicentennial: In response to a 1974 House of Delegates resolution (*Trans.* 1974:233) calling for the development of a program to unite all members of the dental and allied professions in a common effort to provide Americans with the knowledge to recognize and prevent dental disease, the Bureau assembled a kit of program suggestions for constituent and component societies to utilize in their own program planning. The theme, "Serving Dental Health/Century 3," was selected to give dentistry an opportunity not only to review the outstanding progress which has already been achieved in dental care but also to focus on the future.

Among the commemorative activities which are being carried out during the Bicentennial year were a special program introducing the program planning kit at the

Ninth National Public Relations Conference in August, distribution of a special Bicentennial cartoon feature to 4,000 selected weekly and daily newspapers throughout the country in November, and distribution of a public service announcement featuring dentistry in colonial times to approximately 540 television stations around the country in February.

Public Relations Conference: More than 100 public relations personnel from state and local dental societies and affiliated dental groups attended the Ninth National Conference on Dental Public Relations held at Association Headquarters August 11-12, 1975. The conference is made possible through a grant from the Professional Relations Division of the Procter and Gamble Company. Emphasis was given to the introduction of new Public Education Program materials for use by the local and state societies as well as to a report on proposed activities for 1976. Other topics included program planning suggestions for dentistry's involvement in the nation's Bicentennial celebration, a report on how a county dental society's members prepared for the start-up of the auto industry's dental program in 1974, a multistate public relations program involving the effective use of dental health public service announcements on radio and television, and the impact of an innovative prevention-oriented school dental health education program. In addition, small discussion groups considered ways of responding to the consumerism movement as it affects dentistry. The Tenth National Conference on Dental Public Relations will be held September 20-21 in Chicago. The Conference will explore new facets of the Public Education Program, as well as combating "denturism" and new dental health education materials and techniques.

Science Writers: The 10th annual American Dental Association Science Writers Award competition in 1976 was again conducted with a grant from Lever Brothers. A year-by-year increase in the number of entries (in 1975 there was a 13 percent increase) is one indicator that the competition is achieving its goal to "broaden and deepen the public understanding of dental disease, dental treatment, and dental research." First place awards in the two divisions, newspaper and magazine, consist of a plaque, $1,000 in cash and a trip to the Association's annual session where the awards are presented. The 1975 winner in the newspaper division was Sarah Watke, medical reporter for the Green Bay (Wis.) *Press-Gazette,* for a series of five articles entitled "Saving Your Teeth," submitted by the Wisconsin Dental Association. Jean Butler, a free-lance writer from Chicago, won first prize in the magazine division for an article entitled, "False Teeth: The Problems May Be More Mental Than Dental," which was published in the August 1974 issue of *Today's Health* magazine and submitted by the Chicago Dental Society.

Awards of Merit also were presented. Recipients were: Leila Holmes, *Indianapolis Star;* Gene McDaniel, Associated Press-Chicago; Dr. Robert I. Kaplan, *Parents* magazine; and Valorie Weaver, *Vogue.*

Membership Information: The Bureau, in cooperation with other Association agencies, prepared and distributed a special *ADA Information Bulletin* to all members of the Association about dental manpower legislation pending in the Senate and the need for every dentist to express his views to his Senator.

In March, each member of the Association received a copy of the *Index to ADA Member Services.* This was the fourth annual edition of the booklet that serves as a

guide to the free and low-cost services available as a benefit of membership. A complete revision of the Association's booklet, *The American Dental Association—Its Structure and Function,* was accomplished prior to the annual session in Chicago.

International Science Fair: This was the 14th year that a Bureau staff member coordinated and publicized the Association's award program conducted as part of the International Science and Engineering Fair's Health Awards Banquet with the American Medical Association and the American Veterinary Medical Association. The American Pharmaceutical Association, which was a cosponsor in previous years, withdrew from participation in 1976. Dr. Frank F. Shuler, ADA president-elect, presented the awards at the banquet. The two top winners for 1976, who will exhibit at the Las Vegas annual session, are: Deborah Malone of Grant, New Mexico, and Stephen Budak of Michigan City, Indiana. The Association's science fair program is operated in cooperation with the Council on Dental Research.

Boy Scout Merit Badge: A merit badge in dentistry stressing preventive education and career exploration was introduced in 1975 after two and one-half years of Bureau development with the Boy Scouts of America. During the past year, the Bureau completed a full-scale promotional campaign directed to Scouts and to the profession to attract badge counselors. The project, which was underwritten by a grant from the American Fund for Dental Health, has been described by Scouting officials as the most comprehensive promotional campaign ever conducted by an outside organization for a new merit badge. The year-long campaign was concluded at the annual session in Chicago when the first Scout in the country to earn the badge was honored at the Opening Ceremony.

Relief Fund Campaign: Each year the Bureau assists the Council on Relief in conducting its Relief Fund and Disaster Fund campaign. During the 1975-76 campaign, the Bureau handled preparation of seals, a promotional pamphlet, the computerized letter mailings, "advertisements" tailored to each state for constituent society journals, a news release and suggested editorial sent to all dental periodicals and an advertisement which was run in nine issues of *The Journal.* Campaign contributions in 1975-76 far exceeded any previous year. With two months remaining in the campaign, $273,000 had been contributed, 76 percent above the annual goal.

Service to Related Dental Groups: The Bureau again provided limited assistance to the American Student Dental Association, American Fund for Dental Health, Association of American Women Dentists, Association of Component Society Executives, National Foundation for the Prevention of Oral Diseases, and the American Dental Political Action Committee. For the twelfth year, a staff member was assigned to assist the American Association of Dental Schools and the International Association for Dental Research with publicity for their annual sessions in Miami Beach.

"ADA Leadership Bulletin": The *ADA Leadership Bulletin* is a limited-circulation publication distributed to the four percent of the dental profession in leadership positions in national, state and local societies, dental education, research, public health, and Association agencies. The *Leadership Bulletin* contains articles and inserts providing information needed in dental society administration, announcements of upcoming events of importance to dental leaders, and news events which have not been reported in the *ADA News.*

Encyclopedias and Books: Complete articles were written for *Britannica Book of the Year, Britannica Yearbook of Science and the Future, World Book Year Book, Compton Yearbook,* and *Funk and Wagnall's Yearbook.* In addition, consultation service was provided for the *Encyclopedia Britannica, The World Almanac,* and *The World of Learning.* The Bureau also provided consultation service for the dental portion of a new book on men's health by Samuel Julty, and for the dental chapter on a new book on beauty by K. T. Maclay.

RESOLUTIONS

This report is informational in nature and no resolutions are presented.

ADA Health Foundation

Meetings: The Board of Directors of the American Dental Association Health Foundation met in August and December 1975. The meetings of the Board of Directors were held in conjunction with sessions of the Board of Trustees of the American Dental Association.

Projects Considered and Grants Awarded by the Foundation: During the reporting period of the annual report the Board of Directors awarded two grants from the unencumbered Health Foundation funds in the amount of $205,413 as follows:

American Fund for Dental Health
Restricted Grant to Support Expanded Fund Raising Activities.... $ 52,000
ADA Bureau of Economic Research & Statistics
Dental Manpower Study..... 153,413

Patent Policy: An application for an Institutional Patent Agreement was submitted to the Patent Adviser of the National Bureau of Standards, US Department of Commerce. This application was patterned after the agreement approved by the Assistant Secretary for Health, Department of Health, Education, and Welfare in April 1975. Recent communications with the NBS Patent Adviser disclosed that the application will be reviewed by the Contracts Inventions Committee of the Department of Commerce. A recommendation for approval and signature by the Assistant Secretary for Science and Technology, Department of Commerce, is anticipated before the meeting of the Board of Directors of the Foundation in August 1976. Under the provisions of this agreement, the Foundation will be allowed to retain rights to patents resulting from inventions arising from grants and awards sponsored with federal funds and conducted by the research staff members of the ADA Health Foundation Research Unit at the National Bureau of Standards.

RESOLUTIONS

This report is informational in nature and no resolutions are presented.

ADA Health Foundation Research Institute

Hefferren, John J., director

Hefferren, John J., acting chief research scientist, Division of Biochemistry

Moore, Keith B., chief research scientist, Division of Biophysics

Schoenfeld, Charles M., chief research scientist, Division of Clinical Studies

Steffek, Anthony J., chief research scientist, Division of Developmental Biology

The *overall goal* of the ADA Health Foundation Research Institute in Chicago is *better dentistry through research.*

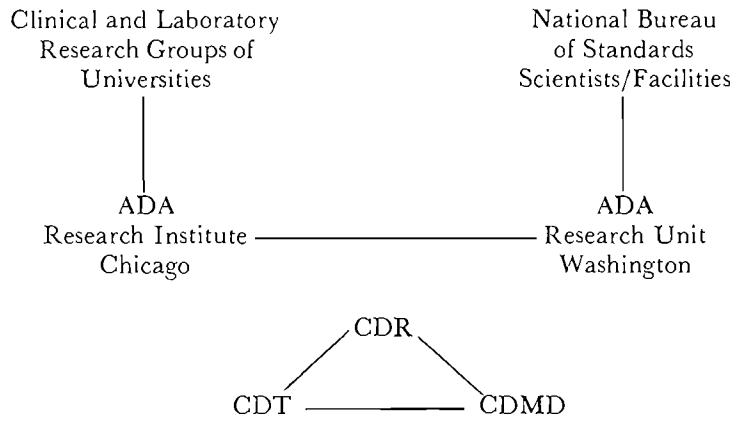
The *Bylaws* (Chapter XIII, Section 30A) of the Association state: The Foundation, through its agencies, the American Dental Association Research Institute and the American Dental Association Research Unit at the National Bureau of Standards shall:

a. conduct basic and applied research for the utilization in and development of oral health.

b. conduct training programs in research disciplines that relate to the basic and applied problems of oral health.

The location of ADA Health Foundation research groups in Chicago and Washington provides the opportunity to intergrade interactions to strengthen the overall ADA research program. The ADA Research Unit in Chicago is located in part on the same floors of the Association building as the scientific councils, namely, Council on Dental Materials and Devices (CDMD), Council on Dental Research (CDR) and Council on Dental Therapeutics (CDT). This geographic proximity facilitates information interchange and cooperation of the councils and research staffs.

Thus, the Association, as directed through its *Constitution and Bylaws* and the ADA administration, has provided the opportunity for the cohesive development of research programs with multilocations, multiagency and multilevel interactions that can be summarized in the following way.



In December 1975, Dr. John J. Hefferren was appointed Director of the ADA Health Foundation Research Institute in Chicago. With the concurrence of the Institute senior staff at that time the *major goals of the Research Institute* were identified as:

> to conduct a balanced research program of basic and applied research in close concert with the ADA Research Unit at NBS, the three scientific councils of the Association, CDMD, CDR, and CDT, and outside agencies and institutions, both private and federal.
>
> to provide a *point of focus for dental research* whereby researchers at dental schools and researchers outside of dentistry but with a relevant competence to a dental problem can be encouraged.
>
> to recognize and emphasize those *areas of research* that are otherwise inadequately stressed in other dental research institutions.
>
> to provide and encourage *educational opportunities* for dental researchers and students.
>
> to seek a *broad base of research support* made possible by the 501 C3 IRS classification.
>
> to provide a sound basis for the *continuance of the long traditional posture of the Association* to support with its funds and to strongly encourage private and federal agencies to support dental research.

One of the *significant contributions of the ADA Research Effort* is the interrelationship with the scientific councils of the Association in achieving a shortening of the time space between research discovery and clinical application. The interaction between the staffs of the scientific councils and ADA researchers is doing much to facilitate the movement of concept, drug, material, or device through the sequential steps of development, documentation, verification, and substantive review.

In these days of federal review of drugs, devices and materials, the strong research and review position of the Association has done much to moderate the application of federal restraints to dentistry. Just as the Federal Drug Administration and other federal agencies have acknowledged the Association's tradition and stature in research and review, this same posture would be equally respected by the Internal

Revenue Service and other agencies concerned with national associations, their income sources, and the uses of that income.

Table 1 lists the current sponsored grants and contracts for the report period.

Table 1

American Dental Association Health Foundation Research Institute

SPONSORED GRANTS AND CONTRACTS: $149,465: The following grants and contracts have been awarded to Division of the Research Institute during the reporting period of the annual report:

Category-Sponsor	Title	Total Amount
Office of the Director		
National Institutes of Health	Biomedical Research Support Grant	$38,392
National Institute of Dental Research	Aging and Optical Changes in Tissues	31,024
Dr. Joseph R. Jarabak	Orthodontic Studies	500
Clinical Studies		
Office of Naval Research	Some Biophysical and Microchemical Properties of Oral Structures in Health and Disease	25,001
National Institute of Dental Research	Rod Anode X-Ray Sources in Dental Radiography	500
Developmental Biology		
University of California	Experimental Orofacial Defects	9,600
National Institute of Dental Research	Cleft Palate and Lip	25,000
Immunology		
National Institute of Dental Research	Delayed Hypersensitivity	19,448

INDIRECT COSTS DERIVED FROM SPONSORED GRANTS AND CONTRACTS: $19,848

Summary of Research Activities: The following are brief summaries of the research activities of the Research Institute. More detailed information can be obtained from the publications and presentations listed as part of this report.

Studies in the Division of Developmental Biology have shown that the *formation of the face* and associated intraoral structures consist of a complex series of delicately balanced interactions involving extensive cell migrations and tissue interactions. Data have further established that these general phenomena are sensitive to a host of genetic and/or environmental influences that are represented clinically as a wide spectrum of distinct craniofacial malformations ranging from a simple cleft of the lip to arhinencephal in which very few structural facial elements are present.

In a number of vertebrate species, it has been shown that alterations in cell migration—*specifically cranial neural crest cells*—can result in a number of distinct facial malformations. The Institute has been attempting to characterize the migration of this important population of cells and define the microenvironment through which they pass. Thus far, the presence of a meshwork, both at the undersurface ectoderm and overlying the neural tube has been observed, and this fibrous meshwork appears to provide a directional vector to migrating cells both by facilitating and restricting their movements. Experiments are currently underway to characterize this meshwork which is presumed from other investigations to be collagen or proteoglycan in nature.

These experimental studies are identifying specific prenatal environmental components associated with normal and abnormal craniofacial development in order to better understand not only the clinical consequences of these debilitating malformations but also define measures that can potentially prevent them in humans.

The *genetic influences* on the production of *craniofacial malformations* have been

investigated over the past few years in our division, particularly those present in the cytoplasm of the cell.

Our findings support the hypothesis that there is a factor, transmitted through the cytoplasm, that makes C57BL/6J mice more resistant than A/J mice to the cleft palate producing effect of a specific teratogen, 6-aminonicotinamide. Since mitochondria are transmitted through the egg cytoplasm, and since 6-aminonicotinamide forms an inactive NAD analogue that interferes with oxidative phosphorylation in mitochondria, it is reasonable to postulate that the cytoplasmic factor is associated with the difference in the mitochondria of the two strains.

If it is possible to further establish biochemically the mitochondrial difference described, it would be the first strain difference in mice correlated to a specific biochemical difference and, also, the first mitochondrial mutant identified in mammals. This example of extrachromosomal transmission of a metabolic characteristic adds a new complexity to the question of gene-environment interactions in general and drug-induced malformations in particular—a complexity of *major* importance.

Lastly, attempts to produce craniofacial malformations in nonhuman primates, a species phylogenetically closer to human than other experimental animals have been successful.

Administration of the glucocorticoid, triamcinolone during the embryonic period (18-47 days gestation) consisted of resorption, intrauterine death, and malformations. Defects were seen in the craniofacial region, thorax, and hind-limbs, and the thymus, adrenal and kidney. Resorption was observed only in the rhesus monkey, but intrauterine death was observed in all three species. The most severe defects of the orofacial region consisted of cleft palate in a bonnet monkey, and choanal atresia and mandibular overbite in a baboon.

Three bonnet monkeys and eight rhesus monkeys also had alteration in facial development characterized by forward protrusion of the forehead, widening of the head, and expansion of the cranial sutures and both the frontoparietal and occipitoparietal fontanelles. This condition becomes more pronounced with the age of the fetus and the general appearance is that of a slight to moderate depression at the bridge of the nose.

The effect of administration of triamcinolone during the embryonic period in three nonhuman primate species indicates that the drug is teratogenic and, furthermore, shows that these species are susceptible to the production of craniofacial defects. Studies are now underway to induce these malformations in a repeatable manner in order to provide not only an animal model for which to delineate causal mechanisms, but also to evaluate subsequent postnatal facial growth on these affected animals.

The ongoing program of radiography research in the Division of Clinical Studies and Biophysics has concentrated on image analysis research and intraoral source radiography in 1975. The *image analysis research* includes resolution measurements in the form of total system modulation transfer functions (MTFs) and component MFTs as well as measurements of image noise, macroscopic contrast, and distortion. The MTFs are being measured directly by a spatial frequency subject in a limited spatial frequency range and indirectly by Fourier analysis of edge scans and slit scans for comprehensive spatial frequency ranges.

Research and development of *intraoral source radiography* was performed under a contract from the Food and Drug Administration. This research concentrated upon the development of an optimum geometry and projection, investigation of image re-

ceptor speeds, and development of beam restrictions and beam filtration. A research proposal for performance of quantitative image analysis and dosimetry for intraoral source radiography was submitted to the National Institutes of Health.

All of the radiography studies are of direct clinical relevancy. However, the conduct of the studies makes extensive use of physics and mathematics. Accordingly, the radiography studies are being carried out with the participation of the Divisions of Biophysics and Clinical Studies and the Statistics and Computer Facility of the Research Institute and of the Radiography Department of Northwestern University.

A procedure for simulating the *in vivo* corrosion performance of dental amalgam is being developed. This is a project of the Council on Dental Materials and Devices in which the Division of Clinical Studies has participated.

A research program has been prepared for the objective and quantitative measurement of the *conscious perception of pain and anxiety.* The research program is based upon Fourier analysis of electroencephalographic (EEG) data and of peripheral surface electrical changes. This research has been planned in conjunction with the Divisions of Biophysics and Clinical Studies and the Statistics and Computer Facility of the Research Institute and the Psychiatry Department of the University of Chicago.

The effectiveness of an enzyme containing *denture cleanser* was investigated by a technique utilizing scanning electron microscopy. This study was carried out with the cooperation of clinic patients in conjunction with the Department of Prosthetic Dentistry at Northwestern University.

A versatile and comprehensive *research operatory facility* capable of supporting a wide spectrum of clinical research is being established. This activity is being carried out under a grant from General Research Support Grant funds from the National Institute of Health.

In-depth study of the optical properties of *dental porcelain teeth and restorative materials* especially under short wavelength illumination (ultraviolet light) has been conducted. A project has been initiated to develop improved, nonradioactive materials for adding to dental porcelains to produce optical properties similar to natural teeth when illuminated by a source with a substantial ultraviolet component.

Studies in the Division of Biochemistry have included *nitrous oxide and halothane,* the two most commonly used dental inhalation anesthetic agents. Since currently utilized anesthetic equipment does not provide for adequate disposal of waste gases, dentists and their staff are constantly exposed to these anesthetic gases. A recent survey of dentists suggests that those exposed to anesthetic gases are more frequently victims of hepatitis and kidney disease, and female staff members as well as the dentist's wife may have higher incidence of spontaneous abortion or offsprings with congenital abnormalities. Studies are in progress involving nitrous oxide and halothane-induced toxicity in model laboratory animals, rats, and mice. The results suggest that halothane metabolites are responsible for liver toxicity rather than halothane, and that there may be a correlation between halothane-hepatitis and intake of commonly used drugs such as barbiturates, that stimulate drug metabolism by the liver.

Diphenylhydantoin-DPH (Phenytoin, Dilantin), a widely prescribed anticonvulsant drug, is known to induce gingival hyperplasia in one out of three patients on prolonged medication. Studies are in progress to determine the etiology of this drug-induced oral adverse reaction in model animal systems, ferrets, and rats with emphasis on gingival drug metabolism as a possible cause of drug toxicity. Contrary to commonly held views, the local metabolism of DPH appears to be significant in the observed toxicity.

Human saliva contains significant quantities of *nitrite* (higher amount in cigarette smokers) which can react with orally administered drugs and amino constituents of oral hygiene products to yield carcinogenic *N*-nitroso compounds. A representative group of commonly used drugs (such as oxytetracycline, piperazine) and agents used in dentifrices and oral hygiene aids are currently being investigated for carcinogenic *N*-nitrosamine formation in the presence of saliva. The effects of phenolic and flavonoid food constituents on salivary metabolism and carcinogenic nitrosamine formation are also being studied.

Malodor in human mouth air is primarily due to hydrogen sulfide and methyl mercaptan which are the end products of oral and systemic bacterial metabolism. During periodontal disease, there is an increase in oral bacterial degradation products with a consequent increase in mouth odor. Studies are in progress to determine whether chemical analysis of mouth odor may provide a useful diagnostic aid to the practicing dentist in the treatment of periodontal disease.

The prime objective of the Computer and Statistics Facility is to provide statistical advice and assistance to the Research Institute as a whole. This includes the planning, design, collection, analysis, and interpretation of data for a research experiment. The computer is used as necessary and may include the on-line collection (ie, directly into) of data as well as the running of the various statistical programs needed in the analysis of a particular experiment. Depending on the particular project, this use is sometimes quite substantial. New statistical programs, either written or canned, are modified for use on the PDP-12 as they are needed in a particular project.

Representative examples of the involvement of the computer facility in the programs include: the enamel biopsy methodology and biological levels of mercury in the dental team of the Division of Biochemistry; radiographic system performance and the pain-electroencephalographic studies of the Divisions of Biophysics and Clinical Studies; and the mitochondrial oxygen uptake studies of the Division of Developmental Biology.

The scanning electron microscope and electron microprobe x-ray analyzer of the Electron Optics Facility were used in various research programs to determine and evaluate: corrosion products (if any) of long-term, chrome-cobalt endosseous implants; healing of severed facial and peripheral nerves; chemical composition of cementum and appositional calculus; fluoride uptake by sound and carious tooth structure; calcium/phosphorous ratios of caries-susceptible and caries-resistant enamel; and the nature of plaque accumulation and the effectiveness of agents for plaque removal. The studies represent collaborative efforts with the University of Illinois, Northwestern University, and the Naval Dental Research Institute, Great Lakes, and are supported, in part, by a grant from the Office of Naval Research.

Training Programs: The staff of the Research Institute served as preceptors for outstanding students participating in the *Traineeship in Dental Research for College Students* sponsored by the National Institute for Dental Research. Miss Pia Susman of City College of New York worked with Dr. Carl Verrusio on genetic factors influencing cleft palate formation using a mice animal model system. Mr. James Robers of Amherst College, Amherst, Massachusetts worked with Dr. Anthony Steffek on the formation of the face in mice and nonhuman primates model systems using the scanning electron microscope. Mr. Kelly McLain of Texas A & M University, Aggieland Station, Texas worked with Dr. John Hefferren on the use of surface profilometers

in measurement of submicrogram quantities of tooth structure and restorative materials removed by dentifrices and other oral hygiene agents.

Graduate students in pedodontics and biochemistry at Northwestern University and dental trainees at the V.A. Research Hospital in Chicago have participated in the research program of the Division of Biochemistry with Drs. Hefferren and Rao. The divisions of Biophysics and Clinical Studies have participated in the Northwestern University cooperative student program. Mr. Ed Smith, B.S. (1975) who worked in our program received a degree in biomedical engineering in this program.

Graduate students from the Zoller Memorial Dental Clinic of the University of Chicago have participated in the research program of the Division of Developmental Biology with Drs. Steffek and Verrusio. Drs. Moore and Schoenfeld of the Divisions of Biophysics and Clinical Studies, and Mr. Muller of the Computer and Statistics Facility, are serving as advisors for graduate thesis research at the University of Chicago, Zoller Memorial Dental Clinic. Dr. John Hefferren has worked with Dr. Higuchi and his graduate students at the University of Michigan in Ann Arbor concerned with the dissolution and remineralization of dental tissues.

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RESOLUTIONS

This report is informational in nature and no resolutions are presented.

ADA Health Foundation Research Unit at National Bureau of Standards

Brown, Walter E., director

Bowen, Rafael L., associate director

Paffenbarger, George C., director emeritus

Mabie, C. P., chief research scientist, Division of Ceramics

Rupp, N. W., chief research scientist, Division of Clinical Studies

Schroeder, L. W., chief research scientist, Division of Crystallography

Chow, L. C., chief research scientist, Division of Dental Chemistry

Waterstrat, R. M., chief research scientist, Division of Metallurgy

The Research Unit is continuing its investigation of dental materials, devices, and techniques of caries mechanisms and of the chemistry of tooth-fluoride interactions. This marks the 48th year of cooperation between the National Bureau of Standards and the Association in which this program acts as a principal interface between dentistry and the physical sciences. In addition to the Association funding, laboratories and other facilities are provided by the National Bureau of Standards, and the Research Unit received $475,218 in grants from the National Institute of Dental Research. It is of interest to note that the current National Bureau of Standards budget is about $119 million and that of the Association is about $15 million; yet it is estimated that one product developed by the Research Unit (composite resins) saves the American public more than twice the combined amount each year in replacement costs for silicate cement restorations. The progress in major research activities during the past year is described briefly in the following.

COMPOSITE RESTORATIVE MATERIALS

The invention and the synthesis of the first dental composites were functions of the Research Unit. Manufacturers were assisted in the development of Blendant, Compodent, Compolite, Concise, Cosmic, Exact, HL-72, Love, Natural, Nuva-Fil, Opotow, Oratec/DRS, Polycap, Portrait, Posite, Precedent, Prestige, Radent, Simulate, and Smile. Currently, over 230,000 restorations consisting of these materials are placed each day in the United States.

Durability: *The composites' resistance to wear is less than it might be. A possible means for solving this problem has been conceived and is under study.* Special glass filler materials were formulated that can be etched to give "semi-porous" particles that will bond with resins by surface penetration and physical interlocking. Twenty-two glass compositions have been prepared. It now appears possible to formulate one that will yield composites that are translucent, X-ray opaque, and nontoxic and have other desirable characteristics. Testing of physical properties and filing of a patent application are planned.

Polymerization Initiators: The amine-plus-peroxide initiator system that was discovered over thirty years ago is now used (with a number of empirical improvements) to harden dental sealants and composites. Yet, the sequence of chemical events that characterizes the amine's role in the hardening of dental resins has not been established. On a per-molecule basis, the amines currently in use are quite inefficient in the initiation of polymerization. *An ongoing theoretical study into the effects of structure on reactivity has resulted in the design of several new, previously unanticipated, compounds as candidates for more efficient accelerators.* Data in the literature show that some of these compounds are closely related to compounds of demonstrated low toxicity.

Hardening Shrinkage: A new study, to investigate chemical means of eliminating the shrinkage that occurs during the hardening of dental resins and composites, has recently been initiated. *A reduction in polymerization shrinkage would probably improve bonding, marginal integrity, dental pulp response, and other characteristics of these materials.*

Adhesion Mechanisms: Significant progress has been made in both the "mordanting" and "polyfunctional surface-active comonomer" studies. In the investigation of mordanting (ie, exchange of strongly chelating ions for weakly chelated calcium ions of the tooth surface), a new research tool has become available. This tool, electron spectroscopy for chemical analysis, measures the relative amounts of each chemical element in the surface of treated or control extracted teeth. By using an etching solution containing equal concentrations of competing mordant ions, the relative affinities of these for tooth surfaces can be determined. *Based on the results of studies thus far it seems quite possible that the etching and mordanting can be done in one operation.*

The polyfunctional surface-active comonomers are chemical compounds having (1) chelating groups that can simultaneously attach to more than one calcium or mordant-metal ion site on the tooth surface, and (2) more than one polymerizable group for reacting with the overlying pit and fissure sealant resin or composite resin. After three ill-fated attempts, *a compound of this type was successfully synthesized in good yield. Its chemical and physical characteristics are now being studied; adhesive bond studies will follow. When combined, the above developments should improve the performance of these materials substantially more than when taken individually.*

CLINICAL RESEARCH

The clinical performance of restorative materials is its final proving ground. It is

essential to observe long-term (4-6 year) response to adequately test the validity of accelerated laboratory methods.

Amalgam: Observations are continuing into the fifth year of a clinical trial designed to identify causes of failure associated with amalgam restorations. Marginal deteriorations of three types were the principal defects: (1) fracture of the amalgam, (2) fracture of enamel, and (3) extrusion of amalgam from the cavity. *Fracture of the enamel is a result of operative procedures* and is not directly dependent on the material and its physical properties. *Fracture of the amalgam and extrusion from the cavity are more frequently a response of the material to corrosion, creep, excessive retained mercury and/or phase changes within the amalgam.* The physical and mechanical properties associated with these changes in the amalgam are being studied in the laboratory. Phase changes and excessive amounts of retained mercury have marked effects on creep and compressive strength values. Delayed compaction, as often occurs clinically when placing large restorations, increases the mercury content. Those alloys that make amalgams with relatively high creep (ie, over 2 percent even when packed immediately), have markedly higher creep after 3-minute and 6-minute delays. *These all emphasize the need to make multiple small mixes of amalgam to insure a fresh mix on the outer layer of the restoration from which all excess mercury can then be compacted.* The role of excess mercury on corrosion and phase changes within the amalgam is being observed in the laboratory to determine its effect on the excessive expansion which is manifested clinically as extrusion from the cavity. Amalgams made from the recently introduced high-copper alloys have rapid setting reactions, as evidenced by the rapid increase of retained mercury when condensation is delayed. *This also dictates that many small mixes be made when using these newer alloys.*

Operative variables are being studied with the scanning electron microscope to observe the cavo-surface margins and to determine the causes of the clinically detectable defects in the enamel. *High-speed rotary instruments cause a splintering or crazing of the enamel; thus, the final finish of the enamel margin must be done carefully.*

Composite Restorations: Marginal staining observed after a composite resin restoration has been in place several years indicates leakage. Acid-etch pretreatment of enamel and the placement of an intermediary polymer coating have been reported to be effective means to seal margins. A scanning electron microscope study of composite restorations without the intermediary polymer shows that those composites with high BIS-GMA content (60-70 percent) have better adaptation at the margin than those with higher percentages of dilutant (eg, 42 percent BIS-GMA). The lower molecular weight dilutants cause greater polymerization shrinkage and larger gaps at the margin. Manufacturers tend to increase the amount of dilutant in an effort to increase fluidity and penetration into the microporosities of the etched enamel. However, *one of the principal advantages of the originally formulated composite resins with 80 percent BIS-GMA is low curing shrinkage; the trend toward greater fluidity defeats dimensional stability during cure.*

METALLURGY

The research program to study the casting behavior of base-metal alloys so that they might displace costly gold alloys for use in dental crowns and bridges has been initiated. This program is being conducted in cooperation with the Navy Dental Service and National Bureau of Standards employees. *The initial experiments indicate that the nickel-chromium alloys generally are suitable for precision casting but the present ceramic investment materials are not entirely satisfactory and may be responsible for a lack of accuracy and for the observed surface roughness in the castings.* A study of the bonding of these alloys to porcelain is under way in cooperation with a National Association of Dental Laboratories research associate. As these programs develop, the use of other alloy systems for precision dental castings will be explored, such as the alloys of titanium.

The development of suitable casting alloys may be greatly expedited by recent developments in the use of computers to predict phase diagrams for alloys containing three or more metals, thereby reducing the amount of experimental work. The Research Unit recently contracted for such services. The initial calculations will be made on nickel-chromium based alloys since they are already in use. Eventually the method will include data for the noble-metal binary phase diagrams obtained by the Research Unit over the past several years. *The use of computers for calculating phase diagrams is a major breakthrough in metallurgical research which may greatly facilitate the search for new and improved alloys. The Research Unit's early entry into this field should insure maximum benefits to dentistry.*

As a preliminary step toward acquiring patent rights on the manganese-containing amalgam alloy developed by the Research Unit, biological and clinical tests are being initiated. *The manganese additive eliminates the undesirable tin-mercury phase from these alloys and improves the "creep" properties, making this type of alloy a promising candidate for improved dental amalgams.*

Work is continuing on the search for other elements which are soluble in the silver-tin alloy used in amalgam restorations. These elements should also eliminate the tin-mercury phase in amalgam. It appears that dental amalgams will continue to be widely used as dental restorative materials despite inroads on their use by the composite resin restorations. *Thus, the majority of posterior restorations will continue to be made with dental amalgams and continued improvements in these alloys will be of great value to clinical dentistry.*

DENTAL CERAMICS

The Research Unit is investigating the advantages of ceramic materials derived from gels over conventional frits. Fillers for composite resins have been prepared from nontoxic ingredients which give x-ray opacity, satisfactory translucency, strength, setting contraction, and microhardness as compared to current products. They provide improved finish and reduced solubility. *These new ceramic filler materials derived from gels offer the possibility of improving the properties of dental porcelains and composite resins where they presently have their major shortcomings.* Major emphasis is now being placed upon the development of porcelains prepared

from gels. These may allow the development of stronger porcelains with less firing shrinkage.

The high temperature reactions of investment materials are being investigated by optical microscopy and thermal expansion techniques. *This is an important aspect of the research to develop investment materials that will permit precision casting of dental devices at the higher temperatures required by base-metal substitutes for gold alloys and to do this under the variable conditions found in dental laboratories.*

DENTAL CHEMISTRY

Topical Fluoride Treatments: A major development during the report period was the discovery that acidulated phosphate fluoride solutions are capable of forming an acidic calcium phosphate (presumably the crystalline compound $CaHPO_4 \cdot 2H_2O$) within the enamel. This compound then can react slowly with excess fluoride to form a permanently retained fluoride compound within the enamel. The significance of this discovery is that it *points the way to possible further improvement of single-step topical fluoride treatments.*

Tooth-Fluoride Interactions: A substantial increase was made in the amount of effort in this area, and progress was made along several different fronts.

New insights were gained into the interaction of fluoride ions with the surfaces of enamel crystallites. It was found that these reactions could be divided into two categories, "lattice" and "interface"; these are affected oppositely by the presence of acids. *A knowledge of these reactions makes possible a better understanding of (1) the effects of fluoride under cariogenic conditions and (2) the chemistry of topical fluoride treatments.*

Contrary to a widely held belief, it was discovered that about equal amounts of fluoridated and nonfluoridated enamel will dissolve under cariogenic conditions. As a consequence, *a new theory was developed of a mechanism by which fluoride represses caries formation.*

Remarkably small amounts of fluoride incorporated into enamel mineral during growth of the teeth have profound effects on the subsequent caries incidence. New experimental evidence was obtained which *gives insight into the nature of the mineral formed when the tooth grows in the presence of fluoride and thus, how fluoride in the drinking water prevents tooth decay.*

Caries Mechanism: Very little is known about the actual events that take place within enamel during formation of a carious lesion. Good progress has been made in developing techniques which will permit the sampling and analysis of solutions within the enamel under various types of cariogenic conditions. These techniques must deal with extremely small volumes of liquid, and this is the first time such a study has been attempted. *The results from these experiments are expected to develop a body of knowledge that will be of great importance in finding new ways to prevent tooth decay.*

Based on a theory previously developed by the Research Unit, positively charged tooth surfaces should impede the formation of carious lesions. A compound was found

that appears to be very effective in developing positive surface charges, and several other possible candidates have been identified. Tests of these materials with an animal experimental model are planned. *If successful, these materials could lead to new procedures for the prevention of tooth decay.*

DENTAL CRYSTALLOGRAPHY

Much of a tooth's inherent susceptibility to caries lies in the structure of its crystals, particularly in its impurities and defects. The structure of an analog of tooth mineral was completed which revealed a new type of disorder in the position of the fluorine atom. In addition, an extensive project is being carried out in cooperation with personnel of the National Bureau of Standards neutron diffraction facility to seek the cause for variations in the composition of tooth enamel; the structure of a compound produced by the interaction of stannous fluoride with tooth mineral was completed; and work on the two calcium phosphates with the composition $Ca_3(PO_4)_2$ was completed. *The crystallographic program is designed to provide a structural basis for understanding the chemistry of tooth mineral that will be useful in finding the basic causes for tooth decay, improved topical fluoride treatments, and mechanisms for bonding restorations to tooth surfaces.*

PERSONNEL

Of a staff of 23 full-time and part-time employees, nine have doctorates in physical sciences, three are dentists, three have masters degrees, one has a baccalaureate, and one has nearly completed work on a doctorate in metallurgy.

HONORS

G. C. Paffenbarger was the recipient of the 1976 Hollenback Award from the Academy of Operative Dentistry.

G. C. Paffenbarger was presented a plaque from the Faculty and Alumni of the Ohio State University College of Dentistry "in recognition of and appreciation for his outstanding contributions to the profession and to the art, science, and literature of dentistry".

M.-S. Tung won first place in the post-doctoral category of the Edward F. Hatton Award at the 1976 meeting of the International Association for Dental Research with his paper "Characterization and Modification of Permselective Properties of Hydroxyapatite Membranes".

Papers Published: Twelve papers, listed below, were published by members of the staff.

The Crystal Structure of $Ca(BF_4)_2$ (Jordan, Dickens, Schroeder and Brown); *Adhesive Bonding*

of Various Materials to Hard Tooth Tissues: VIII. Nickel and Copper Ions on Hydroxyapatite; Role of Ion Exchange and Surface Nucleation (Misra, Bowen and Wallace); *Dental Amalgam, A Plea for Clinical Research* (Rupp); *Formation of $CaHPO_4 \cdot 2H_2O$ from Enamel Mineral and Its Relationship to Caries Mechanism* (Brown, Patel and Chow); *Colored Charge-Transfer Complexes from N,N-Dimethyl-p-Toluidine* (Argentar and Bowen); *Dimethacrylate Monomers of Aromatic Diethers* (Bowen and Antonucci); *Thermodynamic Solubility Product of Human Tooth Enamel: Powdered Sample* (Patel and Brown); *Topical Fluoridation of Teeth Before Sealant Application,* Annotation (Chow and Brown); *Observations on Nb_3Si and the Relative Stability of $A15$ versus Ti_3P-Type Structures* (Waterstrat); *Computer Programs for Structural Chemistry: MATCH1 and MATCH2, FORTRAN Programs to Predict and Evaluate Mutual Orientation of Polycrystals* (Dickens and Schroeder); *Dimethacrylates Derived from Hydroxybenzoic Acids* (Antonucci and Bowen); *Comments on Possible "B-Site" Disorder in $A15$ (β-W Type) Compounds* (Waterstrat).

In addition, nine manuscripts have been accepted for publication and thirteen papers have been cleared for publication.

American Dental Association Health Foundation Research Unit

SPONSORED GRANTS: $475,218: The National Insittute of Dental Research awarded the following grants to Divisions of the Research Unit at the National Bureau of Standards during the reporting period of the annual report:

Division	Title	Total Award
Office of the Director		
	Workshop on Cariostatic Mechanisms of Fluorides	$ 60,606
Dental Ceramics		
	Dental Porcelain Improvement with Inorganic Polymers	15,458
Clinical Research		
	Improvement of Materials for Preventive Dentistry	67,467
	Amalgam: Improved Alloy and Manipulation Techniques	30,984
Dental Metallurgy		
	Constitution Diagrams for Alloys of the Noble Metals	30,244
Dental Chemistry		
	Solubility and Diffusion of Calcium Phosphates	101,489
	Crystal Chemistry of Calcium Phosphate	126,787
	Mechanisms of Dental Caries	42,183
INDIRECT COSTS DERIVED FROM SPONSORED GRANTS:		$117,354

Educational Activities: An important activity of the Research Unit is the dissemination of helpful information to dental practitioners, educators, and manufacturers by direct communications. During the report period, talks were given to 14 dental educational organizations and dental societies, and 17 papers describing original research were presented at scientific meetings. The Unit's laboratories were visited by 59 dental scientists.

The Research Unit was the recipient of a grant from the National Institute of Dental Research to sponsor the first international Workshop on the Cariostatic Mechanisms of Fluorides. *The Proceedings, to be published, should be a major source of information for future research on this important subject.*

RESOLUTIONS

This report is informational in nature and no resolutions are presented.

Delta Dental Plans Association

The Delta Dental Plans Association, the creation of which, under its original name of National Association of Dental Service Plans, was ordered by the House of Delegates in 1964 (*Trans.* 1964:272), embarked in 1976 upon its second decade of effective operation as a trade association and national coordinating agency for dental service corporations. The 1976 Annual Membership Meeting of the Corporation constituted, in part, an observance of this milestone. It is meet, therefore, that this annual report should make more than just passing reference to some of the accomplishments of the first decade.

When the first Annual Membership Meeting was held in June 1966 there were 11 active dental service corporations in the United States, providing professionally designed and supervised prepaid dental care coverage for approximately one million persons. Today, there are 43 active Corporations underwriting and administering dental care programs that cover in excess of 11 million people in the United States, plus four corporations in Canada engaged in counterpart activity in their respective provinces. As stated by the Board of Directors in its report to the 1976 Annual Membership Meeting:

> While these numbers may not, to the uninitiated, appear impressive, those who have trod the steep and rocky path that leads to the creation and activation of a Delta Plan know full well the myriad moments of anguish and frustration, as well as relief and pride of accomplishment, that lie beneath such sterile statistics. Modesty does not require us to demur from observing that, during these past ten years, we must have done more things correctly than not. It is earnestly to be hoped that, over the years to come, this growth will be but the precursor of a geometric increase in our capacity to deliver soundly constructed and equitably administered dental health care programs which meet the needs of the public while serving the legitimate interests of the dental profession.

As a by-product of this success, the Delta System's adherence to program characteristics and administrative modalities which reflect professional judgments exercised in the public interest has obliged other prepayment and insurance agencies to emulate, as near as possible, the Delta approach to dental prepayment in order to be able to compete in the marketplace. This phenomenon, which represents fulfillment of one of the purposes contemplated when the service corporation was embraced by the pro-

fession, is nowhere more dramatically underscored than in the massively negative reaction accorded to the program instituted for employees of the Bell Telephone System, the characteristics of which significantly depart from the norms which Delta, on behalf of the profession, has established. That program had neither professional nor carrier input prior to its being put to bid. Its high visibility as an aberration of major proportions provides compelling testimony to the beneficial impact which Delta's operations have had in educating and influencing the marketplace for prepaid dental care. The Delta System makes no claim to having achieved perfection in its first ten years. It has its flaws. Like democracy, however, it is the best system yet conceived.

Professional Relations: Consistently strong professional relations and professional support comprise the cornerstone for successful dental service corporation operations. Necessarily, these conditions are most vital at the state level, where the individual corporations function as the collective marketing agents for their Participating Dentists in relation to the provision of service benefits. For the most part, sound professional relations and support do exist among the Plans, their respective constituent and component societies and the members of those societies. This is particularly true in states where the impact of dental prepayment has been deeply and widely felt. In some states, however, most notably those wherein dental prepayment has only recently become a tangible reality, professional support is not only less vigorous, but also is frequently buffeted by ill-conceived rhetoric aimed at undermining the viability of the concept. This rhetorical bombast leads to tragic consequences for the profession, if successful. It will not be successful, however, because the profession contains too many men and women of wisdom who are capable of standing outside of themselves and measuring the realities of today's world from a perspective sufficiently broad as to accommodate other than their own parochial interests.

Just as strong professional relations and support are vital at the state level, so, too, must they exist at the national level. For this reason, the Delta System welcomed the assignment placed with the Council on Dental Care Programs by the 1975 House of Delegates (*Trans.* 1975:666) to "reexamine the relationship of the Association and the Delta Dental Plans Association in order that, consistent with its responsibility to the public, the Association shall be better able to encourage and support the Delta Dental Plans in responding to the needs, interests and wishes of the profession. . . ." The examination, since conducted so assiduously by the Council, is certain to be of mutual benefit to the affected organizations and, more importantly, as recognized in the cited resolution, to the public which both organizations are committed to serve. In addition to the study by the Council, the Association's Board of Trustees, at the request of the Board of Directors, appointed one of its members, Dr. Floyd E. Dewhirst, trustee of the Thirteenth District, to serve as liaison between the Corporation and the Board of Trustees. Even though three of the members of the Board of Directors are elected as nominees of the Association, the ongoing relationship which this affirmative action by the Board of Trustees will produce is certain to deliver a much needed new dimension to communication and understanding between the Association and the Delta System, and particularly between the managing bodies of the two national organizations.

Amendment of Bylaws and Membership Standards: In response to a specific mandate from the House of Delegates (*Trans.* 1965:359), notice of amendments to the *By-*

laws and *Membership Standards* approved at the 1976 Annual Membership Meeting is hereby provided in summary detail. The *Bylaws* provision governing the composition of the Board of Directors and the qualifications for election to the Board were amended to permit expansion of the Board from 13 to 14 members and allocation of the newly created director position to the National Dental Association. This action was predicated on a recommendation of the Board of Directors which grew out of the establishment of liaison between the two organizations and subsequent attendance at meetings of the governing board of the National Dental Association by officials of DDPA. The vote on the action, by the membership, was unanimous, reflecting the membership's awareness that the National Dental Association constitutes not only a vital agency for the professional and social communion of black dentists but also a substantial force for improvement of the dental health of minority groups and the economically and culturally underprivileged. Representation of the National Dental Association on the DDPA Board of Directors, it is seriously hoped, will contribute strongly to the ability of both organizations to achieve their common goal of assisting the profession to serve the public well.

The *Membership Standards* were amended, in Section 11C, to enable accommodation of an essentially technical change in the title and character of the principal document which sets forth interplan obligations with respect to participation in national account programs. The document had originally been titled "Interplan Participating Agreement for National Account Contracts" and had been drafted literally as an Agreement to be signed by each Plan, even though adherence to its provisions was an obligation of membership irrespective of whether a member Plan executed the instrument. This last fact tended to become lost in history, however, with resultant misunderstandings emerging as to the binding character of the so-called Agreement. On the recommendation of the Board, therefore, the misleading word "Agreement" was deleted from the *Membership Standards* and the word "Rules" substituted therefor. Similarly, the document itself was recast and promulgated as a set of "Interplan Participating Rules for National Account Contracts." Through this combination of legislative and managerial actions, the problem cited should have been laid effectively to rest.

Enforcement of Membership Standards: The Board of Directors is obliged, under the *Bylaws,* to enforce the *Membership Standards.* Abrogation of that duty would be a major violation of its responsibilities to the membership and to the Corporation. The Board has attempted to avoid imposition of the ultimate sanction—involuntary termination of membership—on the few Plans that have consistently refused to conform their operations to the principles mandated with respect to national account participation or to use the Delta name and service mark. Unfortunately, efforts to persuade those Plans that adjusting their modes of operation, and employment of the Delta Dental Plan identification *indicia,* would serve their own interests fully as much as those of their sister Plans, have not been sufficiently productive. Accordingly, the Board, in keeping with its responsibilities, has reluctantly advised the recalcitrant Plans that, unless substantial evidence of positive remedial action is forthcoming before the end of this calendar year, their entitlement to continue as members of the Corporation will be objectively reviewed at the January 1977 meeting of the Board of Directors. The Board earnestly hopes that such measures as are necessary will be taken since loss of membership by a Plan injures the entire Delta System, not merely the affected Plan. Plans whose practices are fundamentally out of phase, however, endanger all of the other Plans to such an extent that their continued affiliation with the Delta System cannot be afforded.

Return to Membership of Colorado Dental Service: Colorado Dental Service applied for, and was accepted to, active membership in the Corporation for the year 1976, thus ending a one-year hiatus in the membership of that Plan. The dental profession in the Centennial State has actively supported the dental service corporation concept for many years. Colorado Dental Service was one of the original active members of DDPA and was represented on the Corporation's first elected Board of Directors. It is gratifying, therefore, to be able to report that the rupture in relationships between the two organizations proved susceptible to such rapid healing.

Membership: The number of Plans holding active membership in the Corporation has grown to 42, an increase of five since the last annual report of the Corporation to the House of Delegates. This growth was attributable to the aforementioned return to active membership by the Colorado Plan, and the welcome addition to the ranks of active members of the Plans in Arizona, Maine, Mississippi, and Nevada. The recently created Plan in Delaware joined the Nebraska Plan in the associate membership (inactive) category. The number of constituent society members decreased from 28 to 27 as a combined result of the nonrenewal of membership by the societies in Louisiana, Maryland, and Texas and the return to membership of the Montana Dental Association and the New Jersey Dental Association. The number of affiliate members—Plans in other countries—remains at four, those in Alberta, British Columbia, Nova Scotia, and Ontario. With an application for active membership pending on behalf of the District of Columbia Plan, and presuming its acceptance, only six states are not represented in one or more categories of membership: Arkansas, Connecticut, Indiana, Louisiana, North Dakota, and Texas. Dental service corporations do not exist in only three states: Connecticut, Indiana, and Texas. It is earnestly hoped that, for the benefit of both the profession and the public, the constituent societies in these three states will see fit to reverse their stands and join their colleagues from the rest of the country in helping to make the profession's sponsored prepayment mechanism equal in stature, nationally, to the position which American dentistry holds worldwide.

Amendment of Definition of "Reasonable" Fee: The Board of Directors, on the recommendation of the National Accounts Committee, amended the definition of the term "Reasonable Fee", as the term applies in the context of the standard DDPA National Account Contract, to incorporate a concept under which a "usual" fee which exceeds the 90th percentile limitation on the "customary" fee range, may be accepted. This concept, pioneered by California Dental Service in cooperation with the California Dental Association, embraces the rendering of a judgmental determination by the appropriate dental society Peer Review Committee on the issue of whether the practitioner involved renders a service of such superior quality as to justify a higher fee than those charged by 90 percent of the other practitioners in his area. The Board of Directors has also commended this revision to all Plans for application to their programs. The Board feels strongly that the adoption of this broader definition of "Reasonable," together with the earlier change to the 51st percentile of filed fees as the basis for indemnifying patients who receive care from nonparticipating dentists, constitutes firm evidence of the willingness and ability of the Delta System to effect substantive changes in order to meet valid objections, to operational policies.

Dental Service Plans Insurance Company: Since the Corporation's annual report to the 1975 House of Delegates, the Dental Service Plans Insurance Company has secured admittance to do business, as a so-called foreign insurer, in Florida, Maine and Texas, which raises to 13 the number of states in which the company is licensed. In all but two of these states, Texas and Illinois—the latter being its state of domicile- the admittance of the company was pursued to enable, and has enabled, the initiation of broadscale marketing programs by the Delta Plans in those states, none of which possessed statutory underwriting authority at the time of the company's licensure. There is no Plan in Texas, as yet, but the company's attainment of admittance in that state has strengthened greatly the ability of the Delta System to compete effectively for national accounts programs involving employees who are residents in Texas. The company has also entered into a reinsurance agreement with the New York Dental Service Corporation under which the company will reinsure the total book of business of that Plan, on a 50/50 quota-share basis. A similar agreement will be executed with the Vermont Plan as soon as that Plan receives authorization to function from the appropriate state regulatory agency. Each of the three circumstances described fits one of the three purposes envisioned to be served by the company when its creation was endorsed by the 1968 House of Delegates. The stockholders and management of the company are to be complimented for adhering to those objectives and, in the process, aiding substantially the several Plans directly affected as well as, less directly but no less importantly, the entire Delta System.

Election of Directors and Officers: At the 1976 Annual Membership Meeting in Hawaii, the following directors were elected to the Board for three-year terms: Dr. Wendell E. Fitts, New Hampshire, an ADA nominee, to succeed Dr. Joseph Pollack; Dr. Joseph D. McNally, Washington, to succeed Mr. Robert G. MacDonald; Dr. Benjamin F. Davis, an NDA nominee, to the new director position created by the amendment of the *Bylaws* treated earlier in this report; and Dr. F. Gene Dixon, California, to succeed himself for a second term. At the organizational meeting of the Board of Directors which immediately followed the Membership Meeting, the following directors were to the four officer positions for one-year terms:

Dr. Perry L. Taylor, Illinois, president
Dr. F. Gene Dixon, California, vice-president
Mr. Patrick P. Gribben, Jr., Michigan, secretary
Dr. Russell W. Buchert, Missouri, treasurer

The Board also elected Dr. Robert A. Cupples as the at-large director to serve on the Executive Committee with the four officers for the ensuing year.

Encomia: The Board of Directors, on behalf of the membership, wishes to express its appreciation to Dr. Joseph Pollack of New Jersey who served with distinction on the Board as a nominee of the Association for three years, the last as Secretary of the Corporation. Similar gratitude is also extended to Mr. Robert G. MacDonald, former executive vice-president of Washington Dental Service, who served one year in an *ad interim* term.

Special appreciation and commendation is extended to Dr. John Y. Kim, former DDPA president, who retired on July 31 from the position of executive vice-presi-

dent of Hawaii Dental Service. Dr. Kim, during his 14 years in that office, pioneered professionally sponsored dental prepayment in his state and nationally. His contributions to the success of Hawaii Dental Service and of the Delta System are too numerous to catalogue. His wisdom, dignity, and spirit will be sorely missed.

Lastly, the Board wishes to report, regretfully, the resignation of Mr. Herbert C. Lassiter as executive vice-president of the Corporation. Mr. Lassiter, following almost nine years service as secretary of three of the Association's councils, assumed the arduous task of creating the national coordinating agency for dental service corporations in January 1966. The current stature of the Delta System constitutes the most eloquent testimony to the scope and magnitude of his efforts and will serve as a lasting memorial of his contributions to the dental profession and the public which it serves. The Board of Directors is certain that the House of Delegates will wish to join it and all members of the Delta System in extending warmest appreciation to Mr. Lassiter and sincere good wishes for a rewarding and satisfying future.

RESOLUTIONS

This report is informational in nature and no resolutions are presented.

Report of the American Dental Hygienists' Association

General Comment: All too often, because of the need for condensation, reports of this nature concentrate on those issues which are of immediate concern, and the overall relationship which firmly binds us must be de-emphasized. We call upon the leaders of dentistry to understand that, as a professional organization devoted to the delivery of dental health care, ADHA regards it as a fundamental responsibility to communicate its positions at that time when the decisions which will determine the direction of dental health care in the future are being formed.

We fully recognize that ADA is cognizant of the magnitude of its responsibility and is capable of taking that responsibility in stride. This report is offered in the spirit of working together, not separately or at odds, for the improvement of dental health care to the American public.

PROFILE: ADHA TODAY

Membership: ADHA's membership has continued to grow, although a substantial dues increase this year has had a predictable impact upon the growth rate. The Association's new national membership campaign (Project Outreach) is expected to return the Association to the accelerated level of growth it has experienced in recent years.

Year	Active Members	Junior Members	Total
1971	9,813	6,128	15,941
1972	11,115	7,427	18,542
1973	12,651	8,108	20,579
1974	14,950	8,880	23,830
1975	16,884	9,260	26,144
1976	17,826	9,280	27,106

Finance: The ADHA House of Delegates will consider a 1977 Fiscal Year Budget approaching $1,200,000.00, making ADHA one of the largest association activities in the dental profession. Just ten years ago, ADHA's budget was $181,000.00, indicating the increased activity of the dental hygiene profession.

Annual Session: The 1975 Chicago Annual Session attendance held the record level set in Washington, D.C., in 1974, reaching a new high of 2,037 audited paid attendance.

Year	Location	Attendance
1971	Atlantic City	906
1972	San Francisco	1,572
1973	Houston	1,078
1974	Washington, D.C.	2,019
1975	Chicago	2,037

With the cooperation of ADA's Convention Services Director, W. T. McCormick, an analysis of dental hygienist attendance characteristics at the ADA/ADHA Annual Session was performed. The following is a summary of the data compiled:

Analysis of 1975 Annual Session Attendance Figures

Total Registration at 1975 ADHA Annual Session	2,037
Journal of the American Dental Association reported dental hygiene attendance at 1975 ADA Annual Session	1,646
ADHA review of ADA registration cards completed by dental hygienists	1,566
Dental Hygienists who registered at ADA meeting, but not at ADHA meeting	417
ADHA registrants who registered at ADA meeting	1,149
Dental Hygienists who registered at the ADHA meeting but not at the ADA meeting	888

In subsequent meetings with Mr. McCormick and P. C. Goulding, ADA Assistant Executive Director, both Associations expressed concern over these characteristics; ADA because of the 888 dental hygienists who registered at ADHA's Annual Session but did not attend the ADA Meeting. ADHA's concern was directed to the 417 dental hygienists, including many non-members, who attended the ADA Meeting but not ADHA's Annual Session.

ADHA proposed that all dental hygienists be referred to ADHA registration and that the two Associations agree to a reciprocal honoring of badges, thereby encouraging joint attendance by all interested parties. ADA officials could not approve the plan because they felt it was inappropriate to require dental hygienists to pay ADHA's $10 registration fee if they choose not to.

ADA asked to be provided space at the ADHA Registration area to promote the ADA annual session and offered the same to ADHA. ADHA agreed, recording its disappointment that a more equitable solution was not attainable.

As a special innovation for its Annual Session this year, ADHA introduced its computerized pre-registration system, which was successfully tested at the Spring 1976 "Partners in Progress" meeting, jointly sponsored with the American Dental Assistants Association.

Although Anaheim, California, the site of the 1978 Annual Session, has an adequate total number of sleeping rooms, distributed among a number of small hotels and motels, to accommodate the ADHA members during the ADA Annual Session; as ADA has reserved the Disneyland Hotel and the Convention Center for its own functions, there is no single property that can meet the ADHA requirements of our membership. While combinations of two or more hotels might serve our needs, ADA was unable to commit specific properties to us in time for adequate planning. Therefore, at the direction of our National Meeting Planning Committee the new Bonaventure Hotel in Los Angeles (just 22 miles from Anaheim) was secured as the ADHA Headquarters in 1978. Shuttle bus service will be provided to ensure convenient access for all those wishing to view the ADA Exposition and attend scientific, as well as, social functions.

Regional Conferences: A second joint scientific meeting co-sponsored by the ADHA and ADAA was convened in March 1975 at the Sheraton-Biltmore Hotel in Atlanta. This and the first "Partners in Progress" meeting preceding it have been extremely well received by those who attended. From an educational standpoint, the "Partners

in Progress" meetings already rival the ADHA Annual Session in the amount, variety and quality of the educational program. As a result of discussions in several committees including Finance, Long Range Planning and Continuing Education, ADHA envisions the development of an additional educational meeting series which would be limited to a workshop format which could be presented in several geographical locations each year on a rotating basis.

Based on the success of the initial two years and what ADHA anticipates will be a very successful meeting in Boston in 1977, preliminary discussions are already underway for the planning of "Partners in Progress" for 1978 and beyond. It is the intent to rotate the "Partners in Progress" meeting around the country in locations geographically removed from Annual Session sites.

International Conferences: The Sixth International Dental Hygiene Symposium will be held in Stockholm, Sweden, in July 1977 hosted by the Swedish Dental Hygienists' Association. ADHA will sponsor economical group travel to this important international event.

Publications: Beginning in January 1977 ADHA will assume total responsibility for publication of its monthly journal *Dental Hygiene*. It is expected that substantial savings, as well as improved deadlines, will result from this major new staff responsibility.

Educational Directions, ADHA's new quarterly publication designed as a forum for dental auxiliary educators and has been selected as a winner in the 1976 ASAE Management Achievement Awards Program for the initial planning, organization, implementation and evaluation of this major Association project.

Educational Directions was "in the black" its first year of publication, and shows signs of very healthy growth entering 1977.

Administration: As activities grow, so does the need for central office support. The ADHA staff has grown to a total of 23, with additional employees proposed in the 1977 budget.

Central Office space in the ADA Building has doubled since 1974, and ADHA has been informed by the Building Management that further expansion is impractical, unless the Association is prepared to move to another floor.

As ADHA rentals at the ADA Building and elsewhere have reached a level of $35,000 a year, increasing attention has been devoted to the alternative of purchasing a permanent headquarters building. The ADHA Board of Trustees has appointed a special committee whose charge it is to identify one or more buildings of a quality befitting the dental hygiene profession, of a size no less than 15,000 usable square feet, and bring their recommendations to the Board of Trustees without undue delay.

Legislation: On the Federal level, ADHA continues to maintain close liaison with the ADA Washington staff. Due to growing needs of ADA, ADHA has been asked to release part of its office in the Washington complex to facilitate this expansion. As no immediate burden to our activities will result, ADHA acceded to the request.

On the state level, ADHA, faced with a major threat to the dental hygiene profession, has launched a nation-wide program (called ACCENT) designed to combat the reintroduction of preceptor dental hygiene to the profession. The need for such

a program became clear last fall when the Mississippi Dental Association sought legislation establishing a preceptorship dental hygiene program in that state.

The Association has long been committed to maintaining the established standards of formal dental hygiene education as stated by the American Dental Association's Commission on Dental and Dental Auxiliary Education. This educational standard is already a prerequisite for licensure in 49 of the 50 states.

The American Dental Hygienists' Association continues to maintain that any compromise of these standards, in the eyes of the dental hygiene profession, is a compromise of the basic principles of all health care delivery.

The goals of the ACCENT program are twofold: to secure a commitment on the part of the dental profession to oppose preceptorship both on an individual and group basis and to alert the public to the threat of preceptorship and the need for educational standards.

ADHA feels that this effort to resolve the problem by working cooperatively within the structure of the dental profession is far superior to any possible alternative and is confident that the dental profession will respond with strong support for the high standards of patient care that have been maintained in the past.

AN APPEAL

In the past ten weeks, ADHA has gone directly to the dental profession at all levels to seek assistance. The response has been overwhelming.

Thousands of individual dentists have signed pledge cards, expressing their personal support for recognized standards of education and regulation for the practice of dental hygiene and stating their opposition to the reintroduction of preceptor programs which substitute unstructured on-the-job training as preparation for the performance of complex intra-oral procedures on the general public.

At this writing, two international, eight national, two state and a number of component dental associations have acted formally in support of dental hygiene's educational standards. Thirty others have advised that the issue is on their agendas for the earliest possible action.

While ADHA understands and strongly supports the authority of state governments to establish standards of health care within their jurisdictions, and equally recognizes the rights of state associations to take their individual stands on such issues, ADHA is convinced that the dental profession can exert a profound influence upon such critical decision-making by taking the strong leadership role which has brought it to the respected position it holds in society today.

ADHA urges you, the leaders of the dental profession, not only to support Resolution 4 of the Council on Dental Education, which calls for reaffirmation of existing educational standards, but to act in the spirit of the Council's supporting statement (*Annual Reports and Resolutions—1976*, pp. 33, 34) and establish a strong position committing to the application of these standards to whomever is designated the responsibility to perform complex intra-oral functions. As was determined in Mississippi, it is not sufficient to insist on standards just for dental hygienists. Officials in that state informed ADHA simply that the proposed preceptors were not dental hygienists; they were to have a different name.

Education: ADHA's Office of Education has grown to seven permanent staff members including one dental hygienist and one additional full-time dental hygiene educator coordinating a federal contract for basic teacher training workshops. Accelerating educational activities have demanded a budget of $441,500.00 for 1977.

The third edition of Curriculum Essentials was published in October, 1975. Publication of the fourth edition of this document, tentatively planned to incorporate user feedback as well as behavioral sciences, is expected in December. The Committee on Dental Hygiene Education has taken steps to ensure widespread distribution of this material among dental hygiene faculty members. A third printing has already been required this year to meet the demand. It is hoped that the Curriculum Essentials will be utilized as a sharing mechanism among dental hygiene faculty on whose input the continued growth and refinement of the document will depend.

The ADHA regional consultants program has undergone a thorough analysis by the Committee on Educational Services. Goals and objectives have been redefined and specific criteria established for those dental hygiene educators who will be selected to serve in this capacity. Requests for consultation have stabilized in recent years paralleling a similar, but not entirely understandable, pattern in the growth and development of dental hygiene programs.

ADHA was disappointed to learn that the Council on Dental Education has studied the function of its Committee on Auxiliaries and decided to discontinue holding its meeting twice a year as has been done in the past.

This has been one of the primary avenues for liaison and is certainly much needed in a period of accelerated change. The reason given for this action is that "productive discussion does not seem to evolve during the meetings of the Committee" which certainly is a challenge, but hardly a reason for cancellation.

A suggested list of ADA accreditation consultants for dental hygiene, which continues to be of major importance to ADHA, has been submitted to the Council/Commission for their review. The ADHA Committee on Dental Hygiene Education selected individuals to be recommended utilizing a "blind" evaluation process based on criteria established by the Committee. If applicants did not meet the criteria, the Committee concluded that, in their judgment, the ability of these persons to serve effectively as accreditation consultants could not be verified. The Committee on Dental Hygiene Education firmly believes that these criteria are essential prerequisites for appointment as consultants and has urged the Council on Dental Education to adopt similar standards.

At the ADA Workshop on Dental Auxiliary Expanded Functions, ADHA underwrote the participation of twelve dental hygienists and one junior member to provide regional representation for the profession as well as five additional members of its Executive Committee and Staff from its contingency funds at a cost in excess of $6,000 because it was felt that ADHA representation at this meeting was essential. This decision was made at considerable sacrifice in order to be involved in discussions about expanded functions of dental auxiliaries. While ADHA has enthusiastically supported the ADA House of Delegates in its efforts and is committed to participation in any future programs of this nature, it shares the concerns voiced at the meeting by many in attendance regarding the means employed to select participants and the limited practicality of the review mechanism utilized.

Continuing Education: Last year, in its first direct report to the ADA House of Delegates, ADHA reported in detail the progress of its National Continuing Education

Evaluation Program. This program, in full service after three years of development, has successfully applied criteria which are designed to assure acceptable quality for 700 Continuing Education Programs nation-wide. A fully computerized support system provides for the compiling and cataloguing of pertinent data by program and by individual participant. All participants receive verification of attendance and certification of CEU's earned. Print-out rosters are available in several essential formats, including geographic areas, individual programs, individual participants and general subject categories.

As this program was developed, ADHA offered detailed information to the Council on Dental Education through regularly scheduled reports and special reports as well in order to ensure that a practical understanding of its effort was accomplished.

In light of these facts, ADHA recorded its deep regret to have noted the following paragraph in the current Annual Report of the Council on Dental Education.

> The Council on Dental Education appointed an ad hoc committee to determine the feasibility of establishing a national continuing education evaluation program. The eight member committee consisted of general and specialty practitioners, dental educators, dental examiners, and dental auxiliaries. These individuals were selected on the basis of their expertise in continuing education and were representatives of divergent geographic areas.

It appears that the Council has chosen to study the feasibility of establishing a national continuing education evaluation program which would encompass the dental hygiene profession despite the existing system which has been developed with the Council's full knowledge. What is more, it appears that the Council has selected one or more dental hygienists to be involved in this project, but has chosen to exclude this Association and those who have been responsible for the design and implementation of dental hygiene's national continuing education evaluation program.

Conclusion: The ADHA Executive Committee was pleased to participate, along with ADA officers, in the February meeting of the Special Committee on Inter-Agency Affairs, established by the ADA Board of Trustees in an effort to be more responsive to the needs of other dental organizations. Topics discussed included: continuing education, licensure and certification and the maintenance of a single standard of education throughout the system of formal entry-level preparation within dentistry. ADHA has repeatedly reaffirmed its commitment to the philosophy expressed by the Special Committee on Inter-Agency Affairs; that we are all part of one profession, and that we must work together as one. In this spirit, it seems appropriate that all agencies periodically review their actions, and assess their impact upon efforts to build more productive inter-agency cooperation.

Once again, ADHA wishes to thank the ADA Board of Trustees for this opportunity to address the nation's leadership in the dental profession. Additional information and materials on ADHA activities are available through the Association's Central Office.

Resolutions

Submitted by
Constituent and Component Societies
and Other Agencies

Arkansas State Dental Association

AMENDMENT OF ADA "STANDARDS FOR DENTAL PREPAYMENT PROGRAMS"

The following resolution was adopted by the General Assembly of the Arkansas State Dental Association on March 7, 1976 and transmitted under date of July 29, 1976 by Mr. Rex T. Butler, executive secretary.

Background Statement: Effective January 1, 1976 the Southwestern Bell Telephone Company began a dental insurance program for its employees in the states of Arkansas, Kansas, Missouri, Oklahoma, and Texas administered by the Prudential Insurance Company. The plan reimburses the employee for dental services according to a schedule of allowances. The schedules listed in the plan booklet reflect differences in dental charges by geographic area and are based on charges by postal zip code areas. For instance, a schedule is established in Arkansas for Little Rock with the remainder of the state set up on a different schedule.

The practice of different schedules for different areas results in creating some problems for dentists in certain localities that are on or near the dividing line between two such different areas. For instance, Bell employees in North Little Rock are reimbursed $87 for a porcelain crown, whereas Bell employees in Little Rock, just across the Arkansas River, are reimbursed $98 for the same procedure. The customary charge for this service is essentially the same by dentists in both Little Rock and North Little Rock. This difference in schedules has caused some Bell employees living in North Little Rock to utilize Little Rock dentists because they are able to get more of their dental bill paid by the Company.

The Arkansas State Dental Association's General Assembly has voiced opposition to this practice and adopted the following resolution.

54. **Resolved,** that *Standard 9* of the ADA *Standards for Dental Prepayment Programs* be amended by the addition of the following at the end of the first sentence:

Schedules of benefits shall be as uniform as possible, particularly within a state, avoiding differences in scheduled benefits based on geographical areas within a state.

California Dental Association

CLARIFICATION OF TERMINOLOGY IN PEDODONTICS

The following resolution was adopted by the California Dental Association and transmitted under date of July 29, 1976 by Dr. Robert L. Taylor, president.

Background Statement: In 1975, the American Academy of Pedodontics unanimously took action to clarify the terminology in reference to the practice of dentistry for children, and the common use by the medical profession of the terms "pediatrician" and "pediatric medicine." By such action, the American Academy of Pedodontics hoped to develop a more descriptive and universal term to identify this field of dentistry which treats children and adolescents of the same age as the allied field of medicine, known as "Pediatrics." By the use of such terminology, the Academy felt the confusion that exists in the mind of the lay public associated with the term "Pedodontics" could be assuaged.

At the 1975 California Dental Association House of Delegates, a resolution of this nature was submitted and approved, and this resolution was transmitted to the 1975 American Dental Association House of Delegates. However, the resolution was withdrawn prior to its consideration by the ADA House of Delegates.

The 1976 California Dental Association House of Delegates has considered this resolution and again approved this resolution. The California Dental Association, in conjunction with the American Academy of Pedodontics, the American Society of Dentistry for Children, and the California Society of Pediatric Dentistry, strongly urges the ADA House of Delegates to approve the following resolution for the enlightenment of the lay public and the betterment of the profession.

56. **Resolved,** that the 1976 House of Delegates of the American Dental Association approve the terminology "pediatric dentistry" to be synonymous with the terms "pedodontics" and "dentistry for children," and the terminology "pediatric dentist" to be synonymous with the terms "pedodontist" and "dentist for children," and be it further

Resolved, that the ADA Council on Judicial Procedures, Constitution and Bylaws take appropriate action to adopt an advisory opinion to the *Principles of Ethics* to permit the use of the words "pediatric dentistry" as an acceptable alternative for "pedodontics" and "dentistry for children."

California Dental Association

COMMITTEE ON ADVANCE PLANNING

The following resolution was adopted by the Board of Trustees of the California Dental Association in August 1976 and transmitted under date of November 2, 1976 by Mr. Henry L. Ernstthal, executive director.

Background Statement: For the past few years the Board of Trustees of the American Dental Association has had a committee named, "Committee on Advance Planning." The Thirteenth Trustee District is aware that this committee has been studying the basic structure and operation of the American Dental Association and feels strongly that the proceedings of that committee should be made available to the House of Delegates.

It would seem that the most effective means of bringing this material to the House of Delegates would be to have the Board of Trustees report the proceedings of its committee in one of the Board reports to the House of Delegates. Accordingly, the following resolution is presented.

106. Resolved, that the Board of Trustees of the American Dental Association report to the House of Delegates the proceedings of its Committee on Advance Planning.

California Dental Association

GUIDELINES FOR DENTAL DIRECTORIES

The following resolution was adopted by the California Dental Association and transmitted under date of July 29, 1976 by Dr. Robert L. Taylor, president.

Background Statement: In the recent past, dental directories developed by consumer groups such as the Nader organization and others have distressed and disturbed ethical practitioners. Consumer demand for additional information concerning dental practitioners in their area remains strong. Sources other than referral lists seem to be warranted. Clearly, rather than have outside nonprofessionals attempt to more fully describe the provider and his services, it would be more appropriate for the dental profession to accept that responsibility to appropriate information to the public upon which they can base the choice of a dentist.

55. Resolved, that the American Dental Association House of Delegates direct the ADA Board of Trustees to cause to be developed guidelines for dental directories and that these guidelines be submitted to the 1977 House of Delegates for approval.

California Dental Association

MILITARY DEPENDENT CARE

The following resolution was adopted by the California Dental Association and transmitted under date of July 29, 1976 by Dr. Robert L. Taylor, president.

Background Statement: The California Dental Association is concerned over usage of government personnel to deliver oral health care in situations where quite adequate dental manpower already exists—often with local dentists not being as busy as they would like to be.

A most recent example of this has come up in treatment for military dependents, now that the CHAMPUS program has been de-emphasized. The military in any area might want to provide care from its own base to these dependents, even though adequate manpower exists in the private enterprise system.

In addition, efforts to improve accessibility of care for dependents would be most easily facilitated by using the existing thousands and thousands of dental offices, providing a ready-made network. The real problem of accessibility here is one of cost, now that these military dependents are getting little financial help in this context from the government. The solution offered to this *cost* problem is to call it a *manpower* problem; but it is not, and the American Dental Association should stand firm in getting the government to recognize this.

The California Dental Association feels that the American Dental Association should encourage the federal government, particularly those branches overseeing military dependent benefits, to seek relevant other means (such as prepayment) of solving the military dependent's accessibility problem, rather than using government funds to compete with existing, adequate manpower sources in private enterprise.

57. **Resolved,** that the American Dental Association strongly encourage the adoption of the concept of prepaid dental care under the free choice delivery system for military dependents, and be it further

Resolved, that the American Dental Association, through its councils, undertake vigorous action to assure fruition of such a concept and carry this concept for dental care of military dependents to all branches of service.

California Dental Association

PROFESSIONAL EXEMPTION FROM ANTITRUST LEGISLATION

The following resolution was adopted by the California Dental Association and transmitted under date of July 29, 1976 by Dr. Robert L. Taylor, president.

Background Statement: Prior to the Supreme Court decision in *Goldfarb vs Virginia,* the courts had ruled that professions, generally, and the health profession, in particular, were not subject to the provisions of the Sherman Antitrust Act. The court's deci-

sion in *Goldfarb* clearly stated that antitrust law, particularly, applied to associations and other such groups which impose standards of conduct on their members. It should also be noted that states statutory controls have also recently come under attack. Notably, the Supreme Court has ruled that a state may not prohibit pharmacists from advertising prescription drug prices (another case in Virginia maintained by the Virginia Citizens Consumer Counsel, Inc., against the State Board of Pharmacy). A footnote in the *Goldfarb* case indicated that the professions may be treated differently under antitrust laws, but was nonspecific. A footnote to the pharmacy case, and a concurring opinion by Justice Blackmun, indicated that the decision may well be different in a case involving the medical and legal professions and distinguished between the sale of commodities as with a pharmacy, and services as with dentistry.

There are a number of alternative legislative actions that could achieve a reinstatement of the "professional exemption" in the antitrust act. The first would be to seek an exemption by amendment of Section 5 of the Federal Trade Commission Act at 15 USC 45(a)(6) to exempt health associations from the enforcement jurisdiction of the FTC; and second to amend the Antitrust Act at 15 USC 17 to exempt health associations from the application of the federal antitrust laws. As a total alternative, a separate piece of legislation could be prepared that would exempt health associations directly without changing the language of the FTC or Sherman Antitrust Act.

59. **Resolved,** that the American Dental Association, in cooperation with other professions, seek legislation either by amendment of existing statutes or by the creation of an entirely new bill that would exempt health associations from the enforcement jurisdiction of the Federal Trade Commission and the application of the federal antitrust laws.

California Dental Association

REMOTE STATUS DESIGNATIONS FOR MILITARY ESTABLISHMENTS

The following resolution was adopted by the California Dental Association and transmitted under date of July 29, 1976 by Dr. Robert L. Taylor, president.

Background Statement: During the past year, the California Dental Association has been following closely the issue of dependents of military personnel receiving dental care in military facilities which have not been named by the Surgeon General as having "remote status."

The criteria for designating a facility as "remote" are as follows:

> Local commanders may request that consideration be given to authorize routine dental care for dependents at their installation if the per capita of civilian dentists in active practice within a 30-mile radius of the installation is below the average of one dentist per 2,000 population. They also will consider unusual and geographic conditions, and transportation factors such as toll bridges or

ferries which could unreasonably increase the time and expense of travel. Notwithstanding the foregoing criteria, when a local commander believes that adequate justification exists, he may request authorization for the installation to provide routine dental care to dependents. All requests for consideration will be submitted to the appropriate Surgeon General and will include the following:

a. Distance dependents residing on the installation must travel to obtain civilian dental care. Include any unusual travel considerations.

b. The number of civilian dentists engaged in active practice within 30 miles of the installation.

c. The civilian population, including dependents of uniformed services personnel, who reside within 30 miles of the installation.

d. The dependent population residing on or adjacent to the installation.

e. The total number of dependents who would be eligible for dental care at the uniformed services dental facility if the installation was authorized to provide routine dental care.

f. The availability of specialized dental services within 80 miles of the installation.

g. The capability of the uniformed service dental facility to provide dental care to dependents in the area.

h. Statement concerning excessive costs, if any, for civilian dental service in the community.

i. Examples of unusual delays, if any, in obtaining civilian dental service.

j. Statement from the State dental society setting forth its position concerning the proposed authorization that the installation provide routine dental care to dependents. If opposed, the dental society will be requested to furnish detailed information on so many of the above items as are applicable.

It is the opinion of the California Dental Association that unless *all* of the criteria established under Federal Regulations AR 40-121/SECJAVINST 6320.8D/AFR 168-9 are met by a military installation, and unless a definite manpower shortage area can be demonstrated to exist, that vigorous opposition should be voiced to the appropriate military installation and to the appropriate Federal Dental Services Corps by the American Dental Association.

58. **Resolved,** that the American Dental Association vigorously oppose the designation of remote status of any military installation where the criteria for such designation under federal regulation cannot be met, and especially where a dental manpower shortage cannot be demonstrated to exist.

District of Columbia Dental Society

ANNOUNCEMENT OF A SPECIALTY

The following resolution was adopted by the District of Columbia Dental Society and transmitted under date of October 15, 1976 by Mr. Michael L. Cady, executive director.

Whereas, at the coming session of the American Dental Association's House of Delegates the moratorium on announcing in more than one specialty area, if qualified, may be lifted, and
Whereas, if this should pass, a dentist, if he has completed the educational requirements, may announce in more than one specialty area of dentistry, and
Whereas, to eliminate possible confusion to the public between the specialist who announces his limitation of practice to one specialty area of dentistry, as opposed to two or more, therefore be it

99. Resolved, that only the specialist who limits his practice to one specialty area be permitted to announce that he is in the exclusive practice of a specialty, and be it further
Resolved, that the specialist who is qualified and who announces in two or more specialties be required to disclose to his patients and to the profession that he is a dual or multi-specialist.

District of Columbia Dental Society

COMPLETE UTILIZATION OF DENTISTS IN THE TREATMENT OF PATIENTS

The following resolution was adopted by the District of Columbia Dental Society on May 11, 1976 and transmitted under date of May 27, 1976 by Mr. Michael L. Cady, executive director.

Whereas, the American Dental Association is committed to safeguard the dental health and welfare of the American public, and
Whereas, American dentistry provides the highest quality of dental care in the world, therefore be it

33. Resolved, that the American Dental Association urges and endorses the fullest use of dentists in all dental programs, before resorting to the substitution of expanded duty auxiliaries in the treatment of patients.

District of Columbia Dental Society

DEFINITION OF "DENTURISM"

The following resolution was adopted by the District of Columbia Dental Society and transmitted under date of October 15, 1976 by Mr. Michael L. Cady, executive director.

Whereas, the term "denturism" as implied by the American Dental Association is the "illegal practice of dentistry," and
Whereas, by this connotation the action of a legislative body can make it legal, therefore be it

98. Resolved, that the American Dental Association definition of denturism be the unqualified as well as illegal practice of dentistry.

Florida Dental Association

STUDY OF THE DENTIST IN ALL HIS RELATIONSHIPS

The following resolution was adopted by the Florida Dental Association at its annual session on May 27, 1976 and transmitted under date of June 16, 1976 by Dr. Stanley Sutnick, secretary.

Inasmuch as studies show dentists to have the highest suicide rate, a high premature mortality rate, and a high divorce rate, and since these factors result in a waste of valuable professional people, be it

45. Resolved, that the American Dental Association determine the feasibility of conducting a sociological, medical, behavioral, and environmental study of the dentist in all his relationships.

Illinois State Dental Society

AMENDMENT OF SECTION 20 OF "PRINCIPLES OF ETHICS"

The following resolution was adopted by the Executive Council of the Illinois State Dental Society on May 12, 1976 and transmitted under date of July 9, 1976 by Dr. W. J. Greek, executive director.

Background Statement: Section 20 of the American Dental Association *Principles of Ethics* does not permit a dentist to use an assumed name for his practice. During the past decade many group practices have been formed and many of them have three or more partners or shareholders. When this occurs, using the names of the individuals

for the name of the practice presents several problems, such as answering the telephone when three or more names must be given. The alternatives to answer the phone by giving the telephone number or saying "dental office" are unsatisfactory. Either response sounds impersonal and the patient is not completely sure he has called the right dental office. Also, being required to list three or more names as the practice name on cards and letterheads is cumbersome. Using the practice name "Dr. Smith and Associates" is unworkable when you have equal partners and shareholders.

46. **Resolved**, that Section 20 of the American Dental Association's *Principles of Ethics* be amended to read as follows:

> Subject always to applicable state statutes, a dentist may practice under his own name, the name of a dentist employing him who practices in the same office, a partnership name composed of the name of one or more of the dentists practicing in a partnership in the same office, or a corporate name composed of the name of one or more of the dentists practicing as employees of the corporation in the same office.
>
> A dentist, if he prefers, may use the registered professional corporate name for his practice. Such names must be submitted to the appropriate component dental society for prior approval. The name selected should not imply any connection with any institutional or governmental unit or organization, or imply or specify the practice of any special area of dentistry. The full name selected shall be limited to the function of helping the patient identify the practice. Further, the name selected should not constitute any false, fraudulent, misleading, deceptive or unfair statement or claim as defined elsewhere in these *Principles*.
>
> Use of the name of a dentist no longer actively associated with the practice may be continued for a period not to exceed one year.
>
> The use of dentists' names in directories is covered entirely by Section 19.

Illinois State Dental Society

CLASSIFICATION OF DENTAL LABORATORY TECHNICIANS

The following resolution was approved by the Executive Council of the Illinois State Dental Society and transmitted under date of July 21, 1976 by Dr. W. J. Greek, executive director.

Background Statement: Throughout the evolution of dentistry as a profession, allied dental health personnel have been considered to be "dental auxiliaries." As applied to the dental laboratory technician, this was appropriate and served a useful function for many years. In these modern times, with consolidation and merging of financial interests as well as specialized laboratory services, the use of the term "dental auxiliary" when applied to the dental laboratory craft is outdated and misleading. Additionally, to continue this anachronistic terminology is to demean and misrepresent the true relationship which exists between the profession and the laboratory industry.

47. **Resolved**, that this Association recognize only dental laboratory technicians actually employed in the dental office as an auxiliary and that other technicians employed within the laboratory craft be considered to be a part of the dental laboratory industry.

Illinois State Dental Society

PUBLICATION AND DISTRIBUTION OF FEE SURVEYS

The following resolution was approved by the Executive Council of the Illinois State Dental Society and transmitted under date of July 21, 1976 by Dr. W. J. Greek, executive director.

Background Statement: For a number of years access to the results of fee surveys conducted by the Association has been of inestimable value, both to the individual member and the organized profession. As a result of a previous action of the House of Delegates limiting the distribution of fee surveys, further gathering and tabulating of data is questionable and unwarranted.

48. Resolved, that the previous policy limiting publication and distribution of fee surveys be rescinded in order that these results may be made available to the membership through publication in *The Journal of the American Dental Association.*

Illinois State Dental Society

RECONSIDERATION OF FUNDING FOR DENTAL EDITORS' SEMINAR

The following resolution was adopted by the Executive Council of the Illinois State Dental Society and transmitted under date of September 27, 1976 by Dr. W. J. Greek, executive director.

Background Statement: For the past 13 years the Association has conducted the Council on Journalism's Dental Editors' Seminar which has been of inestimable value to constituent editors and to the membership. In reviewing council and bureau askings for the forthcoming year's budget, the Board has voted to eliminate the Seminar, thus effecting a savings. Although fiscal economy is commendable, the Dental Editors' Seminar should be considered of highest priority since it effectively supports a program of communication to the members of this Association.

93. Resolved, that the House of Delegates urges that the Board of Trustees reconsider its elimination of any allocation of monies in the 1977 Budget to support the holding of the Council on Journalism's 14th Annual Dental Editors' Seminar and, while so doing, consider appropriating sufficient monies from the 1977 Contingent Fund to permit scheduling and conducting such Seminar in 1977.

Indiana Dental Association

COMMENDATION TO DR. LLOYD J. PHILLIPS

The following resolution was adopted by the House of Delegates of the Indiana Dental Association in May 1976 and transmitted under date of June 21, 1976 by Mr. Gale E. Coons, executive director.

Background Statement: Dr. Lloyd J. Phillips, trustee of the ADA Seventh District, has served in this capacity for the past six years (1970-1976). Dr. Phillips represents the dentists of Indiana and Ohio as well as the interests of dentists throughout the country.

As trustee, Dr. Phillips has provided special leadership ability and talents at the national level. His expertise in association budgetary and fiscal matters has been especially valuable to the members of the American Dental Association. His leadership brought about the Association's Public Education Program with Burson-Marsteller, public relations firm. He led the way and has continued to provide guidance and direction for meaningful dental manpower data via a study being made in cooperation with the Leonard Davis Institute. Dr. Phillips has provided expert counsel and guidance to the Council on Dental Care Programs through the Board of Trustees' committees. Currently, he serves as president of the American Fund for Dental Health.

Before the ADA activities took so much of his time, Dr. Phillips served the Indiana Dental Association as secretary (1964-1970), delegate to the ADA House of Delegates (1964-1971), and member of numerous councils and committees, many of which he still serves.

Dr. Phillips has provided outstanding leadership and expertise to every level of organized dentistry. As an expression of appreciation for his dedication, ability, time, and effort, the Indiana Dental Association presents this resolution of sincere appreciation.

49. **Resolved,** that the American Dental Association House of Delegates, November 1976, expresses sincere and grateful appreciation for the leadership ability which Dr. Lloyd J. Phillips has provided to organized dentistry during the tenure of his office as Seventh District ADA Trustee.

Indiana Dental Association

NONDISCRIMINATORY POLICY FOR ACCEPTING DENTAL STUDENTS

The following resolution was adopted by the Indiana Dental Association delegation on October 24, 1976 and transmitted under date of November 3, 1976 by Dr. Robert M. Stetzel, president.

Background Statement: The American Dental Association's policy for accreditation of educational programs provides that nondiscriminatory policies must be followed in

selecting postdoctoral students (*Trans.* 1974:54, 664), dental assisting students (*Trans.* 1973:66, 708), dental hygiene students (*Trans.* 1973:75, 710), and dental laboratory technician students (*Trans.* 1973:84, 710). However, the provisions for an accredited school of dentistry (*Trans.* 1970:54, 437) fail to make any mention that nondiscriminatory policies in the admission of dental students must be followed.

109. **Resolved,** that the requirements for an accredited school of dentistry (*Trans.* 1970:54, 437) be amended by adding the following words to the third paragraph under "Admissions:"

> and that nondiscriminatory policies will be followed in admitting students

to make the paragraph read as follows:

> It is the opinion of the Council that the selection of students for admission to dental schools should be based on estimates of their capacity for success in the study of dentistry as determined by evaluation of all available and significant information. Consideration of the qualifications of applicants for admission should include information regarding their character, the quality of their pre-professional education, health status and aptitude for and interest in a career in dentistry. The Council emphasizes that the admission committee has the major responsibility for determining the qualifications of prospective students in the light of educational aims and objectives of the profession and that nondiscriminatory policies will be followed in admitting students.

Indiana Dental Association

REJECTION OF SUPPLEMENTAL REPORT 2 FROM COUNCIL ON DENTAL CARE PROGRAMS

The following resolution was adopted by the Indiana Dental Association delegation on October 24, 1976 and transmitted under date of November 3, 1976 by Dr. Robert M. Stetzel, president.

Background Statement: The 1975 House of Delegates referred Resolution 889 (*Trans.* 1975:664) to the Council on Dental Care Programs for the purpose of re-examining the relationship of the Association and the Delta Dental Plans Association. That study has been made and is reported to this House in the Council's Supplemental Report 2 (p. 32). The report traces the Delta Dental Plans Association's development from beginning to end covering some 19 years in this 25 page report. However, the report fails to make an objective analysis of the relationship of the two organizations. It fails with regard to specificity and with regard to credibility of the ADA as an unbiased input source for the dental benefit programs to government, industry and labor. The report does not consider the fact that thousands of ADA members are not members of dental service corporations. Their position, principles and policies have been totally subjugated to the Delta philosophy. Even more discouraging is the

fact that the report does not take into account the potential antitrust violations that may very well exist in the relationship between the Association and the Delta Dental Plans Association.

110. **Resolved,** that the Council on Dental Care Programs Supplemental Report 2 not be accepted, and be it further

Resolved, that the Board of Trustees direct specialized outside counsel in the area of antitrust involvement to study the close ties in the past and present between the American Dental Association, Delta Dental Plans Association and the constituent dental service corporations, and be it further

Resolved, that this legal counsel report through the Board of Trustees to the 1977 House of Delegates on the results of that study with recommendations for the ADA's future activities involving their relationship with Delta Dental Plans Association and its constituent members.

Kentucky Dental Association

COMMENDATION TO DR. CHARLES D. CARTER

The following resolution was submitted by the Kentucky Dental Association and transmitted under date of September 1, 1976 by Dr. A. B. Coxwell, executive director.

Background Statement: For the past six years Dr. Charles D. "Buddy" Carter has served as Trustee for the Sixth District of the American Dental Association. In this capacity Dr. Carter has represented the dentists of America and, in particular, the dentists of Kentucky, Missouri, Tennessee and West Virginia.

Dr. Carter has provided unique leadership for American dentistry and wisdom and understanding to the Board of Trustees in its deliberations. His guidance in budgetary and fiscal matters has been and is of particular value.

Dr. Carter, in addition to his multitudinous contributions to dentistry at all levels, practices dentistry in his private practice at a level of excellence of which we can all be proud. To express our gratitude to him, the Kentucky Dental Association presents this resolution.

92. **Resolved,** that the American Dental Association House of Delegates, November 1976, wishes to express to Dr. Charles D. Carter its deep appreciation for his unfailing loyalty, unstinting contribution of time and wise leadership during his term as Trustee of the Sixth District of the American Dental Association.

Louisiana Dental Association

REAFFIRMATION OF SECTION 12 OF "PRINCIPLES OF ETHICS"

The following resolution was adopted by the Board of Directors of the Louisiana Dental Association and transmitted under date of July 19, 1976 by Mr. Gerard J. Haddican, executive secretary.

Background Statement: Section 12 of the American Dental Association *Principles of Ethics* states, "Advertising reflects adversely on the dentist who employs it and lowers the public esteem of the dental profession. The dentist has the obligation of advancing his reputation for fidelity, judgment, and skill solely through his professional services to his patients and to society. The use of advertising in any form to solicit patients is inconsistent with this obligation."

It is inconsistent with logical thinking that advertising in any form, either advertently or inadvertently, is used for any other purpose than soliciting patients.

50. **Resolved,** that the American Dental Association reaffirm Section 12 of the American Dental Association *Principles of Ethics* and encourage disciplinary actions on the part of constituent and component societies for violations of this section, and be it further

Resolved, that the American Dental Association assume an aggressive posture in defending Section 12 of the *Principles of Ethics* against any action by the Federal Trade Commission, federal government, state government, or consumer protection agencies which would be in conflict with these *Principles.*

Massachusetts Dental Society

COMMENDATION OF DR. JAMES W. ETHERINGTON

The following resolution was adopted by the Massachusetts Dental Society Board of Trustees and transmitted under date of November 13, 1976 by Dr. William H. McKenna, Secretary.

Whereas, Dr. James W. Etherington has served the First Trustee District and the American Dental Association over the last nine years as American Dental Association Trustee and American Dental Association Treasurer, be it

131. **Resolved,** that the American Dental Association House of Delegates, November 1976, expresses sincere and grateful appreciation for the leadership ability which Dr. Etherington has provided to organized dentistry during the tenure of his office as First District Trustee for six years and as Treasurer of the American Dental Association for three years.

Michigan Dental Association

AMENDMENT TO "GUIDELINES ON THE USE OF RADIOGRAPHS"

The following resolution was adopted by the Board of Trustees of the Michigan Dental Association and transmitted under date of November 3, 1976 by Dr. John G. Nolen, executive director.

Background Statement: Guideline No. 11 of the "Guidelines on the Use of Radiographs" currently reads as follows:

> 11. Radiographs furnished to a peer review committee or third party shall not be transmitted to any other agency without written consent of the dentist.

It is not in the best interest of the associations to require written consent of the attending dentist when radiographs are being forwarded to a peer review body. Such consent will cause untimely delays.

In a state association managing a large number of claims for peer review, such a guideline will add to the ever increasing paperwork.

It appears that as the present guideline is worded, written consent of the attending dentist must be obtained by the third party prior to forwarding the case to peer review, and written consent must be obtained by the state association prior to disseminating the case to the local level peer review committee for review.

At the Michigan Dental Association, the central office requests that third parties forward claim forms, radiographs, and all correspondence pertaining to a claim before it is forwarded to a component peer review committee. A special form has been designed for this purpose and all third parties use this form. Therefore, component peer review committees receive only cases containing complete claims information for review, and this speeds up the entire review process. Only peer review committees receive the information and only peers review it.

If Guideline No. 11 remains as is, third parties will either have to hold cases for review until the attending dentist sends written authorization, or return the radiographs and the dental association or component will be required to contact the dentist to obtain the x-rays. This would be time consuming.

The Michigan Dental Association recommends that Guideline No. 11 be amended by adding the words "than a peer review body" to the latter part of Guideline No. 11. This would allow peer review committees at the state level to disseminate radiographs to component review committees and third parties to forward radiographs to peer review committees without written consent.

111. **Resolved,** that the "Guidelines on the Use of Radiographs" (*Trans.* 1974:653) be amended by substituting the following guideline for Guideline No. 11:

> 11. Radiographs furnished to a peer review committee or third party agency shall not be transmitted to any agency other than a peer review body without written consent of the dentist.

Michigan Dental Association

INSURANCE PROGRAMS FOR ADA MEMBERS

The following resolution was adopted by the Board of Trustees of the Michigan Dental Association and transmitted under date of November 3, 1976 by Dr. John G. Nolen, executive director.

Background Statement: The Michigan Dental Association supports and endorses the various insurance programs offered to ADA members via the ADA. It has encouraged its members to participate in the Professional Protector Plan offered by the ADA and administered through the Poe Agency of Florida.

However, it would appear to the Michigan Dental Association that the ADA and the Poe Agency should be more receptive to the concerns of constituent dental societies in the administration and renewal rating of the Professional Protector Plan when a state such as Michigan has so strongly encouraged its members to participate. Presently, nearly 50 percent of the Michigan Dental Association members participate in this program.

The Michigan Dental Association and its members become concerned when premiums increased 33 percent without advance notice, or without statistics which would substantiate such an increase.

The Michigan Dental Association also becomes concerned with large rate renewal increases when the experience of a state is less than 25 percent of premiums and yet receives a 33 percent increase over the previous rates, without visible justification.

It is the belief of this association that such increases should be discussed with the constituent societies they affect and not unilaterally approved by the ADA Council on Insurance. It is also the belief of this association that documented program or plan experience increases can be assessed.

In other words, it seems most inequitable that a state with favorable experience receives a sizeable increase in the Professional Protector Plan, or any other program, without prior discussion between the ADA, the Poe Agency, and the constituent society. Therefore, the Michigan Dental Association introduces the following resolution.

112. **Resolved,** that the American Dental Association Council on Insurance and the Poe Agency distribute the experience statistics by state, relative to the Professional Protector Plan, 90 days prior to the renewal dates of the program for analysis and discussion with that constituent society, prior to a rate increase, and be it further

Resolved, that the American Dental Association Council on Insurance forward all information pertaining to proposed changes in coverage to constituent societies that endorse ADA insurance programs, for their input prior to definitive action on such changes.

Michigan Dental Association

RESOLUTION TO EXTEND BAN ON SMOKING TO INCLUDE OFFICIAL CONFERENCES OF THE ADA

The following resolution was transmitted under date of November 14, 1976 by Dr. John Nolen, executive director, Michigan Dental Association.

Background Statement: In 1973, the American Dental Association adopted Resolution 8-1973H which prohibited the use of smoking tobacco during House of Delegates and Reference Committee hearings.

The House of Delegates recognized the harmful effects of smoking tobacco and the rights of the nonsmokers to protect themselves from the second-hand smoke of others.

Shortly thereafter, the Board of Trustees banned the use of smoking tobacco during its meetings and in response to a written request from a member, banned smoking during the scientific lectures and meetings of the Annual Session.

These actions established the American Dental Association as the largest private health care organization in the world to assume such exemplary leadership.

Since 1973, many health organizations and state legislatures have taken similar action to provide and promote air free of tobacco smoke. Among these are the states of California, Michigan, Colorado and Minnesota.

California has passed an indoor "Clean Air Act." Michigan has legislated "no smoking" in hospitals and the availability of *no smoking sections* in restaurants.

It is logical and timely that the House of Delegates of the American Dental Association extend the benefits of nonsmoking and further recognize the rights of the nonsmoker who attends its official conferences, therefore be it

160. **Resolved,** that the use of smoking tobacco be prohibited during official conferences of the American Dental Association.

Minnesota Dental Association

SINGLE STANDARD OF PERFORMANCE FOR INTRAORAL PROCEDURES

The following resolution was submitted by the Minnesota Dental Association and transmitted under date of November 14, 1976 by Robert A. Harder, executive director.

Whereas, the Minnesota Dental Association is committed to maintenance of those standards of formal education promulgated by the American Dental Association Commission on Dental and Dental Auxiliary Educational Programs, and

Whereas, these standards are prerequisite for licensure to practice dental hygiene in 49 of the 50 states, now therefore be it

155. Resolved, that the American Dental Association advocate the use of a single standard of performance for each state-regulated, intraoral procedure, and be it further
Resolved, that the American Dental Association will actively oppose efforts seeking to train and qualify those persons to practice dental hygiene who have not completed accredited educational programs.

New Jersey Dental Association

AMENDMENT OF "BYLAWS" ON SCIENTIFIC SESSION

The following resolution was adopted by the Board of Trustees of the New Jersey Dental Association on March 17, 1976 and transmitted under date of April 28, 1976 by Ms. Bette J. Smith, assistant executive director.

Background Statement: The *Bylaws* of the American Dental Association recognizes fourteen sections, which shall be included in each Scientific Session, unless omitted by the Council on Scientific Session. The New Jersey Dental Association believes that oral medicine can present a body of knowledge essential to the practice of dentistry for the general membership of the Association. Although oral medicine is invited to participate in other sessions from time to time, a section of oral medicine would permit those recognized in this field to develop a more useful program for general practitioners.

34. Resolved, that Chapter XV, Scientific Session, Section 40(A) of the *Bylaws* be amended by the addition of "o. Oral Medicine" after "n. Oral Pathology."

New Jersey Dental Association

FORMATION OF SELF-INSURED MALPRACTICE PROGRAM

The following resolution was adopted by the Board of Trustees of the New Jersey Dental Association on September 22, 1976 and transmitted under date of October 15, 1976 by Bette J. Smith, assistant executive director.

100. Resolved, that the American Dental Association meet the crisis of rising malpractice insurance premiums that are occurring throughout the nation with the formation of a self-insured malpractice program, and be it further
Resolved, that the self-insured malpractice program shall be the result of a thorough actuarial investigation, and be it further
Resolved, that said self-insured program shall be financed on a prorated basis throughout the nation, and be it further
Resolved, that this matter be referred to the proper agency for study and report back to the 1977 House of Delegates.

New York, The Dental Society of the State of

AMENDMENT OF ADA "STANDARDS FOR DENTAL PREPAYMENT PROGRAMS"

The following resolution was adopted by the Board of Governors of The Dental Society of the State of New York at the Annual Meeting on May 1-5, 1976 and transmitted under date of May 11, 1976 by Dr. Seymour L. Nash, executive director.

Background Statement: Dental Service Corporations and Blue Cross-Blue Shield among other third-party carriers persist in maintaining the designations of "participating" and "non-participating" dentists in their plans. This artificial schism of the profession leads to abuses that include the use of lists of dentists to sell programs, two levels of payment with attendant pressure on patients to change dentists, and economic coercion on dentists to become "par." With the use of computers and experience, this mechanism is unnecessary.

1. The profession recognizes the existence of third-party programs with their intrusion into the dentist/patient relationship with their attendant advantages and disadvantages. The sale of these programs to unions, employers, and the like now depends on being competitive in the marketplace, not on selling lists of dentists.
2. Third parties no longer need prefiled fees; they can determine "customary" fees more easily than can peer review committees by the use of computer retrieval. Peer review committees function in all fee area problems.
3. It is unfair for patients to be reimbursed at different levels for dental care, depending on whether their attending dentist is "participating" or "non-participating." It is unfair to the dentist since it pressures him to be "participating," and since it pressures his patient to leave him for a "participating" dentist so that reimbursement levels will be higher.
4. Any third-party program that cannot adjust reimbursement to customary fee levels necessarily increased by raises in the cost of practice does not belong in business. The rapid increase in third-party programs by the private insurance carriers and their competitiveness in seeking new groups to cover with their programs, endorses this viewpoint.

With these thoughts in mind, The Dental Society of the State of New York submits the following resolution to be placed on the agenda of the 1976 ADA House of Delegates.

35. Resolved, that *Standard 3* of the ADA *Standards for Dental Prepayment Programs* be amended by the following additional sentence:

> Participating and Non-Participating classifications of dentists by third-party agencies for the purpose of establishing differentials in levels of reimbursement is considered disadvantageous to the profession and insured patients alike.

to make the amended *Standard 3* read as follows:

3. Patients should have freedom of choice of dentist and all legally qualified dentists should be eligible to render care for which benefits are provided. Participating and Non-Participating classifications of dentists by third-party agencies for the purpose of establishing differentials in levels of reimbursement is considered disadvantageous to the profession and insured patients alike.

New York, The Dental Society of the State of

TERMINATION OF "TEAM" PROGRAMS

The following resolution was adopted by the Board of Governors of The Dental Society of the State of New York at the Annual Meeting on May 1-5, 1976 and transmitted under date of May 11, 1976 by Dr. Seymour L. Nash, executive director.

Background Statement: The purported intent of TEAM programs has been to prepare the dental student for the management of expanded duty auxiliaries in a practice. Several points concerning such programs are to be noted:

1. In addition to the intended training of dental students, auxiliaries are being educated to perform expanded intraoral functions.
2. The Dental Practice Act in the State of New York, as in many other states, prohibits the performance of many of these intraoral expanded duty functions.
3. Such training programs therefore develop a core of unemployables.

It should also be acknowledged that under the stimulation of HEW dental schools in New York State and in many other states have ongoing grant programs under the TEAM concept. Such programs can no longer be considered experimental since there has been sufficient evidence for collation and evaluation.

The Dental Society of the State of New York is of the opinion that the extent of TEAM programs now is extended beyond a reasonable level and can no longer be considered beneficial to the dental health of the public. The Dental Society of the State of New York therefore presents the following resolution for the consideration of the 1976 House of Delegates and urges its adoption.

36. **Resolved,** that all TEAM experimental programs and their financial support be terminated upon the expiration of existing contracts or grants, and be it further

Resolved, that the results and conclusions of all such experimental programs be collected and collated by the ADA Council on Dental Education for distribution to all state boards for dentistry and all state dental societies for additional consideration and recommendations relative to implementation.

Ohio Dental Association

ADA ACTIVELY OPPOSE PRECEPTOR DENTAL HYGIENE TRAINING PROGRAMS IN ALL STATES AND TERRITORIES

The following resolution was adopted by the Ohio Dental Association and transmitted under date of October 15, 1976 by Mr. Roger W. Hunter, executive director.

Background Statement: A fundamental challenge to the delivery of quality oral health care is facing the dental profession today. That challenge is the licensure of preceptor trained dental personnel to perform dental hygiene functions.

Preceptor training has played a significant role in the development of all the health professions. However, as the arts and sciences have advanced, many began to question the lack of uniformity in preceptor training and the quality of care rendered by those prepared in this manner. As a result, formal educational programs were established and minimum standards set for the various curricula.

In the case of dentistry and dental hygiene, it is the Council on Dental Education and the Commission on Accreditation of Dental and Dental Auxiliary Educational Programs of the American Dental Association which establish minimal educational standards for the performance of state regulated intraoral functions. Currently, these standards are a prerequisite for licensure in 49 of our 50 states.

It has been long recognized that the scope and level of any educational program to train dental hygienists to perform complex intraoral functions delegated to them by the dental profession could be no less than that required for the comparable portion of the dental curriculum. Otherwise, the high quality of dental care could not be upheld.

Recent activities in several states to enact legislation to recognize preceptor training for dental hygiene functions as adequate for licensure are cause for concern among all oral health professions. Our entire oral health care delivery system is based on the principle that every dental practitioner must be adequately trained in the performance of their legally authorized responsibilities.

The reintroduction of an obsolete system of training for dental personnel who perform complex procedures in the mouths of patients jeopardizes the recognized educational standards of all. There is no place in our oral health delivery system for dual standards of qualifications.

The seriousness and immediacy of the challenge that the reintroduction of preceptor dental hygiene represents to the dental profession cannot be overemphasized. This challenge demands a united nationwide stand in support of a single standard of education for the performance of any state regulated intraoral function, if it is to be defeated.

95. **Resolved,** that the American Dental Association advocate the use of a single standard of performance for each federal government, civil service and state regulated dental hygiene program, and be it further

Resolved, that the American Dental Association actively oppose efforts seeking to train and qualify those persons to practice dental hygiene who have not completed accredited educational programs.

Ohio Dental Association

CONTINUED DEVELOPMENT OF CRITERIA FOR CURRICULUM AND DEVELOPMENT OF AN ACCREDITATION MECHANISM FOR EXPANDED FUNCTION DENTAL AUXILIARY EDUCATION PROGRAMS

The following resolution was adopted by the Ohio Dental Association and transmitted under date of October 15, 1976 by Mr. Roger W. Hunter, executive director.

Background Statement: A review of expanded function dental auxiliary duties, qualifications, education and credentials throughout the United States reveals a great diversity as to what is meant by the term "expanded function dental auxiliary."

In some states, individuals must be licensed to perform certain tasks. In other states, there are virtually no controls whatsoever. This has led to both a communications barrier and a mobility barrier where these individuals are concerned.

It should be noted that common terms used in explaining expanded functions have differing meanings to each of us. Therefore, at national meetings it is sometimes very difficult to communicate with fellow dentists practicing in other states.

There is also a tremendous mobility problem concerning interstate movement of these individuals due to the fact that each state has differing laws, rules and regulations regarding training and utilization of expanded function dental auxiliaries. Many states have no expanded functions at all.

In order to begin some standardization and continuity, it is imperative that the American Dental Association take affirmative action.

96. Resolved, that the American Dental Association House of Delegates direct the Council on Dental Education to continue development of criteria for curriculum concerning expanded function dental auxiliary educational programs to include a standard glossary of expanded function dental auxiliary terminology, and be it further **Resolved,** that the Commission on Accreditation of Dental and Dental Auxiliary Educational Programs, utilizing the criteria for curriculum developed by the Council on Dental Education of the American Dental Association, design and implement a mechanism for accreditation of expanded function dental auxiliary programs in order to continue the high standard of dental care that the citizenry of this country now enjoy and expect from us.

Ohio Dental Association

SHARING AND COORDINATION OF LEGAL EXPERTISE

The following resolution was adopted by the Ohio Dental Association and transmitted under date of October 15, 1976 by Mr. Roger W. Hunter, executive director.

Background Statement: Each constituent society of the American Dental Association retains the services of competent and talented legal counsel to manage the legal affairs of its association.

The legal questions and problems that arise within each constituent are often unique to the constituent. In many instances, however, those questions and problems are common to all or some other constituents. Often the resolution of those problems in judicial or administrative forms can have a precedential effect on other constituents or the profession as a whole.

The legal precedent which is established by one constituent association is often helpful to and of beneficial value to other constituents. On the other hand, it can be harmful or potentially harmful to other constituents or the profession.

Given the vast legal resources in the area of dental law of the many law firms representing the constituent associations of the American Dental Association, it would be of great value if those firms could better communicate and work with each other to resolve common problems.

To accomplish this purpose it is necessary to establish a mechanism to monitor the legal activities of the various constituents and to accumulate and index information relating to legal matters of common interest within the profession.

Often a constituent is faced with a problem which has been resolved formally or informally in other states. Often a legal issue arises in one state, the resolution of which may have little impact on the state of origination but which can result in harmful precedent affecting other state associations or the profession.

The creation of a central mechanism to monitor and coordinate the legal efforts of the various constituent associations cannot only avoid duplication of effort and its concomitant expense but can also serve to channel important legal information to reinforce efforts of state constituents facing issues of common importance to the profession.

It is also important to note that federal legislation and court decisions are rapidly expanding federal law relating to the activities of all constituents. This rapid expansion results in the need for constituents to seek legal advice and guidance in these areas.

Because the organization and activities of the various constituents are similar or identical in numerous respects, the need for legal service in these areas is often similar. Thus, the development of policies and opinions in these new areas of law result in enormous duplication and, in some instances, inconsistency. Furthermore, because of the complex nature of the federal law, a full understanding of its implications requires special expertise not available to all constituents.

The high level of special legal expertise needed to deal with federal law can be found within or is available to the legal department of the American Dental Association. The ADA legal department can play an important role in making such expertise available to constituent associations. Such assistance from the ADA can also serve to eliminate the development of inconsistent approaches to common legal problems shared within the profession.

It is appropriate, therefore, that the ADA legal department establish a mechanism to encourage the free flow of legal information among the many fine firms representing the ADA state constituent associations and to share its own legal expertise in the area of rapidly expanding federal law with those firms.

It is understood that the relationship between each constituent and its legal counsel is a unique one involving many factors. The mechanism established by this resolution is intended only to provide a resource of legal assistance which can be utilized on a voluntary basis where any constituent legal counsel might feel that such assistance would be helpful and appropriate.

97. Resolved, that the American Dental Association, through its legal department, develop a means by which its high level of legal expertise and legal resources can be shared with constituent societies and their respective legal counsels when deemed appropriate, feasible and in the best interests of the dental profession, and be it further

Resolved, that the American Dental Association legal department establish a mechanism whereby the legal counsel of the various constituent societies may better coordinate and share expertise and information with respect to their common legal problems.

Oregon Dental Association

ENGAGEMENT OF ACTUARY FOR ADA INSURANCE PROGRAMS

The following resolution was adopted by the House of Delegates of the Oregon Dental Association on April 4, 1976 and transmitted under date of April 26, 1976 by Dr. Jack D. Over, secretary-treasurer.

Background Statement: The insurance industry is a many-faceted competitive industry. Experience has shown that proposals made by individual companies can be designed to reflect their individual superiority. This superiority may or may not exist in an objective comparison with similar insurance programs offered by others.

Each American Dental Association insurance program develops millions of premium dollars annually.

The ADA Council on Insurance has the responsibility of reviewing these programs and the actuarial experience generated by each program, to assure that overall integrity, comprehensiveness, and value is maintained for the participants as a group. One very important Council responsibility is the review of recommendations proposed by the underwriters as they relate to adjustments in premiums based on actual experience (claims). It is at this point in time that Council decisions on these recommendations enter a very sophisticated area, necessitating, in the interest of thoroughness, an actuarial review and accompanying recommendations by an insurance actuary. An actuary does not sell or purchase insurance but serves to render an independent evaluation of proposals made.

In view of recent large premium increases and a general deterioration of the market for liability insurance of all kinds, as well as the continuing escalation of premiums for health insurance, it is important that the ADA insurance programs receive continuous and critical evaluation.

37. Resolved, that the American Dental Association be directed to engage an independent actuary who is a Fellow of the Society of Actuaries, or a firm of independent actuaries, at least one of whose members is a Fellow of the Society of Actuaries, to review experience of the sponsored life, disability and health programs and, in addition, to engage an independent actuary who is a Fellow of the Casualty Actuarial Society, or a firm of independent actuaries, at least one of whose members is a Fellow of the Casualty Actuarial Society, to review experience of the sponsored liability programs.

Pennsylvania Dental Association

IDENTIFICATION OF DENTAL PROCEDURES BY SCIENTIFIC TERM

The following resolution was adopted by the House of Delegates of the Pennsylvania Dental Association on June 10, 1976, and transmitted under date of July 12, 1976 by Dr. David S. Wagner, secretary.

51. **Resolved,** that all dental procedures shall be identified or designated by a strictly scientific term or terms, and be it further
Resolved, that the use of proprietary terms such as manufacturers' trade names, personalized descriptions and the like shall not be used to determine or identify a treatment or procedure or method of payment.

Rhode Island Dental Association

AMENDMENT OF "BYLAWS" ON SCIENTIFIC SESSION

The following resolution was adopted by the Rhode Island Dental Association and transmitted under date of June 4, 1976 by Dr. Hubert A. McGuirl, executive secretary.

Background Statement: The *Bylaws* of the American Dental Association recognize 14 sections which shall be included in each scientific session unless omitted by the Council on Scientific Session. The Rhode Island Dental Association believes that Oral Medicine can present a body of knowledge essential to the practice of dentistry for the general membership of the Association. Although Oral Medicine is invited to participate in other sections from time to time, a section of Oral Medicine would permit those recognized in this field to develop a more useful program for general practitioners.

38. **Resolved,** that Section 40(A), Chapter XV, of the *Bylaws* be amended by the addition of "o. Oral Medicine" after "n. Oral Pathology."

Texas Dental Association

INVOLVEMENT OF AMERICAN DENTAL ASSOCIATION DELEGATES WITH THIRD PARTY PROGRAMS

The following resolution was adopted by the House of Delegates of the Texas Dental Association at the annual meeting on April 30–May 3, 1976 and transmitted under date of June 29, 1976 by Dr. Joe C. Carrington, Jr., secretary-treasurer.

Background Statement: The Texas Dental Association believes that the delegates to the House of Delegates of the American Dental Association are obligated to represent the general membership in all matters pertaining to third-party relations. It also believes that the election of delegates who are salaried employees of third-party companies creates an obvious conflict of interest. The Texas Dental Association urges that any possible taint of self-serving be removed from the American Dental Association by modifying the privileges of active membership and defining the qualifications of the delegates to the American Dental Association House of Delegates.

52. Resolved, that the ADA *Bylaws* be amended to provide that no member of the American Dental Association House of Delegates be a salaried employee of any third-party company.

Texas Dental Association

NOMINATION FOR OFFICES OF THE AMERICAN DENTAL ASSOCIATION

The following resolution was adopted by the House of Delegates of the Texas Dental Association at the annual meeting on April 30–May 3, 1976, and transmitted under date of June 29, 1976 by Dr. Joe C. Carrington, Jr., secretary-treasurer.

Background Statement: The Texas Dental Association feels that the privilege of nomination for offices of the American Dental Association was abused by certain constituents of the Association at its 1975 annual session when the threat of nomination was used to influence the passage of legislation before the House of Delegates.

The Texas Dental Association also feels that this gross abuse can be eliminated by the passage of the following resolution respectfully submitted by the 1976 House of Delegates of the Texas Dental Association.

53. Resolved, that the *Manual of House of Delegates,* under the section entitled "Rules of the House of Delegates" be amended to provide that all nominations are to be made as the first order of business at the second meeting of the House of Delegates.

Washington State Dental Association

INTRODUCTION OF NEW BUSINESS IN HOUSE OF DELEGATES

The following resolution was submitted by the Executive Council of the Washington State Dental Association and transmitted under date of May 12, 1976 by Dr. Eugene M. Zuck, president-elect.

Background Statement: Each year the American Dental Association House of Delegates holds an annual session covering a period of five days during which decisions are made on many important resolutions affecting some 120,000 dentists and the public interest. It behooves each delegate to be thoroughly informed about each resolution so he can receive input from his constituents, participate in debate, and render an intelligent judgment with his vote. To do this, he must receive a copy of each resolution in a reasonable time before the House session. In 1975, fifty-four resolutions containing new business were distributed to the delegates for the first time after they arrived at the ADA annual session. Combined with the great number of previously submitted resolutions, the new resolutions represented a total impossible for the delegates to absorb, comprehend, and debate in an orderly, intelligent manner. Since this trend has been accelerating rather than decreasing in recent years, the last hours of the last day become chaotic as time runs short and many resolutions are quickly voted on in order to finish the session so that delegates can check out of their hotels and connect with transportation for home. Policy often becomes confused and results both in divisiveness within the profession and skepticism by the public as to the profession's motives. It appears that almost all resolutions could be introduced earlier but a great number are purposely withheld until it is too late for the Board of Trustees and other ADA agencies, as well as the delegates, to study them carefully. A procedure vital to the dental profession's best interests is long overdue whereby resolutions to the ADA House of Delegates will: (1) pass the scrutiny of the ADA agencies; (2) be received by delegates in sufficient time to study them before coming to the House; and (3) be debated before informed reference committees and on the floor of an informed House so they can be passed, rejected, amended, rewritten, tabled, or referred to the appropriate ADA council for further study.

It is also recognized that circumstances and new information should allow for the introduction of entirely new resolutions not previously submitted to the House through regular channels. However, there should be certain limitations on their submission if the House is to conduct its business in an orderly, responsible manner. The burden of proof that a new resolution to the agenda is valid must be shifted to the sponsors if the in-depth scrutiny required of all the other resolutions is to be bypassed.

39. **Resolved,** that Chapter V, House of Delegates, Section 120(Ad), Introduction of New Business, of the *Bylaws* be amended to read as follows:

> d. **Introduction of New Business.** Except with the consent of three-fourths of the delegates present and voting, no new business shall be introduced into the House of Delegates during any session unless submitted at least 45 days prior to the opening meeting of the session and distributed to the delegates at least 30 days prior to the opening meetings of the session. Reference Committee recommendations shall not be deemed new business.

and be it further

Resolved, that the *Manual of the House of Delegates* be amended by the deletion of the paragraph entitled "Introduction of New Business" and substitution therefor of the following paragraph:

> **Introduction of New Business.** Except with the consent of three-fourths of the

delegates present and voting, no new business shall be introduced into the House of Delegates during any session unless submitted at least 45 days prior to the opening meeting of the session and distributed to the delegates at least 30 days prior to the opening meeting of the session. Reference Committee recommendations shall not be deemed new business.

Washington State Dental Association

POLICY ON FUNCTIONS OF DENTAL AUXILIARIES

The following resolution was submitted by the Washington State Dental Association and transmitted under date of May 21, 1976 by Dr. A. Lynn Ryan, secretary.

Background Statement: Within the past few years, and in response to social and governmental influence, and because of the realization by many dentists that the delivery of dental care in their offices could be more satisfying and efficient for patients, dentists, and staff through the utilization of trained auxiliaries in so-called "expanded functions" there have been many varying methods in different states as to how these desirable conditions could be realized. Different governing bodies, boards of dental examiners and offices have followed different methods of authorizing and utilizing the help of trained auxiliaries. These various states feel the determination of which duties are assignable should remain the right of these states so long as the profession itself acts to provide for the health of patients and the dentist remains cognizant that he or she is ultimately and finally responsible for the care which is provided in the individual office. These states ask that the American Dental Association not be made the determining entity as to the methods of utilizing auxiliaries in the individual states.

40. Resolved, that Resolution 40-1974-H, as revised by the adoption of Resolution 861 by the 1975 House of Delegates, be amended by the deletion of the following resolving clause:

> Resolved, that the American Dental Association oppose the preparation of teeth, the placement, carving and contouring of dental restorations, and the injection of local anesthetics by dental auxiliaries, and be it further

to make the amended resolution read:

> Resolved, that in the training, education, and utilization of dental auxiliaries for the purpose of assisting the dentist in providing high quality dental care through expanded functions, it shall be the policy of the American Dental Association that expanded functions shall be performed under the direct supervision of the dentist and that auxiliaries shall perform only those functions as defined in state dental practice acts for which they have had appropriate education and training, and be it further
> Resolved, that final decisions related to dental practice and utilization of dental

auxiliaries rest with the state society and the state board of dentistry, and be it further

Resolved, that the American Dental Association opposes any program, or the funding of such program, of training, education, or utilization of dental auxiliaries that is not in accord with these policies, and be it further

Resolved, that the Board of Trustees take action to effect the intent and purpose of this resolution through appropriate legislative efforts.

Washington State Dental Association

POSITION STATEMENT ON ADVERTISING

The following resolution was submitted by the Washington State Dental Association and transmitted under date of May 12, 1976 by Dr. A. Lynn Ryan, secretary.

Background Statement: Recent actions by the Federal Trade Commission and related developments make it imperative that a position statement be developed to inform legislative and administrative agencies and the public as to the reasons why ethical dentists do not advertise. Since this is a national issue, such a position statement should be developed on a uniform, national basis by the American Dental Association.

41. **Resolved,** that the American Dental Association develop a uniform, national position statement setting forth and substantiating the reasons why advertising by dentists is not in the public interest.

Wisconsin Dental Association

RECONSIDERATION OF 1974 WISCONSIN RESOLUTION 43 REGARDING MODIFICATION OF MEMBERSHIP CARD

The following resolution was adopted by the House of Delegates of the Wisconsin Dental Association at the annual meeting on May 3-5, 1976 and transmitted under date of June 4, 1976 by Mr. Joseph P. D'Amico, executive director.

Whereas, the 1974 Wisconsin Resolution 43, requesting that the American Dental Association issue to each of its members a membership card in the form of a standard plastic multi-purpose type card, was turned down by the Reference Committee of the 1975 American Dental Association House of Delegates, and

Whereas, the plastic multi-purpose membership card would expedite registration at all dental meetings, accurately identify and record a member's attendance at continuing dental education courses, and

Whereas, the cost figures of implementing the Wisconsin Resolution 43, submitted to the Reference Committee, were in gross error, and

Whereas, the American Dental Association members present at the Reference Committee hearings were overwhelmingly in favor of the resolution and spoke in its behalf, therefore be it

42. Resolved, that the 1976 American Dental Association House of Delegates reconsider and implement the 1974 Wisconsin Resolution 43 requesting that the American Dental Association issue to each of its members a membership card in the form of a standard plastic multi-purpose type card.

Wisconsin Dental Association

REDEVELOPMENT OF CONFERENCE ON EXPANDED DUTIES OF DENTAL AUXILIARIES

The following resolution was adopted by the House of Delegates of the Wisconsin Dental Association at the annual meeting on May 3-5, 1976 and transmitted under date of June 4, 1976 by Mr. Joseph P. D'Amico, executive director.

Whereas, the workshop on dental auxiliary expanded functions as directed by the ADA House of Delegates Resolution 864 of 1975 reads as follows:

> Resolved, that the Council on Dental Education sponsor a national workshop on expanded duty dental auxiliary training and utilization, and be it further
> Resolved, that the participants in this workshop represent in the majority those full-time practitioners, both specialists and general practitioners from all sections of the country, who utilize auxiliaries, and be it further
> Resolved, that following the workshop the appropriate agency of the American Dental Association be directed to study and further define, for related agencies (public and private) those functions where formal education requirements may be required for expanded duty dental auxiliaries, and make a report to the 1976 House of Delegates

and

Whereas, the structure of the conference as established was not consistent with the guidelines as set forth in the resolution, and

Whereas, there was a preponderance of representation from the auxiliary organizations, and

Whereas, nearly one third (⅓) of the state societies were not represented at this conference, and

Whereas, instruction by the state societies has not been given to the participants of this conference, therefore be it

43. Resolved, that the ADA House of Delegates direct the Council on Dental Education to redevelop a conference on expanded duties of auxiliary functions as proposed in ADA Resolution 864 of 1975, and be it further

Resolved, that all pertinent information be made available to the state and component societies in ample time for proper study prior to the conference.

Wisconsin Dental Association

REINFORCEMENT OF 1975 RESOLUTION 861

The following resolution was adopted by the House of Delegates of the Wisconsin Dental Association at its annual session on May 3-5, 1976 and transmitted under date of November 3, 1976 by Mr. Joseph P. D'Amico, executive director.

107. **Resolved**, that the American Dental Association's position regarding dental auxiliary expanded functions as expressed in Resolution 861 (*Trans.* 1975:701) continues to reflect the views of the American Dental Association and should be vigorously reinforced and supported.

Second District Dental Association of Pennsylvania

OPPOSITION TO GOVERNMENTAL INTRUSION INTO PRIVATE PRACTICE OF DENTISTRY

The following resolution was proposed by the Second District Dental Association of Pennsylvania and transmitted under date of November 12, 1976 by Dr. Simon A. Horkowitz, secretary.

Whereas, the government is encroaching further and further into the field of dentistry and agencies such as the Federal Trade Commission and the Food and Drug Administration are imposing more control upon the profession of dentistry, and
Whereas, this type of control is also occurring in other professions, and
Whereas, professions have reserved the right to regulate their own membership and problems and disputes internally, and
Whereas, the dental profession has resolved professional problems more than adequately by their own membership acting through the component societies and the American Dental Association, therefore be it

130. **Resolved**, that the American Dental Association is opposed to any unnecessary intrusion, either by state or federal government into the private practice of dentistry.

Second Trustee District

PROBLEMS EXISTING BETWEEN MEDICINE AND DENTISTRY IN THE HOSPITAL

The following resolution was adopted by the Second Trustee District and transmitted under date of November 9, 1976 by Dr. I. Lawrence Kerr, trustee.

Background: Historically, attempts have been made by the medical profession to impose unilateral controls on the practice of dentistry in the hospital without due con-

sideration to the scope of training, experience and customary practice of the specialty of oral surgery. Although the problem has surfaced as a local issue in the State of New York such controls, if successfully imposed, will have nationwide implications of a serious and deleterious nature. The action, limiting the scope of practice of dentistry, would adversely affect the dental profession and would diminish the oral surgeon's established role in the provision of oral health care to the American public.

113. Resolved, that the American Dental Association is strongly urged to assist The Dental Society of the State of New York with all available resources, to ameliorate jurisdictional disputes between medicine and dentistry in the State of New York in order to allow appropriately licensed dentists to practice dentistry within the parameters of their training, experience and demonstrated competence.

Fourth Trustee District

AMENDMENT OF AMERICAN DENTAL ASSOCIATION STATEMENT ON EXPANDED FUNCTION DENTAL AUXILIARY UTILIZATION AND EDUCATION

The following resolution was adopted by the Fourth Trustee District and transmitted under date of November 14, 1976 by Mr. Lyman W. Karr, executive director, Maryland.

149. Resolved, that all reference to condensing and carving amalgam restorations and placing and contouring silicate cement and composite resin restoration in individual teeth in the American Dental Association *Statement on Expanded Function Dental Auxiliary Utilization and Education* be deleted.

Fourth Trustee District

AMENDMENT OF "BYLAWS" REGARDING COMPOSITION OF BOARD OF TRUSTEES

The following resolution was adopted by the Fourth Trustee District and transmitted under date of November 16, 1976 by Dr. Robert J. Wilson, delegate, Maryland. The following resolution has been approved by the Standing Committee on Constitution and Bylaws. The cost to the Association is estimated to be $9,000.

Whereas, at the present time the American Dental Association is wasting one of its greatest human resources, and
Whereas, the Association can benefit enormously from the knowledge and experience of the Immediate Past President, therefore be it

180. Resolved, that Chapter VI, Board of Trustees, Section 10, Composition, of the *Bylaws* be amended by substituting the following sentence for the second sentence:

Such fourteen (14) trustees, a trustee at-large who shall be the Immediate Past President, the President-elect, and the two Vice-Presidents shall constitute the voting membership of the Board of Trustees.

and be it further,
Resolved, that the amendment take effect upon the installation of officers and trustees on November 18, 1976.

Fourth Trustee District

COMMENDATION TO BOARD OF TRUSTEES

The following resolution was adopted by the Fourth Trustee District and transmitted under date of November 14, 1976 by Mr. Lyman W. Karr, executive director, Maryland.

142. **Resolved,** that the Board of Trustees of the New Jersey Dental Association and the Fourth ADA Trustee District commends the American Dental Association Board of Trustees, acting on behalf of the practicing dentists, for its moral and financial support to help defray the expenses being incurred in educating the New Jersey legislature and administration concerning the untoward features of fourth party dental delivery systems whose control lies in the hands of non-professionals and for their foresight in seeing that this New Jersey problem has broad national ramifications.

Fourth Trustee District

CONFERENCE ON ILLEGAL DENTISTRY

The following resolution was adopted by the Fourth Trustee District and transmitted under date of November 14, 1976 by Mr. Lyman W. Karr, executive director, Maryland.

151. **Resolved,** that a conference on illegal dentistry be called by the American Dental Association to discuss all aspects of the illegal practice of dentistry.

Fourth Trustee District

CONFERENCE ON LEGISLATION AND LEGAL ISSUES

The following resolution was adopted by the Fourth Trustee District and transmitted under date of November 14, 1976 by Mr. Lyman W. Karr, executive director, Maryland.

140. **Resolved**, that a conference on legislation and legal issues facing the profession be called by the American Dental Association to discuss problems connected with litigation and that Presidents, Presidents-elect, Executive Directors and Attorneys for each constituent society be invited to participate in this conference, and be it further **Resolved**, that the appropriate agency of the Association schedule such a conference as soon as possible.

The cost estimate for the Conference is $2,500.

Fourth Trustee District

NATIONAL HEALTH SERVICE CORPS

The following resolution was adopted by the Fourth Trustee District and transmitted under date of November 14, 1976 by Mr. Lyman W. Karr, executive director, Maryland.

Whereas, a new law relative to the National Health Service Corps has recently been passed and
Whereas, the Secretary of HEW is required by law to develop criteria for utilization of this mechanism in underserved areas and these must be promulgated by May 1, 1977, therefore be it

148. **Resolved**, that the appropriate agencies of this Association be directed to provide the necessary and timely input into the development of the criteria for utilization of the National Health Service Corps in underserved areas.

Fourth Trustee District

NEED FOR RECOGNITION OF TRAINING IN COMPREHENSIVE DENTAL PRACTICE

The following resolution was adopted by the Fourth Trustee District and transmitted under date of November 14, 1976 by Mr. Lyman W. Karr, executive director, Maryland.

Background Statement: There is a trend for an increasing number of dentists to specialize in one or another of the recognized specialties of dentistry. The federal government has indicated that there is a need for increasing numbers of men to devote their careers to general dentistry. This has been evidenced in proposed manpower legislation which included a requirement that 70 percent of new residencies in dentistry be in the general practice of dentistry or pedodontics. Further, there is a growing call for dentists to practice in isolated areas where specialists in the now recognized specialties are not normally available.

In the Navy, a need has been identified for an individual who has experience and education in general practice above that which a dentist who has not had graduate training in general dentistry would ordinarily be expected to have. A two-year course in comprehensive dental practice for dental officers has been established at the National Naval Dental Center.

It is believed that many dentists would like to remain in general practice, but if they are to train for an additional two years they should have the recognition which is accorded others who complete advanced educational training. This facet of dental practice should be explored. Therefore, to ascertain the views of general practitioners nationwide on this matter, the Fourth Trustee District recommends that a survey be conducted at an approximate cost of $7,000 and submits the following resolution:

144. Resolved, that the appropriate agencies of the American Dental Association develop and conduct a survey of general practitioners who are members of the Association to obtain their opinions as to the need, desirability, and method for recognizing those who study general dentistry in a recognized advanced education program.

Fourth Trustee District

NUMBERING OF PAGES IN "SUPPLEMENT"

The following resolution was adopted by the Fourth Trustee District and transmitted under date of November 14, 1976 by Mr. Lyman W. Karr, executive director, Maryland.

150. Resolved, that the pages of the *Supplement to Annual Reports and Resolutions* be numbered in sequence to the pages of the *Annual Reports and Resolutions.*

Fourth Trustee District

SUBSTITUTE RESOLUTION FOR RESOLUTION 99

The following substitute resolution for Resolution 99 of the District of Columbia Dental Society on Announcement of a Specialty was adopted by the Fourth District Caucus and transmitted under date of November 14, 1976 by Mr. Lyman W. Karr, executive director, Maryland State Dental Association.

99S-1. **Resolved,** that Section 18 of the *Principles of Ethics* be amended by adding to the second paragraph the sentence, "The use of the phrase 'Practice limited exclusively to _____' shall be restricted to those limiting their practice exclusively to only one of the approved specialty areas." so that the second paragraph will read as follows:

> In accord with the established ethical ruling that dentists should not claim or imply superiority, use of the phrases "Specialist in _____" or "Specialist on _____" in announcements, cards, letterheads or directory listings should be discouraged. The use of the phrase "Practice limited to _____" is preferable. The use of the phrase "Practice limited exclusively to _____" shall be restricted to those limiting their practice exclusively to only one of the approved specialty areas."

Fourth Trustee District

SUPPORT OF SENATE BILL 410

The following resolution was adopted by the Fourth Trustee District and transmitted under date of November 14, 1976 by Mr. Lyman W. Karr, executive director, Maryland.

152. **Resolved,** that the American Dental Association actively support Senate Bill 410 which if enacted will repeal "Earnings Test for Social Security Retirement Benefits."

Fourth Trustee District

TAX EXEMPTION FOR SCHOLARSHIPS

The following resolution was adopted by the Fourth Trustee District and transmitted under date of November 14, 1976 by Mr. Lyman W. Karr, executive director, Maryland.

145. **Resolved,** that the ADA support legislation providing a tax exemption for scholarship assistance and stipends awarded to health professions students under federal programs.

Fourth Trustee District

UNIFORMED SERVICE DEPENDENT AND RETIRED PERSONNEL DENTAL CARE

The following resolution was adopted by the Fourth Trustee District and transmitted under date of November 14, 1976 by Mr. Lyman W. Karr, executive director, Maryland.

Background Statement: Since 1956 dental care is the *only* health care not routinely available to the seven million military dependents and retired personnel.

Since 1968, about 19 bills proposing some form of dependent and retired dental care were introduced in Congress. Due to lack of interest and inadequate representation none of these were passed. Most of these came to the Department of Defense and were "killed."

The Chief of the Army Dental Corps is deeply interested in providing dental care to the total Army family in the same manner that medical care is currently available to these beneficiaries. He has already briefed and received enthusiastic support from the Army Staff for any effort that will provide dental care for the dependent and retired military beneficiaries.

If the ADA and its constituent societies would actively and forcefully support the efforts of the Army, this much needed legislation authorizing dental care for all military dependents and retired personnel may be passed into law during the next session of Congress.

You can assist in this effort by:

a. Supporting resolution from the Fourth District on this subject, and by

b. Writing to your Congressional delegation and expressing your concern about the dental care of seven million American citizens.

Whereas, in the civilian sector the number of people provided dental care through a "type" dental insurance plan is rapidly increasing (currently 30 million and estimated to be 80 million by 1980) the amount of dental care provided the military dependent and retiree is minimal or non-existent.

Whereas, nationally, a 6.3 percent of the health dollars is spent on dental care, under CHAMPUS only 0.4 percent of the health dollar (1.7 million out of a total of almost 445 million for FY 76) is devoted to dental care of military dependents and retired (7 million beneficiaries).

139. Resolved, that the American Dental Association strongly encourage constituent societies to actively pursue the passage of legislation (amending existing CHAMPUS legislation or enactment of separate legislation) for third party prepayment programs which would authorize a complete dental care program for all uniformed services dependents and retired personnel, and be it further

Resolved, that the American Dental Association through its councils and offices undertake vigorous action to assure enactment of such legislation during the 95th Congress and rapid implementation of the authorized dental care program by appropriate defense and uniformed service agencies.

Fourth Trustee District

US COAST GUARD DENTAL ADVISOR

The following resolution was adopted by the Fourth Trustee District and transmitted under date of November 14, 1976 by Mr. Lyman W. Karr, executive director, Maryland.

147. **Resolved,** that the Association take measures to assure that the US Coast Guard in its administration of its dental care programs appoint a dental officer to advise the commandant relative to dental matters.

Fifth Trustee District

AMENDMENT TO RESOLUTION 4

The following amendment to Resolution 4 was adopted by the Fifth Trustee District and transmitted under date of November 3, 1976 by Mrs. Joyce B. Rodgers, executive director, North Carolina Dental Society.

4S-1. **Resolved,** that Resolution 4 of the Council on Dental Education be amended by substituting the word "preferred" for the word "essential" in the last line, to make the amended resolution read:

> **Resolved,** that graduation from a dental hygiene program accredited by the Commission on Accreditation of Dental and Dental Auxiliary Educational Programs is the preferred educational eligibility requirement for dental hygiene licensure examination.

Fifth Trustee District

AMENDMENT TO RESOLUTION 8

The following amendment to Resolution 8 was adopted by the Fifth Trustee District and transmitted under date of November 3, 1976 by Mrs. Joyce B. Rodgers, executive director, North Carolina Dental Society.

8S-1. **Resolved,** that Resolution 8 of the Council on Federal Dental Services be amended by the addition of a second resolving clause, to make the amended resolution read:

> **Resolved,** that the American Dental Association strongly urge the federal dental services to improve the productivity of its present workforce of dentists rather

than utilize dental auxiliary personnel in the performance of duties which are in conflict with the ADA policy, and be it further

Resolved, that meetings be continued with the chiefs of all federal dental services in order to persuade them to discontinue the program of training and utilization of expanded duty dental auxiliaries.

Fifth Trustee District

AMENDMENT TO RESOLUTION 25

The following amendment to Resolution 25 was adopted by the Fifth Trustee District and transmitted under date of November 3, 1976 by Mrs. Joyce B. Rodgers, executive director, North Carolina Dental Society.

25S-1. **Resolved,** that Resolution 25 of the Commission on Licensure be amended by striking the words "and opposes use of licensure for any other purpose," to make the amended resolution read:

Resolved, that the American Dental Association believes licensure to be solely for the protection of the public.

Fifth Trustee District

AMENDMENT TO RESOLUTION 58

The following amendment to Resolution 58 was adopted by the Fifth Trustee District and transmitted under date of November 3, 1976 by Mrs. Joyce B. Rodgers, executive director, North Carolina Dental Society.

Background Statement: It has been the experience of several constituent societies that once an area has been designated as "remote" it is virtually impossible to reverse the designation, regardless of changes which may have occurred in the interim. Therefore, a second resolving clause is recommended as an amendment to Resolution 58.

58S-1. **Resolved,** that the American Dental Association vigorously oppose the designation of remote status of any military installation where the criteria for such designation under federal regulation cannot be met, and especially where a dental manpower shortage cannot be demonstrated to exist, and be it further

Resolved, that upon annual renewal of existing remote area designations, complete re-evaluation be performed with strict adherence to these criteria as promulgated herewith for an original designation.

Fifth Trustee District

CHANGES IN PROPOSED "GUIDELINES FOR DENTISTRY'S POSITION IN A NATIONAL HEALTH PROGRAM"

The following resolution was adopted by the Fifth Trustee District and transmitted under date of November 14, 1976 by Dr. Buford Jones, chairman, Fifth Trustee District.

156. **Resolved,** that the following changes be made in Revisions to the proposed *Guidelines for Dentistry's Position in a National Health Program:*

1. *Transactions,* p. 456. Lines 44-45: Strike the word, "of" on line 44 and substitute the word, "or"; insert a semicolon after the word, "jaws" and insert the words, "and treatment of" on line 45.

2. *Transactions,* p. 456, line 51: Insert the words, "when function is impaired" after the word, "teeth", and strike the remainder of the line.

3. *Transactions,* p. 456, line 52: Insert the words, "when function is impaired" after the word, "teeth".

4. *Transactions,* p. 456, line 53: Strike the words, "malocclusion with priority for interceptive treatment and disfiguring and".

5. *Transactions,* p. 457, line 81: strike the words, "and increased".

6. *Transactions,* p. 457, lines 82 and 83: Delete.

7. *Transactions,* p. 457, lines 87-88: Strike the words, "at full capacity"

8. *Transactions,* p. 457, line 90: Strike the words, "and auxiliary".

9. *Transactions,* p. 457, lines 93-94: Delete the sentence reading, "Curriculum flexibility should also be encouraged to allow for the integration of current educational methodologies and procedures."

10. *Transactions,* p. 457, lines 98-99: Delete.

11. *Transactions,* p. 457, lines 118-119: Delete.

12. *Transactions,* p. 458, lines 151-153: Delete.

13. *Transactions,* p. 458, lines 159-164:

> Line 159—Begin Item 12 with the words, "In a".
> Line 160—Strike the words, "should require that" and substitute the words, "which include".
> Lines 160-161—Strike the words "be included as an essential service", strike the period, insert a comma, continue the sentence by changing "The" to "the", strike the word, "however".
> Line 164—Strike the period at the end of the sentence, insert a semicolon and insert the following: "or (4) that permit participation by practitioners not licensed in that state."

The amended section 12 would then read as follows:

12. In a national health program that establishes health maintenance organizations for the delivery of comprehensive health services which include dental care, the American Dental Association is opposed to HMO legislation or regulations (1) that deny freedom for beneficiaries to choose between HMOs and

the traditional private practice fee-for-service system, (2) that award HMOs subsidies, and (3) that permit HMOs to advertise in conflict with the unprofessional conduct provisions of state licensure laws; or (4) that permit participation by practitioners not licensed in that state.

14. *Transactions,* p. 458, lines 173-175:

> Line 173—Insert the word, "and" after the semicolon.
> Line 174—Strike the semicolon, insert a period, and
> Line 175—Strike the remainder of the paragraph.

15. *Transactions,* p. 459, lines 205-206: Delete.

16. *Transactions,* p. 460, lines 226-227: Strike lines 226 and 227 and insert in lieu thereof the following, found on p. 72, lines 289-291:

> 1. Licensed dentists should be involved at all levels of review of the dental aspects in a dental component of a national health program, and review of the quality of professional services should be under the control of licensed dentists.

17. *Transactions,* p. 460, lines 246-263: Delete.

Fifth Trustee District

COMMENDATION TO COMMISSION ON LICENSURE

The following resolution was adopted by the Fifth Trustee District delegation and transmitted under date of November 3, 1976 by Mrs. Joyce B. Rodgers, executive director, North Carolina Dental Society.

108. **Resolved,** that the Commission on Licensure is commended for its in-depth study of the very complex subject of licensure and for completing said study with dispatch.

Fifth Trustee District

NATIONAL HEALTH SERVICE CORPS PLACEMENTS

The following resolution was adopted by the Fifth District Caucus and transmitted under date of November 17, 1976 by Dr. William Lawson, Delegate.

Background Statement: Recent legislation has removed the requirement that HEW consult with constituent and component dental societies before placing a National Health Service Corps dentist in a shortage area.

182. **Resolved,** that the American Dental Association strongly urge the Department of Health, Education, and Welfare to continue to consult voluntarily with the constituent and component dental societies before placing a National Health Service Corps dentist.

Fifth Trustee District

PACKAGE INSURANCE PLANS

The following resolution was adopted by the Fifth Trustee District and transmitted under date of November 14, 1976 by Dr. Buford Jones, chairman, Fifth Trustee District.

Background Statement: The Fifth Trustee District is concerned that the dental profession may find itself in the position of having no competition among insurance carriers of malpractice insurance, in the same way that medicine is now in a position of having no choice in this field.

158. **Resolved,** that the American Dental Association encourage insurance companies to create package plans which include malpractice insurance which package plans would be available to independent agents in order to ensure competitive rate structures and avoid the evolution of a monopolistic situation in the area of malpractice insurance.

Fifth Trustee District

SUBSTITUTE RESOLUTION FOR RESOLUTION 4RC

The following substitute resolution for Resolution 4RC of the Reference Committee on Dental Education and Related Matters on Educational Standards for Dental Hygiene was adopted by the Fifth District Caucus and transmitted under date of November 17, 1976 by Dr. William Lawson, Delegate.

4S-2. **Resolved,** that Resolution 4RC be amended by deletion of the second resolving clause, making the amended resolution read as follows:

> **Resolved,** that graduation from a dental hygiene program accredited by the Commission on Accreditation of Dental and Dental Auxiliary Educational Programs is the essential educational eligibility requirement for dental hygiene licensure examination, and/or practice.

Fifth Trustee District

SUBSTITUTE RESOLUTION FOR RESOLUTION 24

The following substitute resolution for Resolution 24 was adopted by the Fifth Trustee District and transmitted under date of November 3, 1976 by Mrs. Joyce B. Rodgers, executive director, North Carolina Dental Society.

Background Statement: The Fifth Trustee District Organization unanimously reaffirms the rights and obligations of the respective state boards of dentistry to determine appropriate auxiliary duty expansion, utilization and education necessary to protect the public.

The Fifth Trustee District Organization believes that there is no possible way to arrive at a universally acceptable listing of functions which could be delegated to expanded duty auxiliaries unless state dental practice acts were radically modified to conform to a national uniform code. In all the states of the Fifth District this would be totally unacceptable. Therefore, it is the recommendation of the Fifth Trustee District that the American Dental Association approve the *Philosophy* and *Principles* portions of the proposed *Statement on Expanded Function Dental Auxiliary Utilization and Education,* with one amendment, but that the remaining portion, which deals with the delineation of duties—from line 75 through line 216—be deleted and left entirely to the jurisdiction of the respective state boards of dentistry.

The following substitute resolution is offered for Resolution 24:

24S-2. Resolved, that the *American Dental Association Statement on Expanded Function Dental Auxiliary Utilization and Education* be adopted, with the following amendments:

(a) Delete lines 13-18 (p. 234) and substitute therefor the following:

> The purpose of delegating expanded functions to dental auxiliaries is to improve the productivity of the dentist by assigning those functions which will facilitate the availability of services at a continuing reasonable cost, with assurance of quality control.

(b) Delete lines 75-216 (pp. 235-238).

Fifth Trustee District

SUBSTITUTE RESOLUTION FOR RESOLUTION 26

The following substitute resolution for Resolution 26 was adopted by the Fifth Trustee District and transmitted under date of November 3, 1976 by Mrs. Joyce B. Rodgers, executive director, North Carolina Dental Society.

Background Statement: The requirement for sound moral character for licensure has been one of the foundations upon which the profession has built its prestige and ensured the continuity of professionalism through the years. Resolution 26 circumvents the requirement for sound moral character while aiming at the goal of removing unrelated data requirements from licensure applications. The following substitute resolution is recommended.

26S-1. Resolved, that the American Dental Association request each state board of dentistry to review its application for licensure to insure that data inquiring into religious preferences, race, fraternal memberships, marital status or planned location of practice, not related to an individual's qualifications to provide dental treatment, are not required.

Fifth Trustee District

SUBSTITUTE RESOLUTION FOR RESOLUTION 28

The following substitute resolution for Resolution 28 was adopted by the Fifth Trustee District and transmitted under date of November 3, 1976 by Mrs. Joyce B. Rodgers, executive director, North Carolina Dental Society.

28S-1. Resolved, that Resolution 28 of the Commission on Licensure be amended by inserting the word "amended" before the word "Guidelines" and by inserting the words "by Credentials" after the word "Licensure," to make the amended resolution read:

> **Resolved,** that the amended *Guidelines for Licensure by Credentials* be approved and transmitted to each state board of dentistry for consideration, with the following deletions:
>
> (a) Delete the first 34 lines of the *Guidelines* (pp. 256-257) to and including the word "examinations," making the first sentence of the *Guidelines* read, "Issuing a license using a performance record in place of examinations is termed licensure by credentials."
>
> (b) Delete Item No. 4 on pages 257 and 258, referring to teaching experience as a way to meet eligibility for waiver of written and clinical examinations.

Fifth Trustee District

SUBSTITUTE RESOLUTION FOR RESOLUTION 28RC

The following substitute resolution for Resolution 28RC of the Reference Committee on Dental Licensure and Related Matters, on Approval of "Guidelines for Licensure"

was adopted by the Fifth District Caucus and transmitted under date of November 17, 1976 by Dr. William Lawson, Delegate.

28S-2. **Resolved,** that Resolution 28RC be amended by striking the words "an initial" on line 7 of the first resolving clause and substituting therefor the word "a," to make the amended resolution read:

> **Resolved,** that *Guidelines for Licensure* be amended by replacing the first two paragraphs with the following:
>
> > Dental licensure is intended to insure that only qualified individuals provide dental treatment to the public. Among qualifications deemed essential are satisfactory theoretical knowledge of basic biomedical and dental sciences and satisfactory clinical skill. It is essential that each candidate for a license be required to demonstrate these attributes on examinations: a written examination for theoretical knowledge and a clinical examination for clinical skill. These guidelines suggest alternate mechanisms for evaluating the theoretical knowledge and clinical skill of an applicant for licensure who holds a dental license in another jurisdiction.
> >
> > **Licensure by Examination:** A candidate who is seeking licensure in several jurisdictions being required to demonstrate his theoretical knowledge and clinical skill on separate examinations for each jurisdiction seems unnecessary duplication.
>
> and be it further
> **Resolved,** that the *Guidelines for Licensure,* as amended, be approved and transmitted to each state board of dentistry for consideration.

Fifth Trustee District

SUBSTITUTE RESOLUTION FOR RESOLUTION 36aB

The following substitute resolution for Resolution 36aB, the Board of Trustees amendment of Resolution 36, was adopted by the Fifth Trustee District and transmitted under date of November 3, 1976 by Mrs. Joyce B. Rodgers, executive director, North Carolina Dental Society.

36(aB)S-1. **Resolved,** that Resolution 36aB be amended by adding a second resolving clause, so that the amended resolution reads:

> **Resolved,** that all TEAM experimental programs and their financial support be terminated upon the expiration of existing contracts or grants, and be it further
> **Resolved,** that the American Dental Association be directed in all its testimony before Congress to testify that the TEAM experimental program not be reenacted upon its expiration in 1980.

Fifth Trustee District

SUBSTITUTE RESOLUTION FOR RESOLUTION 36bB

The following substitute resolution for Resolution 36bB, the Board of Trustees amendment of Resolution 36, was adopted by the Fifth Trustee District and transmitted under date of November 3, 1976 by Mrs. Joyce B. Rodgers, executive director, North Carolina Dental Society.

36(bB)S-1. **Resolved,** that Resolution 36bB be amended by inserting a period after the words "dental societies" and striking the words "for additional consideration and recommendations relative to implementation," making the amended resolution read:

> **Resolved,** that the results and conclusions of all TEAM and other expanded function auxiliary training programs be collected and collated by the ADA Council on Dental Education for distribution to all state boards for dentistry and all state dental societies.

Fifth Trustee District

SUBSTITUTE RESOLUTION FOR RESOLUTION 37

The following substitute resolution for Resolution 37 of the Oregon Dental Association on Engagement of Actuary for ADA Insurance Programs was adopted by the Fifth Trustee District and transmitted under date of November 14, 1976 by Dr. Buford Jones, chairman, Fifth Trustee District.

37S-1. **Resolved,** that Resolution 37 be amended by striking the period at the end of the resolution and adding the following words:

> and assist constituent societies in the evaluation of state-sponsored programs.

to make the amended resolution read as follows:

Resolved, that the American Dental Association be directed to engage an independent actuary who is a Fellow of the Society of Actuaries, or a firm of independent actuaries, at least one of whose members is a Fellow of the Society of Actuaries, to review experience of the sponsored life, disability and health programs and, in addition, to engage an independent actuary who is a Fellow of the Casualty Actuarial Society, or a firm of independent actuaries, at least one of whose members is a Fellow of the Casualty Actuarial Society, to review experience of the sponsored liability programs *and assist constituent societies in the evaluation of state-sponsored programs.*

Fifth Trustee District

SUBSTITUTE RESOLUTION FOR RESOLUTION 39RC

The following substitute resolution for Resolution 39RC of the Reference Committee on President's Address and Miscellaneous Matters on the Washington State Dental Resolution was transmitted under date of November 17, 1976 by Dr. William Lawson, Delegate.

39S-2. **Resolved**, that the first resolving clause of Resolution 39RC be amended by striking the word, "and" in line 6 and substitute therefor the word, "or,"
to make the first resolving clause read as follows:

> **Resolved**, that Chapter V, House of Delegates, Section 120 (Ad), Introduction of New Business, of the *Bylaws* be amended to read as follows:
>
> > d. Introduction of New Business. No new business shall be introduced into the House of Delegates less than 15 days prior to the opening of the annual session, unless submitted by a Trustee District or with the consent of three-fourths of the delegates present and voting. No new business shall be introduced into the House of Delegates at the last meeting of a session except by unanimous consent; approval of such new business shall require a unanimous vote. Reference Committee recommendations shall not be deemed new business.

Fifth Trustee District

SUBSTITUTE RESOLUTION FOR RESOLUTION 41

The following substitute resolution for Resolution 41 was adopted by the Fifth Trustee District and transmitted under date of November 3, 1976 by Mrs. Joyce B. Rodgers, executive director, North Carolina Dental Society.

41S-1. **Resolved**, that the Board of Trustees develop a national policy position on advertising by dentists and bring to the 1977 House of Delegates.

Fifth Trustee District

SUBSTITUTE RESOLUTION FOR RESOLUTION 58RC

The following substitute resolution for Resolution 58RC of the Reference Committee on Legislative and Related Matters on Remote Status for Military Establishments was adopted by the Fifth District Caucus and transmitted under date of November 17, 1976 by Dr. William Lawson, delegate.

58S-2. **Resolved**, that Resolution 58RC be amended by inserting in the second resolving clause, line one, the words, "state society request" after the word, "upon". The substitute resolution to read:

> **Resolved**, that the American Dental Association vigorously oppose the designation of remote status of any military installation where the criteria for such designation under federal regulation cannot be met, and especially where a dental manpower shortage cannot be demonstrated to exist, and be it further **Resolved**, that upon state society request review of existing remote status designations, complete re-evaluation be performed with strict adherence to these criteria as promulgated for an original designation.

Fifth Trustee District

SUBSTITUTE RESOLUTION FOR RESOLUTION 77

The following substitute resolution for Resolution 77 of the Board of Trustees on Duties of Council on Dental Education was adopted by the Fifth District Caucus and transmitted under date of November 17, 1976 by Joyce B. Rodgers, North Carolina Dental Society.

77S-1. **Resolved**, that Chapter IX, Councils, Section 110, Duties, subsection N, Council on Dental Legislation, of the *Bylaws* be amended by the addition to paragraph N of the following:

> C. To study and make recommendations of policy on matters of licensure related to dentistry.

and be it further
Resolved, that the Board of Trustees be requested to support a *Bylaws* change which would create tripartite membership in the Council on Legislation.

Fifth Trustee District

SUBSTITUTE RESOLUTION FOR RESOLUTION 110bB

The following substitute resolution for Resolution 110bB of the Reference Committee on Dental Care Programs and Health on Rejection of Supplemental Report 2 from the Council on Dental Care Programs was adopted by the Fifth District Caucus and transmitted under date of November 17, 1976 by Dr. William Lawson, delegate.

110(bB)S-1. **Resolved**, that Resolution 110bB be amended by striking the words, "arrange for" in the first line and substituting therefor the word "consider," to make the resolution read as follows:

Resolved, that the Board of Trustees consider a study of potential antitrust questions involved in the relationship between the American Dental Association and Delta Dental Plans Association and report to the 1977 House of Delegates.

Fifth Trustee District

TIMING OF REQUESTS BY FEDERAL AGENCIES FOR COMMENT BY THE DENTAL PROFESSION

The following resolution was adopted by the Fifth Trustee District and transmitted under date of November 14, 1976 by Dr. Buford Jones, chairman, Fifth Trustee District.

Background Statement: In July, 1976, "A Proposal for Credentialing Health Manpower", issued by the Department of Health, Education, and Welfare, was received by the American Dental Association. The proposal was discussed during the August 2-5, 1976, National Conference on Certification.

On August 31, 1976, constituent societies were asked for comment with a suspense date of September 15, 1976. Since receipt of this information was in most cases five to seven days later, there was less than one (1) week allowed for input from the constituent society level which resulted in virtually no input on this most vital issue of credentialing -an area which would affect the entire profession. Without input from the constituent societies, the posture of the American Dental Association is essentially meaningless.

Furthermore this is not an isolated incident wherein the American Dental Association and its constituent societies are not given sufficient time to study and formulate an intelligent, thoroughly considered reply to Federal government agencies, particularly the Department of HEW.

157. **Resolved,** that the American Dental Association through its Board of Trustees use every available source of influence to require of Federal agencies that sufficient time be allowed on all requests affecting the profession for proper dissemination, study and formulation of recommendations.

Fifth Trustee District

USE OF MOTION "POSTPONED INDEFINITELY"

The following resolution was adopted by the Fifth Trustee District caucus on November 16, 1976 and was submitted by Dr. John M. Faust, trustee, Fifth District.

179. **Resolved,** that when a resolution is brought before the House of Delegates with a motion to postpone indefinitely, that the resolution may be debated, amended and all other subsidiary motions may be applied against it, in order of precedence.

Sixth Trustee District

ANNUAL REVIEW OF "GUIDELINES FOR DENTISTRY'S POSITION IN A NATIONAL HEALTH PROGRAM"

The following resolution was adopted by the Sixth District Caucus and transmitted under date of November 16, 1976 by Dr. Joseph M. Grana, Missouri.

Background Statement: In recognition of the realities of today's political climate and in further recognition of the fact that the Association's elected officials and staff must have formal policy guidance to assist them in presenting dentistry's position to all segments of the public and recognizing the need for input from the private practitioners in the development of formal policy guidance, since discussion has disclosed that the views of private practitioners may not have been fully involved up to this point. It may be necessary to call a workshop which could cost $40,000 if involving 100 dentists for two days.

181. **Resolved,** that the *Guidelines for Dentistry's Position in a National Health Program* be reviewed by the Board of Trustees each year, beginning in 1977 with annual reports to the House of Delegates, reflecting the changing views of the private practitioners as influenced by developing governmental policy and the needs of the public.

Seventh Trustee District

SUBSTITUTE RESOLUTION FOR RESOLUTION 39RC

The following substitute resolution for Resolution 39RC of the Reference Committee on President's Address and Miscellaneous Matters on Introduction of New Business in House of Delegates was adopted by the Seventh District Caucus and transmitted under date of November 16, 1976 by Harold E. Barlow, delegate.

Background Statement: Ohio, along with several other states, holds its annual session in the fall. Setting a deadline of 15 days would eliminate, in some years, the possibility of submitting resolutions emanating from the Ohio session, and similar constituent sessions.

39S-1. **Resolved,** that Resolution 39RC be amended in both paragraphs by inserting the following phrase after the words "annual session":

> unless submitted by a constitutent society whose regularly scheduled annual session occurs less than 30 days prior to the ADA annual session, in which case the deadline shall be the opening of the ADA annual session, or

to make the amended resolution read:

Resolved, that Chapter V, House of Delegates, Section 120 (Ad), Introduction of New Business, of the *Bylaws* be amended to read as follows:

d. Introduction of New Business. No new business shall be introduced into the House of Delegates less than 15 days prior to the opening of the annual session, unless submitted by a constituent society whose regularly scheduled annual session occurs less than 30 days prior to the ADA annual session, in which case the deadline shall be the opening of the ADA annual session, or unless submitted by a Trustee District and with the consent of three-fourths of the delegates present and voting. No new business shall be introduced into the House of Delegates at the last meeting of a session except by unanimous consent; approval of such new business shall require a unanimous vote. Reference Committee recommendations shall not be deemed new business.

and be it further

Resolved, that the *Manual of the House of Delegates* be amended by the deletion of the paragraph entitled "Introduction of New Business" and substitution therefor of the following paragraph:

Introduction of New Business: No new business shall be introduced into the House of Delegates less than 15 days prior to the opening of the annual session, unless submitted by a constituent society whose regularly scheduled annual session occurs less than 30 days prior to the ADA annual session, in which case the deadline shall be the opening of the ADA annual session, or unless submitted by a Trustee District and with the consent of three-fourths of the delegates present and voting. No new business shall be introduced into the House of Delegates at the last meeting of a session except by unanimous consent; approval of such new business shall require a unanimous vote. Reference Committee recommendations shall not be deemed new business.

Eighth Trustee District

GRANT SPACE IN HEADQUARTERS BUILDING

The following resolution from the Eighth Trustee District was transmitted under date of November 14, 1976 by Dr. William J. Greek, executive director.

Background Statement: Sound financial management in retiring the mortgages extant on the Headquarters Building has been a hallmark of the Board of Trustees since construction was completed. Occupancy in rented space and appropriate administrative control has not only led to marked reductions in the mortgage but significant appreciation on the initial investment. In order to establish policy in relation to utilization of space and personnel, the following resolution is proposed.

138. **Resolved**, that the House of Delegates urge the Board of Trustees to refuse granting free space and sharing free services to any organization not subject to the policies of this Association nor responsible to the Board of Trustees.

Ninth Trustee District

DEFINITION OF A "DENTURIST" AND "DENTURISM"

The following resolution was adopted by the Ninth Trustee District and transmitted under date of November 14, 1976 by Dr. James V. Barone, vice-president, Michigan Dental Association.

Background Statement: Graduation from a school accredited by the Commission on Accreditation of Dental and Dental Auxiliary Educational Programs is the minimum educational requirement qualifying a person for licensure (a consumer protection measure). The ADA believes that public responsibility requires that a dental license be issued only to qualified persons. A "denturist" does not meet this necessary educational requirement and is, therefore, unqualified to practice dentistry in any form on the public.

141. Resolved, that when the words "denturist" or "denturism" are used in ADA publications, the terms should be accompanied by a brief but prominent footnote indicating that a "denturist" is a person who is educationally unqualified and therefore not licensed, for the necessary protection of the public, to practice dentistry in any form on the public and that "denturism" is the unqualified as well as the illegal practice of dentistry in any form on the public, and be it further
Resolved, that constituent and component societies act in concert with the American Dental Association.

Ninth Trustee District

SUBSTITUTE RESOLUTION FOR RESOLUTION 35RC

The following substitute resolution for Resolution 35RC of the Reference Committee on Dental Care Programs and Health on Fee Reimbursement Differences was transmitted under date of November 17, 1976 by the Ninth Trustee District.

35S-1. Resolved, that there can be a justifiable differential in fee reimbursements in recognition of the valid responsibilities that are assumed by the participating dentist by virtue of his contractual agreement, and be it further
Resolved, that fee differentials be avoided whenever possible, and be it further
Resolved, that when such differential does exist, wherever possible it not be of such magnitude as to result in economic leverage on the dentist or on the patient's freedom of choice.

Tenth Trustee District

COMMENDATION OF DR. JACK H. PFISTER

The following resolution was adopted by the Tenth Trustee District on November 14, 1976 and submitted by D. Dean Ray, president, Iowa Dental Association; Roger J. Burke, president, Minnesota Dental Association; Duane M. Hunt, president, Nebraska Dental Association; G. D. Larson, president, North Dakota Dental Association and Richard J. Schoessler, president, South Dakota Dental Association.

Background Statement: In serving as the Trustee of the ADA Tenth District for six years, Dr. Jack H. Pfister has not only represented the interest of the membership of the states of Iowa, Minnesota, Nebraska, North Dakota and South Dakota both faithfully and effectively; but more importantly has represented the entire ADA membership by displaying leadership that has no geographical boundaries.

As trustee, Dr. Pfister has shown his concern for each of the five constituent societies by working closely with the officers and keeping them advised on issues that were of their prime concern. His devotion to duty and interest in the concerns of the grassroots membership has been displayed by frequent attendance at component society meetings.

The Tenth District owes a great debt of gratitude to Dr. Pfister for establishing an environment in which his call for unity, trust and frank interchange has flourished during his tenure as trustee.

The outstanding expertise and leadership of Dr. Pfister will be missed by the Tenth District, but this ability will continue to be utilized by Dr. Pfister's service as Treasurer to the American Dental Association. It is with sincere appreciation that this resolution is presented.

135. **Resolved,** that the American Dental Association House of Delegates expresses its appreciation for the devotion to duty, the display of leadership, dedication to the profession and loyalty to the American Dental Association and commends Dr. Jack H. Pfister on his service as trustee of the American Dental Association, 1970-1976.

Tenth Trustee District

ESTABLISHMENT OF COMMITTEE ON GOVERNMENT OPERATION

The following resolution was submitted by the Tenth Trustee District and transmitted under date of November 14, 1976 by Dr. William E. Dunn, secretary, Tenth Trustee District.

Background Statement: Government in the United States has grown over the past 200 years to the point where now one in six persons in our population is employed by a governmental unit. This is more than is currently employed in the auto, steel and oil industries combined.

Emboldened by this tremendous size governmental agencies have assumed ever in-

creasing control and regulatory powers. Influenced by reports of these agencies Congress has legislated matters that threaten the liberty and freedom of private citizens, business and the professions. In the area of dentistry this has resulted in federally sponsored HMOs, the June 1976 HEW report on credentialing, FTC investigations of the ethical principles on advertising and proposals for National Health Insurance to name only a few.

It seems incongruous that these threats to freedom should occur while we celebrate the bicentennial founding of our nation whose principal unique characteristic is its dedication to liberty. Typical of the diversities in government is the fact that while the Post Office Department publishes stamps that bear the caption "Proclaim liberty throughout all the land" the FTC, the FAA, the IRS and HEW promulgate new regulations and controls.

Since the ADA has the dual responsibility of representing individual dentists and the profession both of which are being threatened and harassed by the encroachment of government it seems apropos that the organization should take a stand opposing further erosion of our basic national principles. Since no council or committee of the ADA has been assigned the responsibility of examining the operations of government for the purpose of pointing out the abuse of governmental authority and infringement of personal freedom it is suggested that a new committee be appointed for this purpose. Accordingly the following resolution is offered.

Whereas, government in the United States has grown to the extent that it is inefficient and excessively costly, and because of this growth the agencies of government have become steadily more dictatorial and oppressive, and

Whereas, in this bicentennial year we have had a renewal of our dedication to the principles of liberty and freedom which promote the value of the individual and of his ability to think and act independently, and

Whereas, the dental profession is made up largely of private practicing individuals whose services under the free enterprise system have resulted in the best dental care in the world, and

Whereas, governmental proposals are now endangering the private practice system and threaten and harass the profession, therefore be it

137. **Resolved,** that the American Dental Association establish a Committee on Government Operation whose principal duty would be to focus on instances of mismanagement and harassment by government agencies and to report these instances to the Board of Trustees who in turn would report them to higher governmental authority and to the public through the press and news media, and be it further

Resolved, that $1000 be allocated for the expenses of the committee in the 1977 budget.

Tenth Trustee District

PROVISIONS FOR ADVANCE COPIES OF "REPORTS" AND "SUPPLEMENT"

The following resolution from the Tenth Trustee District was transmitted under date of November 14, 1976 by Dr. William E. Dunn, secretary.

Whereas, the House of Delegates is the supreme authoritative body of the American Dental Association and,
Whereas, the voting members of the House of Delegates are selected to represent the will and desire of the constituent society membership, and
Whereas, the general membership has no direct access to the resolutions presented for action by the House of Delegates, therefore be it

134. Resolved, that the American Dental Association provide an opportunity for the general membership to place advance orders for copies of the *Annual Reports and Resolutions* and the *Supplement to Annual Reports and Resolutions* at a cost equal to the printing and mailing costs for these documents.

Tenth Trustee District

SUBSTITUTE RESOLUTION FOR RESOLUTION 24

The following substitute resolution for Resolution 24 on the *Statement on Expanded Function Dental Auxiliary Utilization and Education* was adopted by the Tenth Trustee District and transmitted under date of November 14, 1976 by Dr. Dennis A. Johnson, Minnesota.

Background Statement: The Tenth Trustee District believes that the 1975 ADA House of Delegates spoke clearly when it adopted as its policy Resolution 861 which states:

> Resolved, that the American Dental Association oppose the preparation of teeth, the placement, carving and contouring of dental restorations, and the injection of local anesthetics by dental auxiliaries.

We believe that this should remain as a policy statement of the American Dental Association and, therefore, offer the following resolution amending the *Statement on Expanded Function Dental Auxiliary Utilization and Education* proposed in the Council on Dental Education's *Special Report on Dental Auxiliary Utilization and Education* and which the Council on Dental Education requests adoption in Resolution 24.

24S-3. Resolved, that the American Dental Association *Statement on Expanded Function Dental Auxiliary Utilization and Education* be amended by reordering the items listed under "Principles of Dental Auxiliary Utilization and Education" so that the current item 6, "Decisions on delegation of expanded functions should be based on what is in the best interest of the patient" becomes item 1 and the other sixteen items to be renumbered accordingly, and be it further
Resolved, that the functions listed on lines 90-96, page 159 of the *Annual Reports and Resolutions, 1976* be added to as follows:

> 8. The preparation of teeth, the insertion of restorations, and the carving and contouring of restorations in the oral cavity.
> 9. The injection of local anesthetics.

and be it further
Resolved, that due to the statement of functions and procedures that should not be delegated to dental auxiliaries as stated above, as well as in Resolution 861 (*Trans.* 1975:701), the following numbered procedures on page 160 of the *Annual Reports and Resolutions, 1976* as indicated be deleted:

page 160, line 128, #15
page 160, lines 129-130, #16
page 160, line 136, #3

and be it further
Resolved, that the following numbered procedures on pages 161-162 of the *Annual Reports and Resolutions, 1976,* as indicated, be deleted:

page 161, line 195, #13
page 161, Lines 196-197, #14
page 162, lines 203-204, #3

Twelfth Trustee District

COMMENDATION TO WASHINGTON OFFICE

The following resolution was submitted by the Twelfth Trustee District and transmitted under date of November 14, 1976 by Bob Berry, secretary.

Background Statement: During the last two sessions of the United States Congress, legislation has been considered that contained many provisions that conflicted with ADA policy and would have imposed undesirable restrictions upon and interfered with the education process in our nation's dental schools.
Many of those provisions were removed from this legislation as a result of combined efforts of the Association and coordinated through the Washington Office.

153. **Resolved,** that the Washington Office and particularly its director, Mr. Hal Christensen, be commended for their efforts in amending the Health Professions Educational Assistance Act of 1976 in order to advance and protect the dental profession and the dental education system.

Twelfth Trustee District

REVISION OF "BYLAWS" TO CHANGE ASSIGNMENT OF MANAGEMENT RESPONSIBILITY OF PUBLICATIONS

The following resolution was adopted by the Twelfth Trustee District and transmitted under date of November 17, 1976 by Mr. Bob D. Berry, secretary.

Background Statement: The present *Bylaws* of the Association provide that the Executive Director engage all employees, except as otherwise provided by the *Bylaws*. It is the intent of the following resolution to propose a change in the *Bylaws* that would give the Editor of the Association full administrative control, not only of the editorial content of the Association publications, but also of the hiring and assignment of duties of the editorial department personnel and the administration of the budget assigned to the editorial department. No responsibilities of the Editor to the Board of Trustees would be changed by this resolution. The language of this amendment has been approved by the Standing Committee on Constitution and Bylaws.

183. **Resolved,** that Chapter VIII, Appointive Officers, Section 40(C), Duties, Editor, of the *Bylaws* be amended by adding after the first sentence the sentence, "The Editor shall engage all editorial employees and shall supervise and coordinate all administrative, budgetary, and editorial activities within the Editorial Department," so that the substitution will read as follows:

> **Editor.** The Editor shall be Editor-in-Chief of all journals of the Association and shall exercise full editorial control over such publications, subject only to policies established by the Board of Trustees and by these *Bylaws*. The Editor shall engage all editorial employees and shall supervise and coordinate all administrative, budgetary, and editorial activities within the Editorial Department. He shall perform other duties prescribed by the Board of Trustees and these *Bylaws*.

Twelfth Trustee District

REVISION OF "REQUIREMENTS FOR APPROVAL OF GENERAL PRACTICE RESIDENCY PROGRAMS IN DENTISTRY"

The following resolution was adopted by the Twelfth Trustee District and transmitted under date of November 16, 1976 by Mr. Bob D. Berry, executive director, Oklahoma Dental Association.

Background Statement: The current "Requirements for Approval of General Practice Residency Programs in Dentistry" as approved by the 1972 House of Delegates of the American Dental Association, requires that a general practice residency program must be hospital based to be accredited. This requirement restricts the development of advanced training programs in general practice by dental schools because of difficulties in financing and administration. It appears that acceptable training programs could be developed in a dental school environment that included hospital training without the requirement that the programs be hospital based.

143. **Resolved,** that the Council on Dental Education undertake a revision of the "Requirements for Approval of General Practice Residency Programs in Dentistry" that allows advanced training programs in general practice to be based in either a hospital or a dental school.

Thirteenth Trustee District

AMENDMENT TO THE ADA "PRINCIPLES OF ETHICS"

The following resolution was submitted by the Thirteenth Trustee District and transmitted under date of November 14, 1976 by Mr. Henry L. Ernstthal, executive director, California Dental Association.

Background Statement: Many constituent and component dental societies have their own codes of ethics. The current ADA *Principles of Ethics* encourages a local settlement of questions and appears to leave the interpretation of such local codes of ethics with the component society. The Thirteenth Trustee District feels, however, that the language could use additional clarification that would reemphasize this aspect of local control of one's own code of ethics without destroying any or changing any of the existing rights to due process or appeal that individual members are currently entitled to. And, the clarification is necessary because of the need to define the proper interpreter of constituent codes of ethics, an issue not covered in the existing Section 22 of the ADA *Principles of Ethics.* Accordingly, the following resolution is presented:

136. **Resolved,** that Section 22 of the ADA's *Principles of Ethics* be amended by deleting from that section the words, "of the code of ethics of the component society" and inserting in their place the words, "the interpretation by the component and/or constituent society of their respective codes of ethics," so that the amended Section 22 will read:

> Problems involving questions of ethics should be solved at the local level within the broad boundaries established in these *Principles of Ethics* and within the interpretation by the component and/or constituent society of their respective codes of ethics. If a satisfactory decision cannot be reached, the question should be referred, on appeal, to the constituent society and the Council on Judicial Procedures, Constitution and Bylaws of the American Dental Association, as provided in Chapter XI of the *Bylaws* of the American Dental Association.

Thirteenth Trustee District

AMENDMENT OF "BYLAWS" ON DISCIPLINARY PENALTIES

The following resolution was adopted by the Thirteenth Trustee District and transmitted under date of July 29, 1976 by Dr. Robert L. Taylor, president.

Background Statement: The disciplinary penalty of probation was removed from the ADA *Constitution and Bylaws,* Chapter XI, Section 20B and 20D at the 1971 session of the ADA House of Delegates. The ADA Council on Judicial Procedures, Constitution and Bylaws, however, utilized the "probationary" sentence as a disciplinary sentence in an appeal from the California Dental Association Judicial Council to the ADA Council on Judicial Procedures, Constitution and Bylaws. Apparently, the term

"probation" was deleted from Chapter XI, Section 20B and 20D of the ADA *Bylaws,* but was not deleted from Chapter XI, Section 20C(d) of the ADA *Bylaws,* and was in fact utilized by the ADA Council on Judicial Procedures, Constitution and Bylaws in a decision rendered on February 3, 1976.

A sentence of suspension must be unconditional, as mandated by the ADA *Bylaws,* and for a specified period of time. A sentence of suspension also means that all membership privileges except continued entitlement to coverages under insurance programs are lost during the suspension period. Under the terms of the suspension, a subsequent violation shall require a new disciplinary procedure before additional discipline may be imposed. This is usually a costly procedure, and one that the constituent society (or component society) must bear unaided.

The sentence of expulsion is an absolute discipline and also may not be imposed conditionally.

The penalty of probation has been shown in the past to be a useful sentence in disciplinary situations. Probation, while also for a fixed period of time, does not require the forfeiture of membership privileges and would be a suitable penalty for a first offense or an offense committed due to lack of knowledge of law or ethics. However, and most importantly, a society may impose a sentence combining probation and expulsion if a particular act or failure to act occurs within the probationary period. Although the society would have to conduct a disciplinary procedure in accordance with the *Bylaws* before the discipline may be changed from probation to expulsion to determine whether this act or failure to act has occurred, such a procedure would require less time and expense than an entirely new disciplinary hearing, and would provide a useful alternative when a society must deal with a repeating offender. Probation, then, allows the society to give a member the benefit of the doubt, while retaining his membership privileges, but also warns the member that no further violation of the ethical code (or state law, as appropriate) will be tolerated.

Since the penalty of probation has not only been shown to be useful, but also has been shown to be viable, the Thirteenth Trustee District urges the adoption of the following resolution in order to clarify for all constituent and component dental societies the disciplinary penalty provisions as provided in Chapter XI, Sections 20B, 20C and 20D of the *Bylaws.*

60. **Resolved,** that the 1976 American Dental Association House of Delegates amend Chapter XI, Sections 20B (line 1576 of page 39) and 20D (line 1627 of page 40) of the *Bylaws* by adding the word "probation" on each of said lines so that the language of said sections will read as follows:

> Section 20B. Disciplinary Penalties. A member may be placed under a sentence of censure, suspension or probation or may be expelled from membership for any of the offenses enumerated in Section 20A of this chapter.
>
> Suspension, subject to Chapter I, Section 30 of these *Bylaws,* means all membership privileges except continued entitlement to coverages under insurance programs are lost during the suspension period. Suspension shall be unconditional and for a specified period at the termination of which full membership privileges are automatically restored. A subsequent violation shall require a new disciplinary procedure before additional discipline may be imposed.
>
> Probation shall be for a fixed period. Membership rights are not forfeited during a period of probation. Additional violation during a period of probation shall require a new disciplinary procedure before additional discipline may be imposed. However, a society may impose a sentence combining probation and expulsion if a particular act or failure to act

occurs within the probation period. The society must conduct a disciplinary procedure in accordance with Section 20C before the discipline may be changed from probation to expulsion for the specific purpose of determining whether this act or failure to act has occurred.

Expulsion is an absolute discipline and may not be imposed conditionally.

Section 20D. Appeals. The accused member under sentence of censure, suspension, probation or expulsion shall have the right to appeal from a decision of his component society to his constituent society by filing an appeal in affidavit form with the secretary of the constituent society. Such an accused member, or the component society concerned, shall have the right to appeal from a decision of the constituent society to the Council on Judicial Procedures, Constitution and Bylaws of this Association by filing an appeal in affidavit form with the chairman of the Council on Judicial Procedures, Constitution and Bylaws. An appeal from any decision shall not be valid unless notice of the appeal is filed within thirty (30) days and the supporting brief, if one is to be presented, is filed within forty-five (45) days after such decision has been rendered. No decision shall become final while an appeal therefrom is pending or until the thirty (30) day period for filing notice of appeal has elapsed. In the event of a sentence of expulsion and no notice of appeal is received within the 30 day period, the constituent society shall notify all parties of the failure of the accused member to file an appeal. The sentence of expulsion shall take effect on the date the parties are notified. The component and constituent societies shall each determine what portion of current dues, if any, shall be returned to the expelled member. Dues paid to this Association shall not be refundable in the event of expulsion. The following procedure shall be used in processing appeals:

Thirteenth Trustee District

SUBSTITUTE RESOLUTION FOR RESOLUTIONS 57 AND 139

The following substitute resolution for Resolutions 57 and 139 of the Reference Committee on Legislative and Related Matters, on Military Dependent Care was adopted by the Thirteenth District Caucus and transmitted under date of November 17, 1976 by Dr. Robert L. Taylor, president, California Dental Association.

57S-1. Resolved, that the American Dental Association strongly encourage the adoption of the concept of prepaid dental care under the free choice delivery system for military dependents, by amending existing CHAMPUS legislation or enactment of separate legislation for third party prepayment programs which would authorize a dental care program for all uniformed services dependents.

Thirteenth Trustee District

SUBSTITUTE RESOLUTION FOR RESOLUTION 100

The following substitute resolution for Resolution 100 of the Reference Committee on Budget and Administrative Matters on Formation of Self-insured Malpractice Programs was adopted by the Thirteenth District Caucus and transmitted under date of November 17, 1976 by Dr. Robert L. Taylor, president, California Dental Association.

100S-1. **Resolved,** that the American Dental Association study the crisis of rising malpractice insurance premiums and the possibility of a self-insured malpractice program, such study to involve thorough actuarial investigations, and that the result of this study by the proper agency be reported back to the 1977 House of Delegates.

Thirteenth Trustee District

SUBSTITUTE RESOLUTION FOR RESOLUTION 151

The following substitute resolution for Resolution 151 of the Reference Committee on Legislative and Related Matters, on a Conference on Illegal Dentistry was adopted by the Thirteenth District Caucus and transmitted under date of November 17, 1976 by Dr. Robert L. Taylor, president, California Dental Association.

151S-1. **Resolved,** that a conference be sponsored by the ADA to review all aspects of the illegal practice of dentistry regarding the profession's concern for protection of the public.

Delegate W. Kelley Carr, Indiana

DEVELOPMENT OF A UNIFYING PHILOSOPHY ON PRIVATE PRACTICE

The following resolution was transmitted under date of November 13, 1976 by Delegate W. Kelley Carr, Indiana.

Whereas, the members of this association clearly desire the American Dental Association to work to preserve the private practice of dentistry, and
Whereas, the development of a definition of the functions and unique aspects of private practice would greatly aid in the development of a more uniform philosophical basis for action by dental societies and, therefore, greater unity among dentists, and
Whereas, the Conference on Private Practice in 1974, the Conference on Preservation of Private Practice in 1976, and the PEP program did not develop a definition of private practice, therefore be it

132. **Resolved,** that the function of private practice be defined as:

1. *The action taken should result in quality care.*
2. *The action taken should serve the public well* (i.e., we should serve by providing access to care, adequate volume, and protect our opportunities to have a productive practice in order to provide an economical service to the public),

and be it further
Resolved, the unique aspects of Private Practice be defined as:

1. *The dentist's personal financial responsibility for his practice. There are no subsidies.*

2. *Economical. To date there is no other dental delivery system which produces dental care so inexpensively.*

3. *The freedom for the patient and the doctor to develop a treatment plan without interference from third parties.*

4. *The patient's freedom to choose the dentist of his choice (without economic coercion), and the dentist's freedom to accept or reject the patient.*

5. *Has provided direct financial incentives to the dentist.*

and be it further
Resolved, that these definitions be used as guidelines for our members this coming year and until such a time when the House of Delegates feels additional redefinition might be desirable.

Delegate Joseph A. Devine, Wyoming

FINANCIAL TABULATION OF COST OF PROPOSED PROGRAMS

The following resolution was transmitted under date of October 28, 1976 by Delegate Joseph A. Devine, Wyoming.

Background Statement: While the regular expenditures in the annual budget are a growing concern, we also have the increasing demand on the budget arising from unforeseen problems, i.e., lawsuits, governmental problems, etc., and because of directives of the House of Delegates which call for new programs. It has become apparent that the House of Delegates should be given additional help and/or more detailed information to assist it in exercising its responsibility to approve an annual budget. This assistance could be given in the financial tabulation of each program as it is approved by the House of Delegates. This tabulation could be projected on the screen (now already in use) to be shown in the appropriate positions on the budget. At the end of each session, the projection should total the plus and/or minus positions to show the House of Delegates how its deliberations affected the budget to that point. The responsibility to carry out this projection system should be in the hands of the comptroller. In this manner, the person most responsible for the tabulation of the budget would have the duty to assist the House as it deliberates each proposal. This projection system could be modeled on a tote board as in a stock market room or on a race track odds board. The changing of the monies in the various projects could be shown at once to help in the funding of any proposed programs with the effect they would have on the anticipated budget as projected by the Board of Trustees.

102. **Resolved,** that the Board of Trustees in cooperation with the comptroller and the Speaker of the House of Delegates develop the mechanism to project on the screen a financial tabulation of the cost of each program as it is deliberated by the House of Delegates, so that at the end of each session the projection would show the

House of Delegates how its deliberations affected the proposed budget to that point, and be it further

Resolved, that the mechanism be implemented at the 1977 session of the House of Delegates, and be it further

Resolved, that in order that an intelligent and honest approach be given to the approval of the annual budget, after all the facts are known, it shall be the last order of business at the last session of the House of Delegates to give approval, and be it further

Resolved, that, where applicable, proper changes in the *Bylaws* be made to accomplish the requirements of this resolution, thus creating any necessary dues increase at each annual session.

Delegate Joseph G. Distasio, Massachusetts

RECISION OF RESOLUTION 9-1960-H

The following resolution was transmitted under date of November 14, 1976 by Delegate Joseph G. Distasio, Massachusetts.

Background Statement: Since 1960, when Resolution 9-1960-H (*Trans.* 1960:207) was adopted, there have been marked increases in the number of dental schools and dental auxiliary training programs and graduates. Estimates of future dental needs have been greatly revised.

162. **Resolved,** that Resolution 9-1960-H (*Trans.* 1960:207) be rescinded.

Delegate Harry W. F. Dressel, Jr., Maryland

CLASSIFICATION SYSTEM FOR TRADITIONAL AND NONTRADITIONAL DUTIES

The following resolution was transmitted under date of October 27, 1976 by Delegate Harry W. F. Dressel, Jr., Maryland.

Background Statement: The frequent use of the terms "traditional" and "nontraditional" in attempts to classify duties performed by the auxiliary has led to confusion and various interpretations. In order to create a standard to which dentistry can relate in using these terms, it becomes necessary to define them. The definition offered bases the terms on duties considered normal performance for the dental hygienist and dental assistant prior to 1970. The resolution also provides for an update in 1980 to allow the addition or subtraction of duties to either category as may be allowed by the majority of states at that time. Updates every ten years may be considered as conditions dictate in the future.

105. **Resolved,** that those duties which have been legally performed by the dental

assistant or dental hygienist in the majority of states prior to 1970 shall be classified as "traditional duties" for the respective auxiliary having performed them, and all other duties legally allowed since that date shall be classified as "nontraditional duties" for the respective auxiliary performing them, and be it further

Resolved, that this classification shall continue until 1980 when a reclassification or update of "traditional" and "nontraditional" duties shall be made in the same manner as previously, based on the duties allowed by the majority of states at that time, and be it further

Resolved, that the Council on Dental Education shall be charged with the prompt preparation of said classification for dental assistants and dental hygienists and its publication and distribution to the membership of the American Dental Association and to dental organizations concerned.

Delegate Harry W. F. Dressel, Jr., Maryland

SINGLE STANDARD OF PERFORMANCE FOR INTRAORAL DUTIES

The following resolution was transmitted under date of November 10, 1976 by Delegate Harry W. F. Dressel, Jr., Maryland.

Background Statement: The occurrence of double standards of education, clinical competence and evaluation for auxiliaries performing the same intraoral duty within a state serves to confuse and cloud the circumstances surrounding the utilization of auxiliaries in dentistry. In addition, acceptance of multiple levels of care does a disservice to the public and the profession as well.

Whenever a rational conclusion has been reached on the objectives and qualities desired in the performance of an intraoral duty, the standards required within a state should be the same regardless of whether that auxiliary is a dental assistant or dental hygienist.

Although it would be ideal if the same standards for a given duty would be used in *all* states, at least equality in recognition and performance within individual states would be a beginning toward an equal level of care for patients receiving intraoral services from auxiliaries. The following resolution is offered toward achieving that purpose.

117. **Resolved,** that in order to assure quality patient care, the education, clinical competence and examination of any auxiliary performing a state-regulated intraoral function shall be based on achieving a single standard of performance.

Delegate Harry W. F. Dressel, Jr., Maryland

TERMINOLOGY USED TO DESCRIBE DUTIES PERFORMED IN THE MOUTH BY DENTAL AUXILIARIES

The following resolution was transmitted under date of October 27, 1976 by Delegate Harry W. F. Dressel, Jr., Maryland.

Background Statement: During the last decade dentistry has seen an ever accelerating impetus toward the use of auxiliaries for those duties formerly reserved for no one but the dentist. Although the duties of specific concern to the profession that were being written into state laws as permissible for auxiliaries were of an intraoral nature, terms such as "expanded" or "extended" duties have consistently been applied to describe them. This resolution is being presented to help reduce some of the confusion caused by the terminology applied so that the profession may more accurately focus toward solving essential problems in the use of auxiliaries.

Since duties beyond those performed intraorally have little or no implication legally, and since the terms "expanded" or "extended" may be interpreted above and beyond the intent of the dental profession by legislators, consumers and some dental auxiliaries, dental educators, and dental practitioners, it is important that a more specific term be used for those duties involving work in the oral cavity which have been traditionally designated as practicing dentistry.

The term which most naturally applies to describe procedures involving work in the oral cavity would be "intraoral duties." Use of this term would leave no doubt to all parties interested that the concern of the dental profession with regard to any part of dental practice performed on patients by dental auxiliaries is with those duties performed intraorally and previously reserved for dentists. Change to "intraoral duties" in no way implies more extensive use of dental auxiliaries, but more specifically designates the area which would be involved should duties involving work in the mouth be proposed.

104. Resolved, that whenever reference is made to those procedures which involve the use of the hands or instruments in the mouth by a dental auxiliary, the term "intraoral duties" shall be used rather than the terms "extended duties" or "expanded duties."

Delegates Paul Evans and Lyman Wagers, Kentucky

PUBLICATION OF ACCURATE STATEMENTS CONCERNING INCOME REALIZED BY PROVIDERS UNDER PUBLIC HEALTH PROGRAMS AND OF SALARIES OF PERTINENT GOVERNMENTAL ADMINISTRATORS

The following resolution was transmitted under date of November 14, 1976 by Delegates Paul Evans and Lyman Wagers, Kentucky.

159. Resolved, that the American Dental Association strongly seek from govern-

mental agencies issuing, for public information, income amounts being paid by the government to dentists who provide dental care for those agencies that such statements also reflect that such published amounts are gross income figures, before deduction of expenses and taxes, and be it further

Resolved, that the American Dental Association also exhort such governmental agencies, in fairness, issue for public information in the same manner the salaries of those employees involved in administering the governmental health programs, including dental care.

Delegate Eugene J. Fortier, Jr., Louisiana

AMENDMENT TO RESOLUTION 24

The following resolution was transmitted under date of October 27, 1976 by Delegate Eugene J. Fortier, Jr., Louisiana, as an amendment to Resolution 24 of the Council on Dental Education.

Background Statement: The 1975 House of Delegates adopted several resolutions concerning dental auxiliary utilization and education.

The Council on Dental Education sponsored a workshop and published "Proceedings, Workshop on Dental Auxiliary Expanded Functions, March 31, April 1-2, 1976, Hyatt Regency, Chicago, Illinois." Many of the workshop participants disagree with the findings contained in this document (see "Minority Report to 'Proceedings, Workshop on Dental Auxiliary Expanded Functions, March 31, April 1-2, 1976, Hyatt Regency, Chicago, Illinois' " on p. 239).

The Council on Dental Education has presented for approval by the House of Delegates the "American Dental Association Statement on Expanded Function Dental Auxiliary Utilization and Education" (p. 234). This statement has been developed to a large degree from the findings of the recent workshop.

Accordingly, the following amendments to the statement are offered:

> **Line 2:** Delete "Expanded Function Dental Auxiliary" and after "Utilization and Education" add the words "of Functions Performed by Dental Assistants and Dental Hygienists" to make Lines 1 and 2 read as follows:
>
> > American Dental Association Statement on Utilization and Education of Functions Performed by Dental Assistants and Dental Hygienists

This amendment is offered because the word "expanded" as defined by Webster's dictionary is inappropriate for dental assistants and dental hygienists. While one definition in its broadest concept might be appropriate, the balance is too suggestive to allow this word to continue to be used. Webster defines "expand" as follows: (1) to open wide; to spread out; to diffuse; (2) to make, to occupy more space; to dilate; to distend; to enlarge; (3) to work out or develop in full detail as an argument or an equation; verb intransitive: to spread apart, distend, enlarge, swell.

The word "auxiliary" is inappropriate since the American Dental Association recognizes three auxiliaries and this statement refers only to dental assistants and dental hygienists—not to dental laboratory technicians.

Line 4: Delete "Auxiliaries" and substitute "Dental Assistants and Dental Hygienists" to make Line 4 read as follows:

> and Education of Dental Assistants and Dental Hygienists

Line 35: After the period add the following sentence:

> However, individual states or jurisdictions are urged for the sake of uniformity and consistency to work toward having their state dental acts conform to this statement.

Lines 43, 48, 52, 54 and 56: Delete the word "expanded" and substitute the word "additional."
Line 71: Delete "expanded function education and training" and substitute the words "education and training as pertains to additional functions performed by dental assistants and dental hygienists" to make Line 71 read as follows:

> Education and training as pertains to additional functions performed by dental assistants and dental hygienists should be conducted only in settings. . . .

Lines 38, 50, 59 and 62: Delete the word "auxiliaries" and substitute the words "dental assistants and dental hygienists."
Line 75: Delete the word "Expanded" and substitute the word "Additional."
Line 77: Delete the word "expanded" and substitute the word "additional."
Line 96: After item 7 add the following items:

> 8. Administering local anesthetics.
> 9. Placing temporary sedative intracoronal restorations with hand instruments.
> 10. Applying bases as directed by the dentists.
> 11. Condensing and carving amalgam restorations.
> 12. Placing of silicate acrylic composite or synthetic restorations of all types.

Line 125: Delete the words "Placing and."
Line 127: Delete the words "and bases."
Lines 128, 129 and 136: Delete in entirety.
Line 144: Delete the words "Placing and."
Line 146: Delete the words "and bases."
Lines 147, 148 and 149: Delete in entirety.
Line 192: Delete the words "placing and."
Lines 194, 195, 196 and 197: Delete in entirety.
Lines 151, 153, 161, 171, 174 and 178: Delete the word "expanded" and substitute the word "additional."

Line 192: Delete the words "placing and."
Lines 194, 195, 196, 203 and 204: Delete in entirety.
Line 210: Delete the words "placing and."
Lines 212, 213, 214 and 215: Delete in entirety.

24S-1. Resolved, that the American Dental Association Statement on Expanded Function Dental Auxiliary Utilization and Education, as amended, be adopted.

Delegate Eugene J. Fortier, Jr., Louisiana

MODEL STATE DENTAL PRACTICE ACT

The following resolution was transmitted under date of October 27, 1976 by Delegate Eugene J. Fortier, Jr., Louisiana.

Background Statement: Recently, we have witnessed (1) a questioning of the legality of state dental practice acts by the Federal Trade Commission, (2) attacks by the U.S. Justice Department on national associations of professionals alleging that *Bylaws* provisions violate antitrust laws, and (3) suits brought by individuals in consumer groups attacking state practice acts on constitutional grounds.

It is the responsibility of organized dentistry to encourage the continuation of an efficient system for the delivery of dental care. Each state needs a state dental practice act which is defensible against current interpretations of federal law.

103. Resolved, that the appropriate agency of the American Dental Association investigate the feasibility of preparing a model state dental practice act, and be it further

Resolved, that the results of this study be presented to the Board of Trustees at the earliest possible time for implementation and funding, if feasible.

Delegate Jack W. Gottschalk, Ohio

STUDY, DEFINE AND ACT ON THE MALDISTRIBUTION PROBLEM

The following resolution was transmitted under date of November 14, 1976 by Delegate Jack W. Gottschalk, Ohio.

Background Statement: There is question about the magnitude of the maldistribution problem. There is debate over the criteria used to designate underserved areas and what these criteria really represent. The lack of adequate criteria has caused conflict between members of the profession and the administration of the National Health Service Corps (NHSC).

We can all agree that we want dental services to be available to meet the demand for dental services in all areas of the country. The only method available to the NHSC to increase the supply of services is the placement of dentists. The laws and rules severely limit the options available to achieve a redistribution of *dental services* and are causing unnecessary conflict.

The maldistribution problem should receive serious intellectual effort and study. Better criteria for designating underserved areas should be developed and used. The NHSC laws should be amended to allow additional options including present ADA policy on incentives for dentists who practice in underserved areas (*Trans.* 1974: 695) to increase services in underserved areas. Therefore, be it

154. Resolved, that the ADA Board of Trustees study the maldistribution problem, develop adequate criteria to measure it, develop solutions that are acceptable to the profession including present ADA policy on incentives for dentists who practice in underserved areas (*Trans.* 1974:695), seek harmonious concurrence with key legislators and initiate legislation to implement these proposed solutions.

Delegate Rexford E. Hardin, Ohio

STUDY AND RESPOND TO THE CARNEGIE COMMISSION REPORT, "PROGRESS AND PROBLEMS IN MEDICAL AND DENTAL EDUCATION" 1976

Background Statement: The Carnegie Commission of Higher Education made a report in 1970, *Higher Education and the Nation's Health: Policies for Medical and Dental Education.*

This report had a profound effect on legislation relating to dental education which can be noted from the following recommendations made in 1970.

—increase the number of dental schools
—increase enrollment in existing dental schools
—accelerate the dental curriculum
—create a National Health Service Corps
—create dental associates or dental extenders

Recently the Carnegie Commission has made another report, *Progress and Problems in Medical and Dental Education,* which makes recommendations concerning dental education, some of which are as follows:

—We urge and we propose the provision of financial incentives to medical and dental schools to continue these trends (listed above, established as a result of the 1970 report).

—The report continues to use dentist population ratios as the criteria to determine the future need for dentists and for underserved areas.

—Two new dental schools, one in Arizona and one more in Florida.

—An expanded National Health Service Corps program.

—Training more dental extenders.

—Urgently recommend emphasis on educational approaches (such as preceptorships) that will encourage . . . dentist extenders in underserved areas.

There are a number of recommendations that the dental profession should be happy to endorse.

In view of the effect the 1970 report had on federal support and federal control of dental education and the chance that the 1976 report might have a similar effect, the following resolution is submitted.

133. **Resolved,** that the American Dental Association Board of Trustees study the 1976 Carnegie Commission report, *Progress and Problems in Medical and Dental Education,* the data used and the recommendations, and publish appropriate comment taking into consideration all additional data available to the Board of Trustees.

Delegate Theodore L. Jerrold, New York

CHANGES IN REQUIREMENTS FOR ADVANCED SPECIALTY EDUCATION PROGRAMS

The following resolution was submitted under date of November 14, 1976 by Delegate Theodore L. Jerrold, New York.

Background Statement: At the 1975 American Dental Association meeting, requirements for National Certifying Boards for Special Areas of Dental Practice were approved by the House of Delegates. One of these requirements for eligibility for certification as a Diplomate in a Special Area of Dental Practice has to do with time requirements, which states:

> Although desirable, the period of advanced study need not be continuous, nor completed with successive calendar years. An advanced educational program equivalent to two academic years in length, successfully completed on a part-time basis over an extended period of time as a graduated sequence of educational experience not exceeding four calendar years, may be considered acceptable in satisfying this requirement. (*Trans.* 1975:690)

However, in 1974 the House of Delegates of the American Dental Association passed new *Requirements for Advanced Specialty Education Programs* (*Trans.* 1974:57) (lines 155-174). In these requirements it states "Programs specifically designed for part-time enrollment are unacceptable for accreditation." (Lines 166-167)

Whereas, the latter statement is in conflict with the requirements of certification by the specialty boards, and

Whereas, it is generally agreed that at least one year of general practice is desirable before going into a specialty, and

Whereas, full-time requirements to pursue specialty training leading to Board certification may be a hardship for the general practitioner, who has been in general practice for a number of years, and

Whereas, a program should be accredited its merit and not on its length of time, therefore be it

161. Resolved, that lines 166-167 be deleted from the *Requirements for Advanced Specialty Education Programs.*

Delegate Ronald I. Maitland, New York

TRAINING IN CARDIOPULMONARY RESUSCITATION

The following resolution was transmitted under date of October 28, 1976 by Delegate Ronald I. Maitland, New York.

Background Statement: The dentist of today has a great responsibility, by nature of his profession, to be prepared to render basic life support in the event of a medical emergency in either his office or in the community.

The action taken by the House of Delegates in 1964 (*Trans.* 1964:275) was, at that time, a positive decisive action.

> Resolved, that the constituent dental societies be requested to cooperate with their state health departments in the development of programs to train dentists in the procedure of closed chest cardiac resuscitation.

Today we must step forward and further recommend that the dentist seek out such training.

The "Standards for Cardiopulmonary Resuscitation (CPR) and Emergency Cardiac Care (ECC)" published on page 838 of the February 18, 1974 issue of the *Journal of the American Medical Association* state:

> It has been estimated that about one million persons in the United States experience acute myocardial infarction each year. More than 650,000 die annually of ischemic heart disease. About 350,000 of these deaths occur outside the hospital, usually within two hours after the onset of symptoms. Thus, sudden death from heart attack is the most important medical emergency today. It seems probable that a large number of these deaths can be prevented by prompt, appropriate treatment.

In addition, another one million victims die as a result of other medical emergencies involving sudden collapse. These unfortunate ill events are looking for a place to happen, and the dental office is certainly exposed to large numbers of the public. Many of these victims could be saved by the prompt and proper application of cardiopulmonary resuscitation and emergency care.

The American Heart Association and the American Red Cross have undertaken the task of citizen training in cardiopulmonary resuscitation (CPR) across the nation. Large numbers of the lay public have become and will continue to become trained in the skills of resuscitation. The dental profession is to be encouraged to seek this training so that the level of competency of a dentist in emergency situations is in keeping with the education and training expected in the ladder of responsibility for a

health professional. The sudden death of a patient in the office is almost certain to occur at least once in each dentist's practice lifetime, according to Dr. Frank M. McCarthy, of Los Angeles. as reported in the December 2, 1974 *ADA News*. "Moreover, the dentist who has not prepared himself and his staff to deal with such an emergency may be deprived of his license, sentenced to jail, and heavily fined in a wrongful death judgment."

A new law in Texas, which may portend similar action by other states, requires that by October 1, 1976 "all dentists practicing in Texas using any type of anesthesia or anesthetic agents, including local anesthesia, shall have and maintain emergency equipment and drugs appropriate for patient resuscitation. Such equipment shall include a positive pressure breathing apparatus. All emergency equipment shall be present in the dental office and shall be utilized by the licensed professional or under his direct supervision. Training of emergency procedures and drugs shall be given to all dentist office personnel."

The American Heart Association and the National Academy of Sciences—National Research Council cosponsored a National Conference on Standards for Cardiopulmonary Resuscitation (CPR) and Emergency Cardiac Care (ECC) in Washington, D.C. on May 16-18, 1973. This Conference was conducted because of the changes that have occurred during the past several years. In May 1966, the National Academy of Sciences—National Research Council sponsored a Conference on Cardiopulmonary Resuscitation that recommended the training of medical, allied health, and professional paramedical personnel in cardiopulmonary resuscitation according to the standards of the American Heart Association. Those recommendations resulted in widespread acceptance of cardiopulmonary resuscitation and training in the technique. As a result of these activities, it has become increasingly apparent that a broad national program of life support measures is required to bring the benefits of cardiopulmonary resuscitation and emergency cardiac care to all segments of the public. This can be accomplished only by intensive public and professional programs (JAMA, February 18,1974, pp. 877-878).

Whereas, sudden death and cardiopulmonary emergencies represent a sizeable threat to the American public, and

Whereas, cardiopulmonary resuscitation has been proven effective in saving lives, and

Whereas, training is readily obtainable through local chapters of the American Heart Association, American Red Cross, hospitals, medical and dental schools, as well as other avenues for continuing education, and

Whereas, the dentist has an obligation to his patients to be prepared for the eventuality of medical emergencies, therefore be it

101. **Resolved**, that the American Dental Association recommends that all dentists seek training in cardiopulmonary resuscitation in order that they may completely exercise their professional responsibility when and if the need arises.

Delegate Alex J. McKechnie, Jr., Pennsylvania

REEVALUATION OF DENTAL CLAIM FORM

The following resolution was submitted by Delegate Alex J. McKechnie, Jr., Pennsylvania, and transmitted under date of August 13, 1976 by Mrs. Esther F. Richwine, executive director, Pennsylvania Dental Association.

Whereas, the dental claim form adds to the cost of dental care and is repetitive in content of information such as dentist name, address, phone number, social security number, dental license number and certain patient information, and
Whereas, these items once established with an insurance carrier are no longer necessary to establish identity or payment of a claim, therefore be it

89. **Resolved,** that the dental claim form be reevaluated and redesigned to reduce the amount of repeated and unnecessary material and that the Council on Dental Care Programs be directed to address itself immediately to this cumbersome paperwork before the profession is "locked" into an office procedure which increases cost, consumes valuable time and may restrict the freedom of a dental practice.

Delegate Alex J. McKechnie, Jr., Pennsylvania

USE OF PROCEDURE CODES

The following resolution was submitted by Delegate Alex J. McKechnie, Jr., Pennsylvania, and transmitted under date of August 13, 1976 by Mrs. Esther F. Richwine, executive director, Pennsylvania Dental Association.

Whereas, dental treatment consists of many varied forms of dental care, and
Whereas, a term such as "dental procedure" cannot and will not describe the time and treatment involved in any dental operation, and
Whereas, there is an inherent danger in relegating everything a dentist accomplishes into a computerized number which can and will be used to set fees statewide and nationally, therefore be it

90. **Resolved,** that procedure codes are terms used by third party carriers for administrative purposes and, as such, are not part of the description of dental services and shall not be required on any dental form submitted for payment by a dental office.

Delegate Paul J. McKenna, Massachusetts

AMENDMENT TO SECTION 15 OF "PRINCIPLES OF ETHICS"

The following resolution was transmitted under date of August 9, 1976 by Delegate Paul J. McKenna, Massachusetts.

61. **Resolved,** that Section 15 of the ADA *Principles of Ethics* be amended by inserting the words "and any additional advanced academic degrees earned in health service areas." after the words "or D.M.D."; by deleting the words "a dentist who also possesses a medical degree may use this degree in connection with his name on cards, letterheads, office door signs and announcements"; and by deleting the words "if such usage is consistent with the custom of dentists of the community" to make the amended Section 15 read as follows:

> **Use of Professional Titles and Degrees:** A dentist may use the titles or degrees, Doctor, Dentist, D.D.S. or D.M.D., and any additional advanced academic degrees earned in health service areas. A dentist who has been certified by a national certifying board for one of the specialties approved by the American Dental Association may use the title "diplomate" in connection with his specialty on his cards, letterheads and announcements. A dentist may not use his title or degree in connection with the promotion of any commercial endeavor.
>
> The use of eponyms in connection with drugs, agents, instruments or appliances is generally to be discouraged.

Delegate Robert J. Wilson, Maryland

OVERPRODUCTION OF DENTISTS

The following resolution was transmitted under date of November 14, 1976 by Delegate Robert J. Wilson, Maryland.

Whereas, as there is rapidly increasing evidence to substantiate the proposition that there is a crisis arising in the near future with regard to the overproduction of dentists, and

Whereas, the ADA's Bureau of Economic Research and Statistics, the Leonard Davis Institute of Health Economics and other sources will be producing vital data in this area long before the 1977 House of Delegates, therefore be it

146. **Resolved,** that the Board of Trustees be directed to give extremely high priority to the matter of the production of dentists in this country, and be it further

Resolved, that the Board of Trustees be empowered to use the information obtained in a manner that would serve the best interests of the private practice of dentistry and the patients of the nation, and be it further

Resolved, that the Board of Trustees be requested to give a full report of its activities in this area to the 1977 House of Delegates.

American Society of Maxillofacial Surgeons

AMENDMENT OF "PRINCIPLES OF ETHICS" REGARDING ORAL AND MAXILLOFACIAL SURGERY

The following resolution was submitted by the American Society of Maxillofacial Surgeons and transmitted under date of October 8, 1976 by Dr. Samuel Shatkin, president.

Whereas, Oral Surgery is a specialty of dentistry requiring a dental degree, D.D.S. or D.M.D., and three years of postgraduate training, and
Whereas, the American Society of Oral Surgeons (ASOS) is the professional society name of this dental specialty, and
Whereas, Maxillofacial Surgery is a specialty of medicine requiring a medical degree, M.D., and five years of postgraduate training, and
Whereas, the American Society of Maxillofacial Surgeons (ASMS) was established in 1947 as an Illinois not-for-profit corporation, and
Whereas, the Section of Plastic and Maxillofacial Surgery of the American College of Surgeons was established in 1952, and
Whereas, the Maxillofacial Session and the then Plastic, Reconstructive and Maxillofacial Section of the American Medical Association (AMA) has been in existence since 1963, and
Whereas, in October 1973 there was an amendment to Section 18 of the American Dental Association (ADA) *Principles of Ethics* permitting oral surgeons to identify themselves to the public as "Oral and Maxillofacial Surgeons," and
Whereas, in 1975, Resolution 857 was adopted which added the name "Maxillofacial" to the definition of Oral Surgery, and
Whereas, the above action and use of the name "maxillofacial surgeon" by oral surgeons has been confusing and deceptive to the consumer of medical and dental services, therefore be it

94. **Resolved,** that the House of Delegates of the American Dental Association rescind the amendment to Section 18 of the *Principles of Ethics* which permits oral surgeons to identify themselves to the public as "maxillofacial surgeons," and be it further
Resolved, that Resolution 857 be rescinded so that Oral Surgery is not defined using the name "maxillofacial."

Reports of Board of Trustees

To House of Delegates

ENFORCEMENT OF "PRINCIPLES OF ETHICS" AS RELATED TO "STANDARDS FOR DENTAL PREPAYMENT PROGRAMS"

The 1975 House of Delegates adopted the following resolution (Resolution 81) which was introduced by Delegate Arthur L. Labelle (*Trans.* 1975:729):

> **Resolved,** that the House of Delegates instructs the Board of Trustees to aggressively pursue means whereby the Association's "Principles of Ethics" as related to "Standards for Dental Prepayment Programs" can be enforced, such activity to occupy a position of top priority in Association programs, with detailed report and analysis of results obtained to be presented to the 1976 House of Delegates.

The Board of Trustees calls attention to the fact that it was advised at its December 1975 session that the aggressive pursuit of means to enforce the Association's "Principles of Ethics" as related to "Standards for Dental Prepayment Programs" could have the effect of attempting to restrain the activities of third parties as distinguished from the mere internal regulation of members of the Association (*Trans.* 1975:577). The Board is aware, from legal advice that it has received, that any such attempted restraint could be construed as an illegal boycott, subjecting the Association and those in official positions, including officers, members of the Board of Trustees and councils, and staff, in the Association to civil and criminal penalties and damages under state and federal antitrust statutes. Further, if such enforcement by the Association of the "Principles" as related to the "Standards," whether such be a table of allowances or a usual, customary and reasonable fee arrangement, the Board has been advised that such might be interpreted as a prohibited fee fixing scheme in violation of antitrust laws.

The Board of Trustees notes that the Association's "Standards for Dental Prepayment Programs" by reason of the careful and consistent use throughout the text of the "Standards" of such a precatory word as "should" rather than such a command word as "shall" are purely advisory as to what the Association believes to be essential

to a good dental prepayment program. Such an approach to the "Standards" from a legal and the Board's viewpoints appears reasonable, and the "Standards," in and of themselves, should not place the Association in a position of jeopardy with respect to antitrust statutes. However, if the "Principles" were used to impose sanctions, directly or indirectly, as a means of enforcing the "Standards," the Board warns that law enforcement agencies or injured parties could allege in complaints that the activities of third parties were being restrained and that such restraints were *per se* violations of the antitrust laws, rendering any good intentions the Association may have had in enforcing the "Principles" irrelevant.

In support of these comments on Dr. Labelle's resolution, the Council on Judicial Procedures, Constitution and Bylaws has requested that specific attention be called to the legal opinion of May 9, 1975, which was submitted in the name of the law firm of Peterson, Ross, Rall, Barber & Seidel by attorney Peter M. Sfikas concerning the antitrust dangers involved in attempting to use the "Principles of Ethics" to require third party agencies to conform to the Association's "Standards for Dental Prepayment Programs" (*Trans.* 1975:148). In addition, the Council also has referred to its comment in its 1975 report on the rights guaranteed by the *First Amendment to the United States Constitution* (*Trans.* 1975:145). The Council cited pertinent paragraphs from the 1964 United States Supreme Court opinion in the case of the *Brotherhood of Railroad Trainmen vs Virginia State Bar,* 277 U.S.1, which vacated as unconstitutional a Virginia Supreme Court injunction against plaintiff's advising union members to obtain legal advice from specified lawyers.

In addition, the Board of Trustees was advised that the United States Supreme Court has handed down a number of other decisions of like import, for example, *National Association for the Advancement of Colored People vs Button,* 371 U.S.415 (1963), holding Virginia "running" and "capping" statutes adopted in 1849 violative of First Amendment activities against discrimination; *United Mine Workers vs Illinois State Bar Association,* 389 U.S.217 (1967), setting aside an injunction against a union plan providing salaried attorneys to prosecute members' personal injury and related claims; and *United Transportation Union vs State Bar of Michigan,* 401 U.S.567 (1971), nullifying an injunction against plaintiff's recommending designated attorneys who had agreed to limit their fees.

The Board of Trustees concurs in the opinions of the Council on Judicial Procedures, Constitution and Bylaws and the Association's House Counsel that the "Principles of Ethics" are an inappropriate and illegal vehicle for the enforcement of standards governing dental prepayment programs and recommends that the 1976 House of Delegates be advised that the Board of Trustees cannot legally "aggressively pursue means whereby the Association's 'Principles of Ethics' as related to 'Standards for Dental Prepayment Programs' can be enforced."

GUIDELINES FOR DENTISTRY'S POSITION IN A NATIONAL HEALTH PROGRAM

Introduction

This report presents the policies of the American Dental Association with respect to dentistry in national health programs. The policies were adopted by the House of Delegates at the annual session in Atlantic City, October 1971. In enacting these policies, the House of Delegates studied the ADA Task Force Report on National Health Programs as it was presented to the House and painstakingly considered the Comments on the Report from the Board of Trustees. Of the 93 original Task Force recommendations, a number were modified, seven were referred to appropriate Association agencies for further study, two were incorporated into other actions, one was deleted, and two were rejected. The Task Force Report was published in the September 1971 issue of *The Journal* and Comments on the Report from the Board of Trustees appeared in the October 1971 issue.

Fundamental Principle

In the consideration of a national health program, the dental profession should take an active position in the design and support of a program that includes a dental program that serves the needs of all people of this nation. The dental profession continues to be in opposition to any national health program that uses public funds to provide health care for persons who are financially able to pay for health services themselves. This principle governs all provisions and recommendations of the American Dental Association with respect to national health programs.

Priorities

The following guidelines are recommended in the development of a national health program.

1. Comprehensive dental services for children and emergency dental services for all eligible for the program should have the highest dental priority in any national health program, and any deferred inclusion of children that may be necessary should follow a progressive schedule beginning with the youngest age group feasible. The following is one recommended means for accomplishing such phasing of children by age groups.

PROPOSED REVISIONS*

Fundamental Principles

It is the dental profession's firm belief that the dental component of any national health program should be founded upon the traditional private system of delivering dental care.

The dental profession is engaged in efforts to ensure that available dental care services are sufficient to the needs of all the people of this nation.

The dental profession would support a national health program which meets these needs, assuring to all equal access to dental care. However, the profession believes that the use of public funds for direct health benefits in a national health program should be limited to the provision of care only for those financially unable to pay for health services themselves.

(Change title from "Priorities" to "Beneficiaries and Benefits.")

1. Comprehensive dental services for children through 17 and emergency dental services for all eligible for the program should have the highest priority in any national health program. Any deferred inclusion of children that may be necessary should follow a progressive schedule beginning with children six years and under.

*See page 483 for comments of the Board of Trustees.

a. Two-, three-, and four-year-old children should be included in the first year of the program.

b. Each new class of two-year-old children should be included each program year thereafter if experience shows this arrangement to be practical.

c. All children who have had an initial year in the program should be kept on a reasonable maintenance basis in subsequent years.

d. In the second through the fourth year, an additional age class of eligible children should be added from the top age groups to expedite the coverage of the child population.

e. No further additions of new children should be made from the top until the ninth year, at which time the 16-year-old youths will be added to the program.

f. All children ages 2 to 17 should be included in the program by the tenth year.

2. There should be provision for emergency dental care for all.

3. The dental program should begin at the same time any national health program is initiated.

4. Dental Health services should be defined according to the following outline.

Emergency Dental Care Services

These services should be available to those eligible for the program from the first day of the program.

—Control of oral and maxillofacial bleeding in any condition when loss of blood will jeopardize the patient's well-being. Treatment may consist of any professionally accepted procedure deemed necessary.

—Relief of respiratory difficulty from any oral and maxillofacial condition which can involve the airway (respiratory system) in a life-threatening manner. Treatment may consist of any professionally accepted procedure deemed necessary.

—Relief of severe pain accompanying any oral or maxillofacial condition affecting the nervous system, limited to immediate palliative treatment only but including extractions where professionally indicated.

- -Immediate and palliative procedures for (1) fractures, subluxations, and avulsions of teeth, (2) fractures of jaw and other facial bones (reduction and fixation only), (3) temporomandibular joint subluxations, and (4) soft tissue injuries.

—Initial treatment for acute infections.

—Emergency dental care services include (1) all necessary laboratory and preoperative work, including examination and radiographs and (2) appropriate anesthesia (local, general, sedative) for optimal management of the emergency.

Preventive Dental Services

Preventive procedures, including dental health education.

(Note: In view of the revision of number 1, directed by the 1975 House of Delegates, number 2 should be deleted as unnecessary.)

2. A professionally sound dental benefits component should begin at the same time any national health program is initiated.

3. There follows a priority listing of other services which we consider appropriate for incorporation as defined:

(Note: Emergency, Preventive and Comprehensive services are listed as in existing guidelines.)

Comprehensive Dental Health Services

—Periodic examination and diagnosis, including radiographs when indicated and detection of oral manifestations of systemic diseases;

—Elimination of infection and life-hazardous oral conditions, for example, oral cancer, cellulitis, fractures of the face and jaws, major handicapping malocclusion and congenital disfiguring oral deformities;

—Treatment of injuries;

—Elimination of disease of bone and soft tissue of the oral cavity and adjacent areas;

—Treatment of anomalies;

—Restoration of decayed or fractured teeth;

—Maintenance or recovery of space between teeth when this service will affect occlusion;

—Replacement of missing permanent teeth;

—Treatment of malocclusion with priority for interceptive treatment and disfiguring and handicapping malocclusions.

5. On the tenth anniversary of the dental program, those people then covered by the program should be offered continued coverage, and in addition, all persons age 65 years and over should be offered comprehensive coverage. Before the addition of other groups, the program should be reviewed totally and modified according to experience and resources available.

Preventive Procedures and Dental Health Education

The following guidelines are recommended in the development of a national health program.

1. The American Dental Association should take immediate action to design a comprehensive educational program to be used in conjunction with federally funded health programs for the purpose of motivating people to practice good personal oral hygiene habits and to utilize all dental care benefits available to the fullest extent.

2. The dental profession should press the federal government to institute a national fluoridation program that would provide grants for the purchase and installation of fluoridation equipment for community and rural school water supplies, plus financial assistance to help meet the costs of installing or modernizing and operating the programs for a specified time.

3. State dental societies should press state legislatures to enact statewide fluoridation laws requiring the fluoridation of all community water supplies.

4. Prevention of dental disease through community measures and preventive practices in dentists' offices should be given prime emphasis and first dollar priority.

5. Dental schools and practitioners should give greater emphasis to the teaching and application of preventive procedures in clinical practice.

6. The Association should conduct studies on the long-term implications of preventive and therapeutic measures on the delivery of dental services and on dental manpower.

Education and Training

In all programs that provide federal funding for dental education this long-standing policy of the Association shall apply: "The government shall not exercise any control over, or prescribe any requirements with respect to, the curriculum, teaching personnel, or administration of any school or the admission of applicants thereto." (*Trans.* 1949:244) The following guidelines are recommended in the development of a national health program.

4. After three years in operation or before considering expansion of any national health program's dental benefits, a comprehensive study of the program's cost-effectiveness and efficacy in providing dental health service should be accomplished.

1. A preventively-oriented dental health educational program should be implemented in conjunction with a national dental health program for the purpose of informing and motivating people on personal oral hygiene care as well as on the most effective use of the program. Emphasis should be placed on reaching school children and their parents.

2. The federal government should institute a national fluoridation program to maximize the cost/effectiveness of dental health benefits for children. Grants should be provided for the purchase and installation of fluoridation equipment for communities and for rural school water supplies. Incentives should be provided to states to take legislative or regulatory action to mandate fluoridation.

3. State dental societies should encourage and assist state legislatures to enact statewide fluoridation laws requiring the fluoridation of all community water supplies.

4. States and communities should be urged to provide dental health education and preventive programs for children in the school setting to maximize the benefits included under a national dental health program. Consideration should be given to providing various types of topical fluoride applications, preventive education, and screening and referral.

Recommend deletion of 5 as inappropriate for these guidelines.

Recommend deletion of 6 as inappropriate for these guidelines.

1. The present program of federal expenditures in partial support of the construction of new dental schools and the expansion of existing schools should be continued and increased.

2. There should be a much larger program of federal financial participation in the construction of new dental auxiliary schools.

3. The federal construction programs should provide earmarked funds for dental education facilities and they should be funded fully for as long as the shortage of personnel exists.

4. There should be operating assistance grants to existing and new dental auxiliary schools from the federal government to ensure that all schools are producing qualified dental personnel at full capacity.

5. Dental schools, in conjunction with constituent and component dental societies should explore and establish at an early date community dental health projects, preferably located outside the dental school proper, to maintain close ties with the community of which the school is a part, to give students valuable learning experiences in community health, and to fulfill partially the school's responsibility to the community. Full use should be made of existing facilities, including community health centers, community colleges, and area health education centers.

6. There should be federal funds to encourage the development of training programs to prepare teachers for dental and auxiliary schools.

7. Dental and dental auxiliary curriculums should be made flexible so that the more talented and motivated students can move through educational programs at the fastest possible rate, thus becoming productive health service workers in a shorter time.

8. Community colleges and post high school technical schools should be encouraged to develop training programs for dental auxiliaries, provided such programs meet accepted educational standards and are accredited by the American Dental Association.

9. There should be a program of federal support for the accelerated development of training programs for expanded function auxiliaries, including construction, operational, and faculty training support.

10. The criteria for accreditation of auxiliary training schools should be revised to permit broader experimentation with curriculums, program content, and length of training. Students should have the opportunity to advance from one type of auxiliary program to another.

11. There should be a greater emphasis in dental schools on teaching students the use of auxiliaries, especially expanded function auxiliaries. Federal support for research, experimentation, and development of these activities should be increased and financial incentives should be provided to those schools that expand "TEAM" programs rapidly and that experiment with new teaching methods in such programs. ("TEAM" is an acronym for Training in Expanded Auxiliary Management.)

12. There should be formal programs of training in the performance of expanded functions for those auxiliaries currently in the work force consistent with the dental practice acts.

13. The federal program of loans and fellowships for dental students should be expanded and funded at a level determined by a survey of need.

14. Funds should be earmarked for fellowships in dental and dental auxiliary education.

15. The student assistance program of the federal government should provide special arrangements for assisting students from minority and other disadvantaged groups to enter careers in dental fields. In so doing, the government should not exercise any control over, or prescribe any requirements with respect to the curriculum, teaching personnel, or administration of any school or the admission of applicants thereto. The program should be designed to encourage young people to enter the dental and auxiliary professions. Every student who meets basic entrance qualifications of educational programs in dental fields should have the right of equal consideration to such education.

16. A national program of recruitment should be developed to attract capable young men and women into the dental and dental auxiliary fields.

17. Entry into training programs for dental auxiliaries should be simplified and coordinated to provide promotional career opportunities.

18. As an additional measure to maintain the quality of dental practice, the Association reaffirms its policy that "constituent dental societies in consultation with state boards of dentistry, are urged

3. The federal construction programs should provide earmarked funds for dental educational facilities and the program should be fully funded on the basis of demonstrated need.

5. Recommend deletion as inappropriate in this context.

6. Dental and dental auxiliary curriculum should be made flexible so that the more talented and motivated students can move through the educational programs at a rate consistent with their learning abilities. Curriculum flexibility should also be encouraged to allow for the integration of current educational methodologies and procedures. (existing no. 7)

8. There should be a program of federal support for the accelerated development of training programs for auxiliaries, including construction, operational, and faculty training support. (existing no. 9)

10. There should be a significantly greater emphasis within dental education programs on teaching students the use of auxiliaries. (existing no. 11)

to develop mechanisms to foster the continued education of dentists licensed in their jurisdiction." (*Trans.* 1968:257)

Delivery of Services

The following guidelines are recommended in the development of a national health program.

1. All dental societies should establish emergency dental services that ensure ready accessibility of professional services at all times.

2. Federal legislation should provide reasonable financial arrangements including loan forgiveness features with dental students to pay the total cost of their dental education in return for practicing in underserved areas in the military or health agencies, for a specific period of time.

3. Dentists should be encouraged to practice in underserved areas through federal financial incentives including guaranteed loans and tax benefits.

4. A national health service corps or other federal or federal-state health personnel system should be established to provide dental services in areas where the dental work force is insufficient to meet demands generated by a national dental health program. Such arrangements should be temporary until a more satisfactory system for such areas can be established, and should be contingent on the approval of component and constituent societies.

5. Community health centers having dental components, such as neighborhood health centers, should be encouraged only if the availability of dental care from the private sector is determined to be inadequate in consultation with constituent and component dental societies.

6. Extended health care facilities and hospitals should consider providing dental services as an integral part of comprehensive care. Outpatient dental treatment also should be provided only if the availability of dental care from the private sector is determined to be inadequate in consultation with constituent and component dental societies.

7. A national health program should provide for research, experimentation, and development of programs to deliver dental care more effectively and efficiently to population groups with special handicapping or confinement problems.

8. The dental profession, in conjunction with the military dental and medical services, should design and implement programs for the recruitment, training, and utilization of returning medical and dental corpsmen for employment in the dental profession.

9. There should be a moratorium on licensure, registration, or certification of additional kinds of dental auxiliaries until more definitive information is available about the relative role of the dentist and his expanded function auxiliaries.

10. The Association should establish a national clearinghouse of information for dentists seeking locations and for communities seeking dentists.

11. A national dental health program should provide incentives to solo practitioners to increase their productivity through the use of multiple dental auxiliaries. Such incentives should include guaranteed loans for capital improvements and equipment and office overhead protection insurance.

12. A national dental health program should encourage the development of group practices not considered closed panels through guaranteed loans for capital investment and grants to dental schools to teach students the principles of organizing, developing, and administering group practices meeting criteria established by the American Dental Association.

13. The Association should conduct studies to evaluate various practice patterns of dentists and various methods of payment for services provided.

14. A dental component of a national health program should allow prepaid group practice but program beneficiaries should be given a choice between the prepaid group practice and care by other practitioners, with options for periodic change, and assurance of high quality of care delivered.

4. A national health service corps or other federal or federal-state health personnel programs should provide dental personnel only in areas where the existing dental work force is insufficient to meet demands generated by a national dental health program. Such arrangements should be contingent on the approval of constituent dental societies. (Separate item on dental school loan forgiveness might be subsumed in this more general provision.)

5. Community health centers, such as neighborhood health centers or out-patient facilities providing comprehensive health services, should include dental services only if the availability of dental care from the private sector is determined to be inadequate in consultation with constituent and component societies.

6. Extended health care facilities and hospitals should consider providing dental services as an integral part of comprehensive care. Outpatient dental treatment also should be provided.

7. Recommend deletion.

8. Recommend deletion.

10. Recommend deletion as inappropriate in this setting.

9. A national dental health program should provide incentives to practitioners to increase their productivity through the use of multiple dental auxiliaries. Such incentives should include guaranteed loans for capital improvements and equipment and office overhead protection insurance. (existing no. 11)

12. Recommend deletion.

11. Whenever a prepaid group practice is included in a program, program beneficiaries should be given a choice between the prepaid group practice and care by other practitioners, with options for periodic change and assurance of high quality of care delivered. (existing no. 14).

15. A national health program that establishes health maintenance organizations for the delivery of comprehensive health services should require that dental care be included as an essential service. The American Dental Association, however, is opposed to HMO legislation or regulations (1) that deny freedom for beneficiaries to choose between HMOs and the traditional private practice fee-for-service systems, (2) that award HMOs unfair subsidies, and (3) that permit HMOs to advertise in conflict with the unprofessional conduct provisions of state licensure laws.

16. Dental societies or service corporations, or both, should be eligible along with other groups to qualify as dental components in health maintenance organizations.

17. Studies should be conducted to determine the need, utilization, and distribution requirements of dental specialties in a national dental care program.

18. The clinical dental specialty organizations should establish an interspecialty committee to study the role and functions of specialists in a national dental health program and to present an appropriate report to the various specialties and the Association.

19. The Association should conduct studies to determine why dentists choose practice locations; what the attrition rates are for auxiliary personnel; why auxiliary personnel leave the field for other occupations; and what the professional and international implications of more liberal admission to practice by graduates of foreign dental schools would be.

Payment Mechanisms

The following guidelines are recommended in the development of a national health program.

1. Various methods of reimbursement of dentists should be allowed in the dental component of a national health program so that the most efficient arrangements can eventually be determined by experience and by consumer choice. The mandating of capitation as the only system in a national health program should be opposed. Private methods of reimbursement through the use of dental service corporations, insurance companies, and other private means should be encouraged.

2. The usual, customary, and reasonable fee concept should be given priority in the dental component of a national dental program. The fixed fee concept, set on a state or regional basis, and the table of allowances concept should be recognized as appropriate for use. When used, all three concepts should realistically relate to the cost of delivery of dental services.

3. Determination of fee arrangements, including the verification of fees, should be made at the component level in consultation with the constituent dental society.

4. Patient participation in the costs of care in a dental component of a national health program preferably should be through copayment rather than through deductibles.

5. Deductibles or coinsurance should not be applied to basic services, such as periodic examinations, diagnosis, prophylaxes, fluoride topical applications, plaque control programs, and emergency treatment.

6. Programs should be encouraged that provide incentives to continuing maintenance by reducing the patient's coinsurance at stated time intervals, provided he avails himself of the necessary dental services on a regular basis.

7. The Association should conduct studies on how fees are determined, overhead costs, and on all forms of payment methods now known for the purpose of evaluating such methods in the light of a national dental health program.

12. A national health program that establishes health maintenance organizations for the delivery of comprehensive health services should require that dental care be included as an essential service. The American Dental Association, however, is opposed to HMO legislation or regulations (1) that deny freedom for beneficiaries to choose between HMOs and the traditional private practice fee-for-service system, (2) that award HMOs subsidies, and (3) that permit HMOs to advertise in conflict with the unprofessional conduct provisions of state licensure laws. (existing no. 15)

(It should be noted that the recommended revision differs from existing policy only in the deletion of the adjective "unfair," which would serve to place the Association in opposition to HMO legislation or regulations that award any subsidies to HMOs.)

Guidelines 16, 17, 18 and 19 should be renumbered as 13, 14, 15 and 16.

1. Private methods of reimbursement through the use of dental service corporations, insurance companies, and other private means should be strongly encouraged.

2. Various methods of reimbursement of dentists should be allowed in the dental component of a national health program so that the most efficient arrangements can eventually be determined by experience and by consumer choice. In the absence of such basis for determining efficiency, the usual, customary, and reasonable fee concept should be given priority. The table of allowance concept should be recognized as appropriate for use. The mandating of capitation as the only system in a national health program should be opposed. Any concept used should realistically relate to the cost of delivery of dental services and should be clearly explained to all eligible for the program.

3. Patient participation in the costs of care in a dental component of a national health program preferably should be through copayment rather than through deductibles.

4. Deductibles or coinsurance should not be applied to basic services, such as periodic examinations, diagnoses, prophylaxes, fluoride topical applications, plaque control programs, and emergency treatment.

5. Programs should be encouraged that provide incentives to continuing maintenance by reducing the patient's coinsurance at stated time intervals, providing he avails himself of the necessary dental services on a regular basis.

Funding

The following guidelines are recommended in the development of a national health program.

1. A national health program should mandate the inclusion of specified dental benefits, for which payment is assured in the budget.

2. Dental benefits for the poor should be financed through federal general revenue.

3. Dental benefits for the employed could be funded through payroll deductions with employer and employee contributions, possibly with additional employee participation in cost through co-payment or deductibles, or both, used to purchase dental benefits through a variety of prepayment plans. A similar plan could be developed for self-employed persons.

4. Whatever funding mechanism is used, dental benefits should be included in the costs of essential health services.

Dental and Dental Hygiene Licensure

The following guidelines are recommended in the development of a national health program.

1. Regional examinations for dentists and dental hygienists should be encouraged and tested in all areas of the United States and its territories.

2. It is the right and responsibility of each individual state to protect the health and welfare of its citizens. Therefore the American Dental Association recognizes the rights of the individual states to determine the professional qualifications of those who practice in the dental health professions. (This guideline was added by the House of Delegates.)

Program Design and Administration

The following guidelines are recommended in the development of a national health program.

1. The national dental health program should provide for current information on dental fees and make such information available to interested agencies.

2. The American Dental Association should take definitive steps to remove every trace of racial discrimination from the profession.

3. The national dental health program should provide funds for research, demonstration, and training in the organization and administration of public and private dental care programs.

4. The Association should establish a national liaison committee of representatives of dental education, the dental trade and laboratory industries, and the profession to study major issues of common interest and to advise the Association on programs and policies indicated.

5. The design and administration of a dental component of a national health program should take into consideration the differences between the delivery of dental care and other health services.

6. The dental component of a national health program should make specific provision for conducting research on administrative, economic, and costs analysis aspects of dental services in prepayment programs.

7. A mechanism for prepayment, preferably a dental service corporation, should be established by the constituent dental society in every state.

8. Dental prepayment programs should be encouraged for dental benefits and categories of beneficiaries not covered under the dental component of a national health program.

9. The preferred carriers for the dental component of the national health program should be nongovernmental agencies.

1. Public funds supporting dental health benefits for the needy should be provided through general revenue and should be clearly earmarked for such purpose.

2. Private funds expended in the private sector should provide the principal financial base for any national health program.

3. In structuring such funding, several methods may be considered, such as tax credits scaled to income, or employer-employee contributions.

4. (Note: it is recommended that existing guideline 4 be deleted.)

1. The dental component of any national health program should be developed in consultation with organized dentistry, primarily the American Dental Association.

2. The preferred carriers for the dental component of a national health program should be nongovernmental agencies.

3. The design and administration of the dental component of a national health program should take into consideration the differences between the delivery of dental care and other health services.

4. The dental component of a national health program should make specific provision for conducting research on administrative, economic, and cost analysis aspects of dental services in prepayment programs.

5. If a national health program mandates specific health benefits, dental benefits should be clearly delineated and mandated in a manner identical with all other health benefits.

Review Procedures

The following guidelines are recommended in the development of a national health program.

1. Licensed dentists should be involved at all levels of review of the dental aspects in a dental component of a national health program, and review of the quality of professional services should be under the control of licensed dentists.

2. Dental societies should establish effective committees that have consumer representation to ensure accountability to the public. The committees should be well publicized and should provide for discourse between consumers and dentists.

3. Review in a dental component of a national health program should include review of program design and administration, quality of services rendered, fee questions, and utilization of services.

4. Continuing review of the design and administration of the dental component of a national health program should include such matters as effectiveness in meeting the dental needs of the population, patient utilization, economy in administration, effect of benefit patterns on dental health and dental practice, provision of uniform forms and procedures, efficiency of administrative requirements, accessibility of dental care, utilization of fluoridation, and effectiveness of review procedures.

5. Review of quality of dental care in a national program should include review of the quality of services performed, review of the reasonableness of procedures and whether the services were performed in accordance with professional standards.

6. Review of treatment should be performed according to professionally established guidelines through review techniques, such as screening of claims, statistical audits, random sampling of records, review of radiographs, random examination of patients, and evaluation of complaints.

7. Dental society review committees should be used in the dental component of a national health program for review of professional matters, such as review of services rendered and fee questions.

8. Channels of referral to dental review committees under a national program should be open to the program administrators, dentists, insuring agencies, and patients.

9. Appeal procedures for all participants should be provided in the review structure of a national program.

10. A dental review structure, in order to be creditable, must include appropriate sanction against abuse.

11. Effective review procedures should be developed to resolve fee questions, to determine if fees are in accordance with provisions of the program, and to assess whether fees are in fact usual, customary, and reasonable when this payment method is used.

12. Effective procedures should be instituted to protect members of review committees. (This guideline was added by the House of Delegates.)

GUIDELINES FOR REPRESENTATION OF CONSUMERS IN NATIONAL DENTAL HEALTH PROGRAMS

The following guidelines were approved by the House of Delegates in 1972-1973:

Representation of Consumers in National Dental Programs: The Association endorses the concept of consumer representation in any national dental health program. The Association accepts the following definition of consumer: A consumer is a person who might use dental health services, but does not depend upon these services for a livelihood.

The following guidelines for consumer representation set forth some general principles which will be subject to modification depending upon the nature of the national dental health program:

1. Consumer representatives should be involved in an advisory capacity in the development of regulations and procedures during the initial design of the program.

1. Review of the dental component of a national health program must involve the participation of licensed dentists.

2. Initially, program design and administration should be reviewed. Continuing review should encompass such matters as utilization of services, effectiveness in meeting the dental needs of the population, economy in administration, effect of benefit patterns on dental health and dental practice, provision of uniform forms and procedures, efficiency of administrative requirements, accessibility of dental care, utilization of fluoridation, and effectiveness of quality review procedures.

3. Review of dental care in a national health program should include assessment of the quality of services performed, the appropriateness of procedures, and whether the services were performed in accordance with professional standards.

4. Dental society review committees should be utilized in the dental component of a national health program for evaluation of professional matters. In the event Professional Standards Review Organizations are designated the review mechanism in a national health program, dentists should be afforded full and equitable participation at all levels of these organizations as they relate to the assessment of dental care.

5. Effective review procedures should include methods to resolve fee questions.

6. Effective procedures should be instituted, wherever necessary, to protect members of review committees.

7. A clear distinction should be maintained between quality assurance and cost control in any national health program.

2. Consumer representatives should be selected on the basis of geographic region with particular attention given to appropriate broad representation of all segments of the population.

3. Consumer representatives should be involved at the national level and all state and local levels of operation of the program.

4. Consumer representatives should be retained subject to attendance at meetings and carrying out of assigned functions.

5. Consumer representatives should be involved in an advisory capacity on such issues in any proposed national dental health program as the following: review of the program, education of the public to prevention of dental disease and appropriate utilization of the program, grievance procedures established for the program, and administration and evaluation of the program.

SUPPLEMENT TO GUIDELINES FOR DENTISTRY'S POSITION IN A NATIONAL HEALTH PROGRAM

The following additions to the guidelines were approved by the House of Delegates in 1972 for the section, *Guidelines for Education and Training in a National Health Program:*

1. The development of all types of dental and dental auxiliary education programs should be based on the determination of shortage and need in relationship to geographic considerations. Further, the establishment of dental and dental auxiliary education programs shall be restricted to institutions whose programs are eligible for accreditation by the Council on Dental Education.*

2. The profession, through its various agencies, should accelerate the training and use of expanded function auxiliary personnel in accordance with state dental practice acts.

3. Programs in continuing education should be developed to prepare practicing dentists to use expanded function auxiliaries in accordance with state dental practice acts.

*As amended by the 1973 House of Delegates.

GUIDELINES FOR DENTISTRY'S POSITION IN A NATIONAL HEALTH PROGRAM
(Incorporating all proposed revisions)

Fundamental Principles

It is the dental profession's firm belief that the dental component of any national health program should be founded upon the traditional private system of delivering dental care.

The dental profession is engaged in efforts to ensure that available dental care services are sufficient to the needs of all the people of the nation.

The dental profession would support a national health program which meets these needs, assuring to all equal access to dental care. However, the profession believes that the use of public funds for direct health benefits in a national health program should be limited to the provision of care only for those financially unable to pay for health services themselves.

Beneficiaries and Benefits

The following guidelines are recommended in the development of a national health program.

1. Comprehensive dental services for children through 17 and emergency dental services for all eligible for the program should have the highest priority in any national health program. Any deferred inclusion of children that may be necessary should follow a progressive schedule beginning with children six years and under.

2. A professionally sound dental benefits component should begin at the same time any national health program is initiated.

3. There follows a priority listing of other services which we consider appropriate for incorporation as defined.

Emergency Dental Care Services

These services should be available to those eligible for the program from the first day of the program.

—Control of oral and maxillofacial bleeding in any condition when loss of blood will jeopardize the patient's well-being. Treatment may consist of any professionally accepted procedure deemed necessary.

—Relief of respiratory difficulty from any oral and maxillofacial condition which can involve the airway (respiratory system) in a life-threatening manner. Treatment may consist of any professionally accepted procedure deemed necessary.

—Relief of severe pain accompanying any oral or maxillofacial condition affecting the nervous system, limited to immediate palliative treatment only but including extractions where professionally indicated.

—Immediate and palliative procedures for (1) fractures, subluxations, and avulsions of teeth, (2) fractures of jaw and other facial bones (reduction and fixation only), (3) temporomandibular joint subluxations, and (4) soft tissue injuries.

—Initial treatment for acute infections.

—Emergency dental care services include (1) all necessary laboratory and preoperative work, including examination and radiographs and (2) appropriate anesthesia (local, general, sedative) for optimal management of the emergency.

Preventive Dental Services

Preventive procedures, including dental health education.

Comprehensive Dental Health Services:

—Periodic examination and diagnosis, including radiographs when indicated and detection of oral manifestations of systemic diseases;

—Elimination of infection of life-hazardous oral conditions, for example, oral cancer, cellulitis, fractures of the face and jaws, major handicapping malocclusion and congenital disfiguring oral deformities;

—Treatment of injuries;

—Elimination of disease of bone and soft tissue of the oral cavity and adjacent areas;

—Treatment of anomalies;

—Restoration of decayed or fractured teeth;

—Maintenance or recovery of space between teeth when this service will affect occlusion;

—Replacement of missing permanent teeth;

—Treatment of malocclusion with priority for interceptive treatment and disfiguring and handicapping malocclusions.

4. After three years in operation or before considering expansion of any national health program's dental benefits, a comprehensive study of the program's cost-effectiveness and efficacy in providing dental health services should be accomplished.

Preventive Procedures and Dental Health Education

The following guidelines are recommended in the development of a national health program:

1. A preventively oriented dental health educational program should be implemented in conjunction with a national dental health program for the purpose of informing and motivating people on personal oral hygiene care as well as on the most effective use of the program. Emphasis should be placed on reaching school children and their parents.

2. The federal government should institute a national fluoridation program to maximize the cost/effectiveness of dental health benefits for children. Grants should be provided for the purchase and installation of fluoridation equipment for communities and for rural school water supplies. Incentives should be provided to states to take legislative or regulatory action to mandate fluoridation.

3. State dental societies should encourage and assist state legislatures to enact statewide fluoridation laws requiring the fluoridation of all community water supplies.

4. States and communities should be urged to provide dental health education and preventive programs for children in the school setting to maximize the benefits included under a national dental health program. Consideration should be given to providing various types of topical fluoride applications, preventive education, and screening and referral.

Education and Training

In all programs that provide federal funding for dental education this long-standing policy of the Association shall apply: "The government shall not exercise any control over, or prescribe any requirements with respect to, the curriculum, personnel, or administration of any school or the admission of applicants thereto." (*Trans.* 1949:244) The following guidelines are recommended in the development of a national health program.

1. The present program of federal expenditures in partial support of the schools should be continued and increased.

2. There should be a much larger program of federal financial participation in the construction of new dental auxiliary schools.

3. The federal construction programs should provide earmarked funds for dental educational facilities and the program should be fully funded on the basis of demonstrated need.

4. There should be operating assistance grants to existing and new dental auxiliary schools from the federal government to ensure that all schools are producing qualified dental personnel at full capacity.

5. There should be federal funds to encourage the development of training programs to prepare teachers for dental and auxiliary schools.

6. Dental and dental auxiliary curriculums should be made flexible so that the more talented and motivated students can move through the educational programs at a rate consistent with their learning abilities. Curriculum flexibility should also be encouraged to allow for the integration of current educational methodologies and procedures.

7. Community colleges and post high school technical schools should be encouraged to develop training programs for dental auxiliaries, provided such programs meet accepted educational standards and are accredited by the American Dental Association.

8. There should be a program of federal support for the accelerated development of training programs for auxiliaries, including construction, operational, and faculty training support.

9. The criteria for accreditation of auxiliary training schools should be revised to permit broader experimentation with curriculums, program content, and length of training. Students should have the opportunity to advance from one type of auxiliary program to another.

10. There should be a significantly greater emphasis within dental education programs on teaching students the use of auxiliaries.

11. There should be formal programs of training in the performance of expanded functions for those auxiliaries currently in the work force consistent with the dental practice acts.

12. The federal program of loans and fellowships for dental students should be expanded and funded at a level determined by a survey of need.

13. Funds should be earmarked for fellowships in dental and dental auxiliary education.

14. The student assistance program of the federal government should provide special arrangements for assisting students from minority and other disadvantaged groups to enter careers in dental fields. In so doing, the government should not exercise any control over, or prescribe any requirements with respect to the curriculum, teaching personnel, or administration of any school or the admission of applicants thereto. The program should be designed to encourage young people to enter the dental and auxiliary professions. Every student who meets basic entrance qualifications of educational programs in dental fields should have the right of equal consideration to such education.

15. A national program of recruitment should be developed to attract capable young men and women into the dental and dental auxiliary fields.

16. Entry into training programs for dental auxiliaries should be simplified and coordinated to provide promotional career opportunities.

17. As an additional measure to maintain the quality of dental practice, the Association reaffirms its policy that "constituent dental societies in consultation with state boards of dentistry, are urged to develop mechanisms to foster the continued education of dentists licensed in their jurisdiction." (*Trans.* 1968:257)

Delivery of Services

The following guidelines are recommended in the development of a national health program.

1. All dental societies should establish emergency dental services that ensure ready accessibility of professional services at all times.

2. Federal legislation should provide reasonable financial arrangements including loan forgiveness features with dental students to pay the total cost of their dental education in return for practicing in underserved areas in the military or health agencies, for a specific period of time.

3. Dentists should be encouraged to practice in underserved areas through federal financial incentives including guaranteed loans and tax benefits.

4. A national health service corps or other federal or federal-state health personnel program should provide dental personnel only in areas where the existing dental work force is insufficient to meet demands generated by a national dental health program. Such arrangements should be contingent on the approval of component and/or constituent dental societies.

5. Community health centers, such as neighborhood health centers or outpatient facilities providing comprehensive health services, should include dental services only if the availability of dental care from the private sector is determined to be inadequate in consultation with constituent and component societies.

6. Extended health care facilities and hospitals should consider providing dental services as an integral part of comprehensive care. Outpatient dental treatment also should be provided.

7. A national health program should provide for research, experimentation, and development of programs to deliver dental care more effectively and efficiently to population groups with special handicapping or confinement problems.

8. There should be a moratorium on licensure, registration, or certification of additional kinds of dental auxiliaries until more definitive information is available about the relative role of the dentist and his expanded function auxiliaries.

9. A national dental health program should provide incentives to practitioners to increase their productivity through the use of multiple dental auxiliaries. Such incentives should include guaranteed loans for capital improvements and equipment and office overhead protection insurance.

10. The Association should conduct studies to evaluate various practice patterns of dentists and various methods of payment for services provided.

11. Whenever a prepaid group practice is included in a program, program beneficiaries should be given a choice between the prepaid group practice and care by other practitioners, with options for periodic change and assurance of high quality of care delivered.

12. A national health program that establishes health maintenance organizations for the delivery of comprehensive health services should require that dental care be included as an essential service. The American Dental Association, however, is opposed to HMO legislation or regulations (1) that deny freedom for beneficiaries to choose between HMOs and the traditional private practice fee-for-service system, (2) that award HMOs subsidies, and (3) that permit HMOs to advertise in conflict with the unprofessional conduct provisions of state licensure laws.

13. Dental societies or service corporations or both should be eligible along with other groups to qualify as dental components in health maintenance organizations.

14. Studies should be conducted to determine the need, utilization, and distribution requirements of dental specialties in a national dental care program.

15. The clinical dental specialty organizations should establish an interspecialty committee to study the role and functions of specialists in a national dental health program and to present an appropriate report to the various specialties and the Association.

16. The Association should conduct studies to determine why dentists choose practice locations; what the attrition rates are for auxiliary personnel; why auxiliary personnel leave the field for other occupations; and what the professional and international implications of more liberal admission to practice by graduates of foreign dental schools would be.

Payment Mechanisms

The following guidelines are recommended in the development of a national health program.

1. Private methods of reimbursement through the use of dental service corporations, insurance companies, and other private means should be strongly encouraged.

2. Various methods of reimbursement of dentists should be allowed in the dental component of a national health program so that the most efficient arrangements can eventually be determined by experience and by consumer choice. In the absence of such basis for determining efficiency, the usual, customary, and reasonable fee concept should be given priority. The table of allowance concept should be recognized as appropriate for use. The mandating of capitation as the only system should be opposed. Any concept used should realistically relate to the cost of delivery of dental services and should be clearly explained to all eligible for the program.

3. Patient participation in the costs of a care in a dental component of a national health program preferably should be through copayment rather than through deductibles.

4. Deductibles or coinsurance should not be applied to basic services, such as periodic examinations, diagnoses, prophylaxes, fluoride topical applications, plaque control programs, and emergency treatment.

5. Programs should be encouraged that provide incentives to continuing maintenance by reducing the patient's coinsurance at stated time intervals, providing he avails himself of the necessary dental services on a regular basis.

Funding

The following guidelines are recommended in the development of a national health program.

1. Public funds supporting dental health benefits for the needy should be provided through general revenue and should be clearly earmarked for such purpose.

2. Private funds expended in the private sector should provide the principal financial base for any national health program.

3. In structuring such funding, several methods may be considered, such as tax credits scaled to income, or employer-employee contributions.

Dental and Dental Hygiene Licensure

The following guidelines are recommended in the development of a national health program.

1. Regional examinations for dentists and dental hygienists should be encouraged and tested in all areas of the United States and its territories.

2. It is the right and responsibility of each individual state to protect the health and welfare of its citizens. Therefore, the American Dental Association recognizes the rights of the individual states to determine the professional qualifications of those who practice in the dental health professions.

Program Design and Administration

The following guidelines are recommended in the development of a national health program.

1. The dental component of any national health program should be developed in consultation with organized dentistry, primarily the American Dental Association.

2. The preferred carriers for the dental component of a national health program should be nongovernmental agencies.

3. The design and administration of the dental component of a national health program should take into consideration the differences between the delivery of dental care and other health services.

4. The dental component of a national health program should make specific provision for conducting research on administrative, economic, and cost analysis aspects of dental services in prepayment programs.

5. If a national health program mandates specific health benefits, dental benefits should be clearly delineated and mandated in a manner identical with all other health benefits.

Review Procedures

The following guidelines are recommended in the development of a national health program.

1. Review of the dental component of a national health program must involve the participation of licensed dentists.

2. Initially, program design and administration should be reviewed. Continuing review should encompass such matters as utilization of services, effectiveness in meeting the dental needs of the population, economy in administration, effect of benefit patterns on dental health and dental practice, provision of uniform forms and procedures, efficiency of administrative requirements, accessibility of dental care, utilization of fluoridation, and effectiveness of quality review procedures.

3. Review of dental care in a national health program should include assessment of the quality of services performed, the appropriateness of procedures, and whether the services were performed in accordance with professional standards.

4. Dental society review committees should be utilized in the dental component of a national health program for evaluation of professional matters. In the event Professional Standards Review Organizations are designated the review mechanism in a national health program, dentists should be afforded full and equitable participation at all levels of these organizations as they relate to the assessment of dental care.

5. Effective review procedures should include methods to resolve fee questions.

6. Effective procedures should be instituted, wherever necessary, to protect members of review committees.

7. A clear distinction should be maintained between quality assurance and cost control in any national health program.

Representation of Consumers in National Health Programs

The Association endorses the concept of consumer representation in any national dental health program. The Association accepts the following definition of consumer: A consumer is a person who might use dental health services, but does not depend upon these services for a livelihood.

The following guidelines for consumer representation set forth some general principles which will be subject to modification depending upon the nature of the national dental health program:

1. Consumer representatives should be involved in an advisory capacity in the development of regulations and procedures during the initial design of the program.

2. Consumer representatives should be selected on the basis of geographic region with particular attention given to appropriate broad representation of all segments of the population.

3. Consumer representatives should be involved at the national level and all state and local levels of operation of the program.

4. Consumer representatives should be retained subject to attendance at meetings and carrying out of assigned functions.

5. Consumer representatives should be involved in an advisory capacity on such issues in any proposed national dental health program as the following: review of the program, education of the public to prevention of dental disease and appropriate utilization of the program, grievance procedures established for the program, and administration and evaluation of the program.

GUIDELINES FOR EDUCATION AND TRAINING IN A NATIONAL HEALTH PROGRAM

1. The development of all types of dental and dental auxiliary education programs should be based on the determination of shortage and need in relationship to geographic considerations. Furthermore, the establishment of dental and dental auxiliary education programs shall be restricted to institutions whose programs are eligible for accreditation by the Council on Dental Education.

2. The profession, through its various agencies, should accelerate the training and use of expanded function auxiliary personnel in accordance with state dental practice acts.

3. Programs in continuing education should be developed to prepare practicing dentists to use expanded function auxiliaries in accordance with state dental practice acts.

REPORT 1 OF BOARD OF TRUSTEES TO HOUSE OF DELEGATES: ASSOCIATION AFFAIRS AND RESOLUTIONS

This is the first of a series of reports to be presented by the Board of Trustees to the House of Delegates at the 117th annual session.

Appreciation to Committee on Local Arrangements: The convening of the 1976 annual session in Las Vegas, Nevada, marks the third session to be scheduled in this exciting city in the Sagebrush State within the last eleven years. Previous sessions were noted for the record attendance at meetings of the House of Delegates and at the scientific program as well as the technical exhibits. The organization and planning of an annual session of more than 25,000 members and guests can be accomplished only with the support and cooperation of many people. The Committee on Local Arrangements plays a major role in planning and management of the many activities required to ensure the success of the annual session. Dr. Louis J. Hendrickson, as General Chairman of the Committee on Local Arrangements, has provided outstanding leadership to the organization of the Las Vegas session and he has been ably assisted by Dr. Ralph D. Hargrave as Vice Chairman. Committee chairmen who have provided valuable support in specific areas are: Dr. Dan Halseth, Committee on Clinics and Motion Pictures; Dr. James Jones, Committee on Reception; Mrs. Ann Hett, Committee on Women's Activities; and Dr. Robert L. Morrison, Committee on the President's Dinner-Dance.

The Nevada Dental Association and the Clark County Dental Society, serving as host societies, have been generous in their warm hospitality and most cooperative in all aspects of the session.

On behalf of all members and guests who will attend this session, the Board of Trustees expresses its gratitude to Dr. Hendrickson and the members of the Committee on Local Arrangements and to all others who have provided assistance to ensure the success of the 1976 annual session.

Death of Former ADA Officials: Since the 1975 session of the House of Delegates the following former officers and trustees have passed away: Dr. C. Willard Camalier,

who served as president in 1937-1938 and as director of the Washington Office for several years; Dr. James P. Hollers, who served as president in 1963-1964; Dr. Charles E. Hebert, Jr., a past trustee who completed six years on the Board in 1975; and Dr. Charles F. Bartels, who served as second vice-president in 1967-1968. The Board of Trustees joins the members of the House of Delegates in expressing sympathy to the families of these departed friends.

Nomination to Honorary Membership: The Board of Trustees is pleased to nominate to the House of Delegates five distinguished professionals for Honorary Membership in accordance with the provisions of Chapter I, Section 20D, of the *Bylaws*.

Dr. Donald E. G. D. Derrick: Born in Montreal, Canada, Dr. Derrick attended the Royal Dental Hospital and Charing Cross Hospital, London, and earned his Licentiate in Dental Surgery at the Royal College of Surgeons in England and a Doctorate in Dental Surgery at the University of Pennsylvania School of Dental Medicine.

A resident of London, Dr. Derrick has been in private general practice since 1948 and is currently serving as Chairman of the Publications Committee of the *Fédération Dentaire Internationale,* consultant editor to *The Journal of Dentistry,* member of the Editorial Board of the *Journal of Operative Dentistry,* and consultant dental editor to a publishing firm in Bristol.

A past treasurer, secretary and president of the American Dental Society of Europe, Dr. Derrick is a fellow of the International College of Dentists, American College of Dentists, Royal Society of Arts and the New York Academy of Dentistry. He holds membership in the American Association of Endodontists, American Academy of Operative Dentistry, Delta Sigma Delta and other professional and civic organizations. In addition to his appointments as dental surgeon in hospital dental departments, the Royal Naval College and US Department of Veteran's Affairs, Dr. Derrick has made significant contributions to the dental profession internationally as an author, clinician and essayist, editor and dental historian.

Mr. George A. Roose: Mr. Roose of Sandusky, Ohio, has for many years demonstrated a high interest in dentistry and especially in the history of developing dentistry in Ohio. He has aided various dental activities in that state and has hosted visiting foreign dental dignitaries on many occasions. A highlight of his interest in the profession has been his continuing support of the "Cradle of Dentistry" and his contributions to the John Harris Foundation of Bainbridge, Ohio. This year he provided the space and the facilities for the creation in the Town Hall of Cedar Point's Frontier Land of a replica of the John Harris Museum in Bainbridge which served as the quarters for a dental office of 100 years ago.

Mr. Roose is a native of Perrysburg, Ohio, earned a Doctor of Laws degree from Harvard Law School and currently is the Chairman of the Board of Roose, Wade and Company, Investment Bankers in Toledo. He is the recipient of many other awards and appointments including a proclamation from the Mayor of the City of Cleveland for his civic contributions as well as an appointment to the Executive Order of the Ohio Commodores by Governor James Rhodes of the State of Ohio.

Lieutenant General George E. Schafer, Surgeon General, USAF: General Schafer is the Surgeon General of the United States Air Force and a graduate of the College of Liberal Arts and the College of Medicine of the University of Cincinnati, Ohio. He is past president of the Aerospace Medical Association and a fellow in Aviation Medicine; a past president of the Society of USAF Flight Surgeons; member of the American Medical Association and the American College of Preventive Medicine. General Schafer is board certified in Aerospace Medicine by the American Board of Preventive Medicine and is the author of several professional publications in the field of aerospace medicine. He was the first flight surgeon to be assigned full time to a jet organization. General Schafer has a keen understanding of dental problems and has at all times demonstrated outstanding support for Air Force dental programs and for the Chief Dental Officer, United States Air Force.

Professor Marjorie L. Swartz: Professor Swartz is the Professor of Dental Materials of the School of Dentistry at Indiana University. She earned a B.S. degree in chemistry at Butler University and an M.S. degree in biochemistry from Indiana University and has held teaching and administrative positions in the area of dental materials at Indiana University. Professor Swartz has been active in national and international organizations concerned with dental research and the delivery of health services. She is an honorary member of Omicron Kappa Upsilon, a fellow of the American Association for Advancement of Science, past president and secretary of the Dental Materials Group of the International Association for Dental Research, the 1967 recipient of the Wilmer Souder Award and has served on virtually every important committee at Indiana University School of Dentistry and has had a positive input into each one. Professor Swartz has lectured extensively at postgraduate courses and has authored over 80 scientific articles in the field of dental materials. Although not a dentist, Professor Swartz has demonstrated outstanding leadership ability in dental education and research and is truly one of dentistry's finest.

Dr. William B. Walsh: Dr. Walsh is a graduate of the Georgetown University School of Medicine where he now is the Clinical Professor of Internal Medicine. He served as a medical officer aboard a destroyer in the South Pacific during World War II. Poor health conditions in the area prompted his desire to return some day with a floating medical center. The vision materialized in 1958 when President Eisenhower agreed that one of the Naval hospital ships, then in mothballs, should be converted into the world's first peacetime hospital ship. Dr. Walsh established the People-to-People Health Foundation, Inc., a private nonprofit foundation to raise funds. The foundation became the parent organization of Project HOPE (Health Opportunity for People Everywhere) with its principal object to teach techniques of US science to physicians, dentists, nurses and allied health personnel in developing areas of the world. From its unpretentious start with a dilapidated ship and $150, Project HOPE has become the largest and most effective international health program in the world with a $10 million annual budget. Dr. Walsh is the president as well as the founder of Project HOPE.

Dr. Walsh is an internationally known physician, humanitarian, administrator, educator, innovator and author and the recipient of many national and international awards for his contributions to the people of the world and his promo-

tion of friendship and understanding between the people of the United States and those of other countries.

70. **Resolved,** that in accordance with Chapter I, Section 20D, of the *Bylaws,* the following be elected to honorary membership:

Dr. Donald E. G. D. Derrick
Mr. George A. Roose
Lieutenant General George E. Schafer, Surgeon General, USAF
Professor Marjorie L. Swartz
Dr. William B. Walsh

Distinguished Service Award: The Distinguished Service Award was established by the Board of Trustees in 1970 as the "highest award which the Association can confer on members of the dental profession or of allied health professions." The Board of Trustees takes great pleasure in announcing that the recipient of the sixth Distinguished Service Award is Dr. Percy T. Phillips.

Dr. Percy T. Phillips: Dr. Phillips' service to the profession of dentistry extends well over half a century, from 1919 when he earned his Doctor of Dental Surgery degree at Columbia University to his present position as the elected Secretary of The Dental Society of the State of New York, a post which he assumed in 1962 and in which he continues to serve at the age of 78. In addition to his long and continuing years as an officer of various professional societies, including a term as president of the American Dental Association from 1958 to 1959, Dr. Phillips served on committees of the Department of Defense, the Navy Department, the Veterans Administration, the United States Public Health Service and other federal agencies.

Prior to election as president of the Association, Dr. Phillips was a member of the Board of Trustees for six years. He has been a member of the House of Delegates uninterruptedly for 39 years, a member of the Association's Committee on Constitutional and Administrative Bylaws for four years and a member of its Council on Constitution and Bylaws for three years. As chairman of the Association's Committee on Constitution and Bylaws, he rewrote the entire document, initiating many internal changes in the operation of the Association. One of these was the establishment of the office of Speaker of the House of Delegates, a position which Dr. Phillips held during the first three years of its existence and in which he set a high standard of leadership.

Dr. Phillips conducted a general practice in dentistry in New York City from the time of his graduation from dental school in 1919 until he became the Secretary of The Dental Society of the State of New York in 1962. In succession, he served as President of the Bronx County Dental Society, of the First District Dental Society of New York and of the International College of Dentists.

For achievements in the fields of administration and dental journalism, Dr. Phillips has been awarded the Henry Spenadel Award, the William Jarvis Award, the Pierre Fauchard Medal, the New York University Alumni Award, the William J. Gies Award, the Centennial Award of the First District Dental Society and the Chevalier del orde de la Ceuronne from Belgium. His international prestige is evidenced by honorary memberships in the dental societies of

Great Britain, Australia, France, Italy, Japan, the Philippines and Peru. He is also an honorary member of Omicron Kappa Upsilon and received an honorary law degree (L.L.D.) from Fairleigh Dickinson University.

Dr. Phillips is a Fellow of the American College of Dentists, the New York Academy of Dentists, the New York Institute of Clinical Oral Pathology and the Pierre Fauchard Academy, and a member of the *Fédération Dentaire Internationale,* Psi Omega fraternity, the American Public Health Association, the National Safety Council and the National Health Council.

Dr. Percy T. Phillips is indeed a distinguished member of the dental profession and the Board of Trustees is honored and pleased to confer upon him the Distinguished Service Award of the American Dental Association in recognition of his outstanding service.

Appointive Officers: On December 31, 1976, Dr. C. Gordon Watson will complete seven years as Executive Director of the American Dental Association. On the same date, Dr. Herbert C. Butts will have completed two and one-half years as Editor of the American Dental Association. The Board of Trustees is pleased with the contributions which these two appointive officers continue to make to the Association's programs and objectives.

Dr. James W. Etherington will complete his three-year term as the Association's Treasurer with the conclusion of the 1976 annual session. Dr. Etherington was appointed to this office following his six-year service as the trustee from the First District. His supervision and stewardship of the Association's finances during his term as Treasurer is gratefully acknowledged by the Board of Trustees.

The Board of Trustees is pleased to announce that it has appointed Dr. Jack H. Pfister, retiring trustee of the Tenth District, to a one-year term as Association Treasurer to succeed Dr. Etherington.

Retiring Trustees: The Board of Trustees expresses its gratitude for the service which the following trustees have rendered to the Association during their six years on the Board: Dr. Charles D. Carter, District 6; Dr. Jack H. Pfister, District 10; and Dr. Lloyd J. Phillips, District 7.

Appreciation to Employees: The Board of Trustees is pleased to bring to the attention of the House of Delegates four members of the Headquarters staff for their years of service to the Association: Miss Lina Salfner, manager of the Executive Dining Room who retired this year after 20 years of service with the Association; Mr. Henry M. Koehler, Editorial Department, 20 years; Miss Eunice Olson, Council on Legislation, 20 years; Miss Marian F. Driscoll, secretary, Council on International Relations, 25 years. These employees have served the American Dental Association with loyalty and competence and they deserve the appreciation of all members of the Association for their contributions to the dental profession.

Life Membership: An amendment to the *Bylaws* adopted by the 1973 House of Delegates (*Trans.* 1973:634) revised the Life Membership procedures. Life membership can be obtained upon application to the Executive Director and upon proof of qualification in lieu of nomination by the Board of Trustees and election by the House of Delegates. Therefore, in accordance with Chapter I, Membership, Section 20B of the *Bylaws,* the following life memberships have been granted as of June 30, 1976:

Air Force	2
Alabama	11
Alaska	0
Arizona	9
Arkansas	7
Army	3
California	124
Colorado	11
Connecticut	25
Delaware	2
District of Columbia	6
Florida	14
Georgia	10
Hawaii	4
Idaho	0
Illinois	92
Indiana	18
Iowa	14
Kansas	7
Kentucky	17
Louisiana	12
Maine	3
Maryland	16
Massachusetts	60
Michigan	43
Minnesota	24
Mississippi	3
Missouri	25
Montana	6
Navy	5
Nebraska	5
Nevada	1
New Hampshire	1
New Jersey	54
New Mexico	2
New York	289
North Carolina	18
North Dakota	2
Ohio	48
Oklahoma	4
Oregon	13
Panama Canal Zone	0
Pennsylvania	81
Public Health	0
Puerto Rico	3
Rhode Island	3
South Carolina	1
South Dakota	1
Tennessee	9
Texas	35
Utah	1
Vermont	2
Veterans Administration	10
Virgin Islands	0
Virginia	16
Washington	14
West Virginia	7
Wisconsin	22
Wyoming	3
Total	1,218

Retired Membership: The 1973 House of Delegates adopted an amendment to the *Bylaws* (*Trans.* 1973:635) establishing procedures for Retired Membership classification similar to those for Life Membership. Therefore, in accordance with Chapter I, Membership, Section 20G of the *Bylaws,* the following new retired memberships have been granted as of June 30, 1976.

Air Force	4
California	6
Connecticut	6
Georgia	1
Illinois	3
Kentucky	1
Massachusetts	1
Montana	1
Navy	1
New Hampshire	1
New Jersey	1
New York	32
North Carolina	1
Ohio	1
Oregon	1
Pennsylvania	1
Public Health	2
Texas	2
Veterans Administration	8
Washington	1
Wisconsin	1
Total	76

Nominations to Councils: In accordance with Chapter VI, Section 9oH of the *Bylaws,* the Board of Trustees presents the following nominations for membership on the councils of the Association. Election to councils will take place at the third meeting (Wednesday afternoon) of the House of Delegates.

Nominations to Councils

Dental Care Programs, Council on

Booth, William A., Pennsylvania, 1979 (ad interim)
DiStasio, Joseph G., Massachusetts, 1979 (ad interim)
Howard, William W., Oregon, 1979
King, Duncan A., Kentucky, 1977 (ad interim)
Larson, Gerald A., Wisconsin, 1978 (ad interim)
Lentchner, Emil W., New York, 1979
Moran, Bernard J., Nebraska, 1977 (ad interim)
Ticknor, Robert C., Arizona, 1977 (ad interim)
Truono, Eugene J., Delaware, 1979 (ad interim)
Weil, Lewis L., Illinois, 1977 (ad interim)

Dental Education, Council on

Brown, William E., Oklahoma, 1979, AADS*
Fortenberry, Marshall M., Mississippi, 1979, ADA**
Freedman, Gerson A., Maryland, 1979, AADE***
Hazen, Stanley P., Illinois, 1979, AADS*
Joseph, Michael J., West Virginia, 1978, AADE*** (ad interim)
Nienaber, William B., Minnesota, 1979, ADA**
Wolfsehr, Gerald R., Oregon, 1979, AADE***

*American Association of Dental Schools
**American Dental Association
***American Association of Dental Examiners

Dental Health, Council on

Cabot, Joseph, Michigan, 1979

Dental Laboratory Relations, Council on

Flad, Daniel L., Pennsylvania, 1979
Labelle, Arthur L., Jr., California, 1977 (ad interim)

Dental Materials and Devices, Council on

Christensen, Gordon, Utah, 1979
Gilmore, H. William, Indiana, 1978 (ad interim)
Vining, Robert V., Nebraska, 1979
Von Der Lehr, William, Louisiana, 1979

Dental Research, Council on

Forrest, Edward J., Pennsylvania, 1979

Dental Therapeutics, Council on

Corpron, Richard E., Michigan, 1979
Goodson, Jo Max, Massachusetts, 1979
Weaver, Joel Milton, III, Ohio, 1979

Federal Dental Services, Council on

Chavoor, Ashur G., District of Columbia, 1979

Hospital Dental Service, Council on

Iverson, Paul H., North Dakota, 1979 (ad interim)

Insurance, Council on

Casey, William L., Arkansas, 1979

International Relations, Council on

Nassimbene, Jack D., Colorado, 1979

Journalism, Council on

Doerr, Robert F., Michigan, 1979

Judicial Procedures, Constitution and Bylaws, Council on

Michelson, Leonard, Alabama, 1979

Legislation, Council on

Henderson, Howard B., Washington, 1979

Ackerman, Frederick W., 1977, AMA*,***

National Board of Dental Examiners, Council on

Dworkin, Samuel F., Washington, 1979, AADS*

Nishimura, Pete H., Hawaii, 1979, ADA**

Bradshaw, Thomas C., Virginia, 1979, AADE***

Relief, Council on

Podruch, Louis L., Wisconsin, 1979

Scientific Session, Council on

Wolff, Roy M., Missouri, 1979

The Board of Trustees wishes to acknowledge with appreciation the years of service of the following members who complete their terms with this annual session: Dr. Ellwood F. Davidson, Washington, Council on Dental Care Programs; Dr. John R. Champagne, Michigan, Council on Dental Education; Dr. Charles A. McCallum, Alabama, Council on Dental Education; Dr. Noel W. Hiatt, Ohio, Council on Dental Therapeutics; Dr. Joseph R. Salcetti, District of Columbia, Council on Federal Dental Services; Dr. Everett C. Claus, Colorado, Council on International Relations; Dr. Charles J. Defever, Jr., Michigan, Council on Journalism; Dr. Paul W. Kunkel, Jr., Oregon, Council on Legislation; Dr. Guy R. Willis, North Carolina, Council of National Board of Dental Examiners; Dr. John F. Chimienti, Kansas, Council on Scientific Session.

71. **Resolved,** that the nominees for membership on the councils of the Association, submitted by the Board of Trustees in accordance with Chapter VI, Section 90H of the *Bylaws,* be elected.

Nominations to Commission on Accreditation of Dental and Dental Auxiliary Educational Programs and Commission Appeal Board: In accordance with the *Bylaws of the Commission on Accreditation of Dental and Dental Auxiliary Educational Programs,* the Board of Trustees presents the following nominations for membership on the Commission and Commission Appeal Board to the House of Delegates for confirmation. The 12 members of the Council on Dental Education shall serve as core members of the Commission.

*American Association of Dental Schools
**American Dental Association
***American Association of Dental Examiners
****American Medical Association

COMMISSION ON ACCREDITATION

Special Area of Dental Practice
Bowers, Dr. Gerald M., Maryland, 1978

Dental Laboratory Technology
Morr, Mr. Douglas, North Carolina, 1979

Public Members
Lawson, Mr. Thomas J., Alabama, 1977 (ad interim)
Buckner, Mr. Donald R., Maryland, 1977 (ad interim)

APPEAL BOARD

Special Area of Dental Practice
McDonald, Ralph E., Indiana, 1979

General Practice Residency
Thompson, Robert R., California, 1979

72. **Resolved,** that the nominees for membership on the Commission on Accreditation of Dental and Dental Auxiliary Educational Programs submitted by the Board of Trustees in accordance with Article IV, Section 2 of the *Bylaws of the Commission on Accreditation of Dental and Dental Auxiliary Educational Programs* be elected.

73. **Resolved,** that the nominees for membership on the Appeal Board of the Commission on Accreditation of Dental and Dental Auxiliary Educational Programs submitted by the Board of Trustees in accordance with Article V, Section 2 of the *Bylaws of the Commission on Accreditation of Dental and Dental Auxiliary Educational Programs* be elected.

Nominations to Commission on Licensure: In accordance with the action taken by the 1974 House of Delegates (*Trans.* 1974:669), the Board of Trustees presents the following nominations for membership on the Commission on Licensure. Election of these nominees will take place at the third meeting (Wednesday afternoon) of the House of Delegates.

Barrett, C. F., Iowa, 1978
Cole, Robert J., Florida, 1978
Connolly, James E., Massachusetts, 1978
Doerr, Robert E., Michigan, 1978
Durham, John G., Missouri, 1978
Haines, Lee E., New Mexico, 1977
Klooster, Judson, California, 1977
Kozal, Richard A., Illinois, 1977
Minatra, Randolph D., Texas, 1979
Roeck, Dale F., Pennsylvania, 1979
Schlansker, William P., New York, 1978
Shellenberger, Robert E., Indiana, 1977

Shuford, Frank, District of Columbia, 1979
Wight, Robert G., Washington, 1979

74. **Resolved,** that the nominees for membership on the Commission on Licensure, as presented by the Board of Trustees, be elected.

Annual Session Sites: The Board of Trustees has previously selected the following sites and dates for future annual sessions of the American Dental Association:

1977	Miami Beach, October 9-13
1978	Anaheim, October 22-26
1979	Dallas, November 4-8
1980	New Orleans, October 12-16

The Board of Trustees has now selected Kansas City, Missouri, with dates of October 25-29, for the site of the 1981 annual session. At the same time, the Board of Trustees voted to select Atlanta as the site for the 1982 annual session if suitable dates can be arranged.

Criteria for Awarding Assistance Grants: The Board of Trustees has adopted, for its guidance, and the guidance of outside agencies seeking grant assistance from the Association, criteria and guidelines. It should be noted that while the criteria and guidelines are not intended to be inflexible, deviations will have to be justified. The following criteria and guidelines are submitted to the House of Delegates for its information and the information of those agencies affected.

The following criteria are to be used for grant assistance by the American Dental Association to dental societies and/or other health-related organizations:

1. In the case of health-related organizations, the organization must be making significant contributions to the art and science of dentistry or to the policies and aims of the American Dental Association.
2. The financial aid requested is commensurate with the national benefit reasonably expected to result to the dental profession.
3. The dental society or other health-related organization has made every effort to obtain the funds needed from not only its own resources but other organizations as well, if feasible.
4. The need for additional funds is necessary and immediate.
5. Failure to obtain the requested funds from the American Dental Association would impair seriously the purpose for which the funds are needed.
6. Any request for grant assistance to support a project emanating from a component dental society is to be submitted through the component's constituent dental society which, in turn, is to indicate the extent to which it is supporting the component's need for financial assistance.
7. A grant budget proposal and a concluding financial statement will be expected of all those applying for grants and those awarded grants.

The following criteria are to be used in determining financial assistance to dental societies by the American Dental Association in support of litigation:

1. A dental society has notified the Association of the litigation at a time which permits the agencies of the Association to be of maximum assistance in offering suggestions on the enforcement program or the litigation.

2. The dental society has made every reasonable effort to obtain the funds needed to sustain the litigation from its own resources.

3. The need for additional funds is immediate.

4. Failure to obtain additional funds would seriously impair the dental society's efforts to pursue the litigation to a successful conclusion.

5. The disposition of the issue or issues under litigation would have a direct and substantial impact upon the dental profession nationally.

6. The financial aid requested is commensurate with the benefit reasonably expected to result, on a nationwide basis, from a favorable result of the litigation.

7. Any request for funds to support litigation emanating from a component dental society is to be submitted through the component's constituent dental society which, in turn, is to indicate the extent to which it is supporting the component's need for financial assistance.

8. A grant budget proposal and a concluding financial statement will be expected of all those applying for grants and those awarded grants.

REPORT 2 OF BOARD OF TRUSTEES TO HOUSE OF DELEGATES: RECOMMENDATIONS ON REPORTS AND RESOLUTIONS

The following are the comments of the Board of Trustees on reports and resolutions which will be considered by the House of Delegates.

Dental Care Programs, Council on: (p. 22) The Board of Trustees wishes to express its appreciation to Dr. Ellwood F. Davidson, retiring vice chairman of the Council, for his many contributions to the advancement and improvement of dental care programs and to the Association.

Professional Standards Review Organizations: The Board noted the continuing pending status of the Association's proposed amendments to the PSRO law, which remain under consideration in the Senate, and urges a sustained effort by all appropriate agencies of the Association to obtain legislative action to correct the discriminatory aspects of this law.

Medicare/Medicaid: The 1975 House of Delegates (*Trans.* 1975:735) requested the Board of Trustees to study the feasibility of developing a legislative draft for a national program of dental care for indigent persons and to report on that matter to the March 1976 meeting of the Board of Trustees.

At the March 1976 meeting the Board reported that, in its view, preparation of a legislative draft would not be an appropriate approach but, instead, the Councils on Dental Care Programs and Dental Health should undertake review of existing Association policy relative to Titles XVIII and XIX of the Social Security Act, together

with relevant experience under those two titles with respect to dental care, and propose such actions as they deem appropriate.

Work by the two Councils began in mid-1976. In addition to compilation and review of existing policy, meetings have been held with HEW officials and, in July and August, two pilot conferences on dental problems related to Medicaid in Illinois and Ohio were held under the joint sponsorship of the Association and the Social and Rehabilitation Service Administration of the Department of Health, Education, and Welfare involving representatives of the respective state agencies and constituent dental societies. It is hoped that additional conferences of this type can be held elsewhere in the nation. The Councils submitted a progress report to the August 1976 session of the Board of Trustees and are continuing with their efforts.

Dental Care Programs, Council on, Supplemental Report 1 on UCR and Table of Allowance, and Indiana Resolution (Res. 884) to 1975 House of Delegates: (p. 28) Resolution 44; *Trans.* 1975:661) The Board of Trustees reviewed Council on Dental Care Programs: Supplemental Report 1 to the House of Delegates, evaluating the relative merits of the usual, customary and reasonable fee and table of allowance reimbursement mechanisms which was directed by the 1975 House of Delegates. The Board was impressed with the comprehensive nature of the study, noting the advantages and disadvantages of each method as reported by representatives of the profession, major purchasers of dental prepayment programs, employee-group representatives, insurers and insurance brokers, as well as the substantial preference for the UCR method, expressed by the profession in the fall, 1975 *Survey of Dentists.*

The Board of Trustees concurs in the view of the majority of respondents to the Council's survey that the UCR method possesses the capability of providing the more substantial benefit to the patient. The Board fully supports the Council's observation that any dental prepayment plan, regardless of the reimbursement mechanism utilized, can be ineptly administered and that responsible design, including absolute clarity in presenting the program's benefits and exclusions, is the first essential of a satisfactory plan. The Board stresses that proper administration is always fundamental. This concern is expressed throughout the *Standards for Dental Prepayment Programs* (*Trans.* 1974:639). The Board does not believe that it need be specifically stated with regard to payment mechanisms. Accordingly, *the Board presents the following substitute resolution for Resolution 44 and recommends that it be approved:*

> 44B. Resolved, that the *Standards for Dental Prepayment Programs* (revised November 1974 -*Trans.* 1974:639) be amended by substituting the following standard for Standard 21:
>
> > 21. The usual, customary and reasonable fee reimbursement method is preferred but other methods, such as a table of allowance, are acceptable.

Dental Care Programs, Council on, Supplemental Report 2 on Delta Dental Plans, and Trustee District Resolution 92 (Res. 889) to 1975 House of Delegates: (p. 32; Trans. 1975:664) The Board of Trustees reviewed Council on Dental Care Programs: Supplemental Report 2 to House of Delegates and wishes to commend the Council for its thorough study of the relationship of the Association to Delta Dental Plans, which was directed by the 1975 House of Delegates. The Board believes that

the historical context which the report provides will be of particular value to all members of the profession when dealing with this issue.

The Board of Trustees notes further that the report provides an exceptionally fine context for overall consideration by all concerned individuals in the Reference Committee hearing and floor discussion at the 1976 House of Delegates.

Of the twelve recommendations that are part of the Council report, the Board was pleased to learn that action has already occurred on the seventh recommendation and that Delta Dental Plans has asked the Council on Dental Care Programs to designate a member to serve in a liaison position with Delta. The Council has, for 1976-1977, appointed Dr. William A. Booth to that post. The Board strongly recommends that Delta Dental Plans now urge all of its member plans to develop a similarly close, formal liaison with the appropriate councils of the respective constituent societies.

The Board was most impressed with those aspects of the report which noted that failures in communication were a particularly troublesome source of problems. In order to reinforce the need for timely action to solve this difficulty, *the Board believes that a formal resolution would prove helpful and consequently submits the following resolution and recommends that it be approved.*

> 75. **Resolved**, that Delta Dental Plans be urged to expand and improve its program of public and professional relations, the intent of which should be the establishment of thorough and consistent communications between the Delta plan and the members of the profession.

Dental Care Programs, Council on, Supplemental Report 3 on Fee Reimbursement Differences, and Indiana Resolution 46 to 1975 House of Delegates: (p. 57/Resolution 46-1975; *Trans.* 1975:656) The Board of Trustees considered Council on Dental Care Programs: Supplemental Report 3 on its study conducted in response to a directive of the 1975 House of Delegates. The Board was impressed with the analysis of reimbursement differentials vis-à-vis patients' freedom of choice as delineated in the report. The Board shares the Council's concern that a differential may become so great as to interfere with the patient's freedom of choice. However, the Board supports the Council's conclusion that, in service benefits plans, the services provided by the participating dentist and the obligations that he frequently accepts justify some differential in reimbursement. Accordingly, *the Board returns the following resolution to the House of Delegates with the recommendation that it be postponed indefinitely.*

> 46-1975. **Resolved**, that the freedom of choice statement adopted by the House of Delegates in 1965 (*Trans.* 1965:354) and cited in the 1975 booklet, "Policies on Dental Care Programs," page 14, be amended by deleting the phrases "within the agreed limitations of the plan" and "within the same limitations" and adding the following sentence:
>
> > To assure the patient's freedom of choice of dentist, the Association considers it improper and unacceptable to the dental profession anytime a third party limits reimbursement in any way due to a dentist not signing a contractual agreement.
>
> and be it further
>
> **Resolved**, that this statement be included in all appropriate policy statements of

the Association (e.g., in "Policies on Dental Care Programs": General Statements on Prepayment, pages 15-16; Methods of Payment, pages 26-27; and Joint Statement of AFL-CIO and ADA, pages 44-45).

Dental Care Programs, Council on, Supplemental Report 4 on Diverse Prepayment Policies, and Board of Trustees Resolution 234 (Res. 873) to 1975 House of Delegates: (p. 60; *Trans.* 1975:648) The Board of Trustees noted with interest this interim report of the Council on Dental Care Programs concerning its efforts to fulfill the request of the 1975 House of Delegates "to undertake a study of the prepayment experience of dental practices in states with diverse policies." In the Board's view, the overall approach taken by the Council was appropriate and could be expected to elicit meaningful information. The Board regrets that agreement on conduct of the survey in question has not yet been achieved, but it is pleased to note that the Council is continuing discussions with the constituent societies involved in the hope that differences can be satisfactorily resolved. The Board joins in that hope and expects to receive a further report from the Council for consideration at its November 1976 meeting.

Joint Report of Council on Dental Care Programs and Council on Dental Health on Cosmetic Dentistry, and Reference Committee Resolution 910 to 1975 House of Delegates: (p. 243; *Trans.* 1975:683) The Board of Trustees reviewed the statement of the two Councils concerning the question of cosmetic dentistry and believes that the statement will prove useful to the Association in its continuing attempts to resolve this issue in accordance with sound professional opinion. *The Board, considering a formal definition of cosmetic dentistry useful to the profession, offers the following resolution and recommends that it be approved:*

76. Resolved, that cosmetic dentistry be defined as "those dental services which are performed solely for the purpose of improving appearance. Treatment performed to improve form or function or to prevent or correct pathologic conditions is not cosmetic," and be it further
Resolved, that notice of this action be given to all parties involved in dental prepayment, and be it further
Resolved, that this definition be included in the next revision of the Council on Dental Care Programs' Glossary of Dental Prepayment Terms.

Dental Education, Council on: (p. 83/Resolutions 1-4) The Board of Trustees recommends approval of Resolutions 1-4.

Curriculum Study: The Board reviewed the comprehensive report concerned with the study of dental curriculums of US dental schools. The report details the progress made in implementing the study since the resolution was adopted by the 1974 House requesting that such a study be made (*Trans.* 1974:675).

Although the House requested that a completed report with recommendations be provided to the 1976 House, it was understandable to the Board that the Council was unable to comply with the timetable for several reasons. Chief among these reasons is the fact that the Council did not receive official notification of funding, and the level of that funding, for the project from the W. K. Kellogg Foundation until late 1975. For this reason, the Council was delayed considerably in the development

of the survey instruments needed to collect the data. Coupled with this is the fact that the Council was directed by the 1975 House to complete two other major assignments- -the feasibility study relating to the development of an evaluation program for continuing education and the directive that a workshop on delegation of expanded functions to dental auxiliaries be convened.

The Board noted that what has been identified as Phase II of the curriculum study was reported in the May 1976 issue of *JADA*. It appears that the information will be useful to the Council in the development of recommendations in the broader curriculum study.

It was brought to the Board's attention also that the Curriculum Study Coordinating Committee had established June 1 as the deadline for institutions to complete the survey instruments and return them to the American College Testing Program. Since a significant number of schools have found it impossible to complete the instruments within the prescribed time-frame, the deadline was extended to July 1.

Revised Definitions of Special Areas of Dental Practice: The Board considered the revised definitions approved by the Council on Dental Education for the recognized special areas of dental practice which were developed during the 1976 Workshop Conference on Specialty Practice. The Board supports the Council's position that rigid and formal definitions are difficult to establish and undesirable in view of the changing concepts of dental practice. The Board approved the revised definitions for the special areas of dental practice, with the exception of oral surgery, which has been approved by the House of Delegates. Further the Board noted that these definitions are substituted for those approved by the Council on Dental Education in 1966 (*Trans.* 1966:24). In addition the Board is submitting the revised definitions to the House of Delegates as information.

It is recognized there are overlapping responsibilities among the recognized areas of dental practice. However, as a matter of principle, a specialist shall not provide routinely procedures that are beyond the scope of his specialty.

Dental Public Health: Dental public health is the science and art of preventing and controlling dental diseases and promoting dental health through organized community efforts. It is that form of dental practice which serves the community as a patient rather than the individual. It is concerned with the dental health education of the public, with applied dental research, and with the administration of group dental care programs as well as the prevention and control of dental diseases on a community basis.

Endodontics: Endodontics is that branch of dentistry that is concerned with the morphology, physiology and pathology of the human dental pulp and periapical tissues. Its study and practice encompasses related basic and clinical sciences including biology of the normal pulp, etiology, diagnosis, prevention and treatment of diseases and injuries of the pulp and resultant pathological periapical tissues.

Oral Pathology: Oral pathology is that branch of science which deals with the nature of the diseases affecting the oral and adjacent regions, through study of its causes, its processes and its effects, together with the associated alterations of oral structure and function. The practice of oral pathology shall include the

development and application of this knowledge through the use of clinical, microscopic, radiographic, biochemical or other such laboratory examinations or procedures as may be required to establish a diagnosis and/or gain other information necessary to maintain the health of the patient, or to correct the result of structural or functional changes produced by alterations from the normal.

Oral Surgery: Oral surgery is that part of dental practice which deals with diagnosis, the surgical and adjunctive treatment of disease, injuries and defects of the oral and maxillofacial region.

Orthodontics: Orthodontics is that area of dentistry concerned with the supervision, guidance and correction of the growing or mature dentofacial structures, including those conditions that require movement of teeth or correction of malrelationships and malformations of their related structures. Major responsibilities of orthodontic practice include the diagnosis, prevention, interception and treatment of all forms of malocclusion of the teeth and associated alterations in their surrounding structures; the design, application, and control of functional and corrective appliances; and the guidance of the dentition and its supporting structures to attain and maintain optimum occlusal relations in physiological and esthetic harmony among facial and cranial structures.

Pedodontics: The specialty of pedodontics is the practice and teaching of comprehensive preventive and therapeutic oral health care of children from birth through adolescence. It shall be construed to include care for special patients beyond the age of adolescence who demonstrate mental, physical and/or emotional problems.

Periodontics: Periodontics is that branch of dentistry which deals with the diagnosis and treatment of disease of the supporting and surrounding tissues of the teeth. The maintenance of the health of these structures and tissues, achieved through periodontal treatment procedures, is also considered to be the responsibility of the periodontist.

Prosthodontics: Prosthodontics is that branch of dentistry pertaining to the restoration and maintenance of oral functions, comfort, appearance and health of the patient by the restoration of natural teeth and/or the replacement of missing teeth and contiguous oral and maxillofacial tissues with artificial substitutes.

Board of Trustees Resolution 77 on Amendment of "Bylaws" on Duties of Council on Dental Education: In view of the thorough study of licensure that the Commission on Licensure has conducted, the Board agrees with the Commission on Licensure that continued, regular operation of such a large study group is no longer needed. Concurring with Commission recommendations, the Board recommends that the study of licensure matters be assigned to the Council on Dental Education. If this were done, the Council on Dental Education should call on the expertise of former members of the Commission on Licensure as needed. In identifying a permanent agency to study licensure matters, the Board noted that the Council on Dental Education has educator and examiner members as well as representatives from the general membership

and was asked to study licensure issues that came up before 1972. Also, because accreditation has been assigned to the Commission on Accreditation of Dental and Dental Auxiliary Educational Programs, charging the Council on Dental Education with the study of licensure would not create a conflict of interest. Therefore *the Board offers the following resolution with the recommendation that it be adopted:*

77. **Resolved**, that Chapter IX, Councils, Section 110, Duties, Subsection B, Council on Dental Education of the *Bylaws* be amended by the addition to Subsection B of the following:

(7) Dental licensure and dental auxiliary licensure.

Special Report on Dental Auxiliary Utilization and Education, Council on Dental Education: (p. 208/Resolution 24; *Trans.* 1975:697/Resolution 864) The Board studied thoroughly the comprehensive report on dental auxiliary utilization and education. The Council on Dental Education and Advisory Committee on the Study of Dental Auxiliary Expanded Functions are commended for their response to the 1975 House directives that a position statement on functions which should be delegated to auxiliaries be developed and functions which may require formal education be studied and defined further for consideration by the 1976 House of Delegates. The report for the first time brings together pertinent information on dental auxiliary education and utilization and expanded functions. The Board believes it accurately reflects deliberations of the workshop participants. Also sections on research, manpower and productivity, educational resources and legal provisions which were the basis for the Council's and Advisory Committee's conclusions provide adequate information for the House to make definitive decisions.

The Board views the controversy over representation at the Workshop on Dental Auxiliary Expanded Functions with concern and concurs with the Council's conclusion that there was adequate opportunity for representation of the practicing profession through the invitations extended to constituent societies and state boards of dentistry. Failure to achieve the desired representation of dental practitioners rests, in the Board's view, solely with societies and boards of dentistry. The Board agrees that although there was question about representation, the accommodation of the problem through separate balloting of practicing dentists, and the discussions made the workshop a valuable resource for the advisory committee and Council.

The Board noted particularly that acceptance of the report by the House would not constitute a mandate to states. The Council has not taken the position that the identified functions *should* be delegated but has only identified functions which *could* be delegated under certain conditions if a jurisdiction desired to enact legislation or promulgate rules and regulations to enable such delegation. The Board also believes it is important to note that the position statement presented to the House encourages, but does not require, uniformity among states in the specific functions or number of functions which could be delegated. The statement would however provide to states the Association's position on appropriate limitations of expanded functions delegation. Further, the report emphasizes that the dentist should be utilized fully to meet demands for care and that the potential effect of utilization of traditional assistants and hygienists should be realized before expanded functions are delegated. The Board noted that the report also emphasizes that a dentist is more than the sum of given

functions and that the practice of dentistry constitutes the synthesis and application of knowledge and skill acquired through professional dental education.

Ramifications of adopting the position statement and consequences of delaying action were discussed at some length by the Board. Failure of the Association to adopt a comprehensive and consistent position statement on delegation of functions to dental assistants and dental hygienists will, in the Board's opinion, result in serious consequences.

1. The profession will continue to lose its credibility and its leadership in determining direction for future utilization of dental assistants and dental hygienists.
2. In the absence of a definitive position, decisions which are creating greater diversity among states and increasing controversy will continue to be made. It is this diversity and controversy that allows other agencies to step in and provide direction.
3. Other agencies, private and governmental, will assume even more significant leadership roles in determining the direction and extent of dental auxiliary utilization.

The 1975 House recognized these problems. The Association could continue to base its actions and testimony on existing policy, but in the Board's view this would result in further erosion of the profession's authority and responsibility for making decisions which relate to utilization of auxiliaries.

The Board is of the opinion that if a statement on dental auxiliary utilization and education is adopted by the 1976 House it will advance the profession's efforts to reestablish its leadership in determining direction for delegation of functions to auxiliaries. Adoption of a statement would:

1) establish a comprehensive and definitive position for the Association on dental auxiliary utilization and education,
2) identify the principles which underlie the Association's position on dental auxiliary utilization and education,
3) establish, on the basis of study and research, the profession's position on appropriate limits of delegation of expanded functions,
4) provide guidance for delegation of functions to dental assistants and dental hygienists, and
5) acknowledge that demand for dental care varies with state and region and reiterate the Association's support of delegation of expanded functions for the purpose of increasing dentists' productivity.

Also, in the Board's view adoption of a statement is necessary to provide a policy for extending study into areas of highest priority. Areas identified by the Council and Advisory Committee include:

1) study of credentialing dental auxiliary personnel and development of recommendations for consideration by the House,
2) reassessment of the Association's position on categories of personnel and development of recommendations for consideration by the House,

3) study of the effect of expanded functions delegation on traditional dental assistants and dental hygienists,

4) assessment of educational systems' capacity to provide expanded functions training, and

5) development of guidelines for expanded function training.

On the basis of its discussion of the report and the position statement the Board recommends the following amendments of the American Dental Association Statement on Expanded Functions Dental Auxiliary Utilization and Education.

The Board believes the philosophy section of the report dealing with the purposes of expanded functions could be clarified by restating lines 13-18. Therefore, the Board recommends that the following statement be substituted for lines 13-18:

> The purpose of delegating expanded functions to dental auxiliaries is to improve the productivity of the dentist by assigning those functions which will increase the availability of services at a reasonable cost, with assurances of quality control.

The Board believes the need for consistency among the states in provisions for delegation of functions should be emphasized. Therefore, it is recommended that principle 2 (lines 34-35), "Individual states or jurisdictions should make the final decisions on which functions may be delegated and the qualifications for performance of those functions.", be amended by addition of "however, adherence to the American Dental Association policy statement is encouraged as it would provide desirable consistency." The amended principle to read:

> 2. Individual states or jurisdictions should make the final decisions on which functions may be delegated and the adherence to the American Dental Association policy statement is encouraged as it would provide desirable consistency.

In the Board's view a restatement of principle 13, (lines 59-61) which reads, "The need for consistency in identification of auxiliaries, definition of their roles and assurances of competence should be recognized by states or jurisdictions in decisions on provisions for delegation of functions." would add emphasis to the need for national consistency. Therefore, the Board recommends that the following be substituted for principle 13:

> 13. In decisions on provisions for delegation of functions, states and jurisdictions should recognize the need for consistency in identification of auxiliaries, definition of their roles and assurances of competence.

The Board considers it important to emphasize within the position statement that the practice of dentistry constitutes more than performance of functions. Therefore, the the Board recommends that the following sentence be inserted at the beginning of line 86:

> The practice of dentistry is more than the performance of functions which constitute the technical procedures of dentistry, and a dentist is more than the sum of those functions.

The Board recommends that Resolution 24, as amended, be approved.

24B. Resolved, that the American Dental Association Statement on Expanded Function Dental Auxiliary Utilization and Education, as amended, be adopted.

Dental Health, Council on: (p. 106/Resolutions 5-6) The Board of Trustees reviewed the Council's annual report and wishes especially to commend Dr. James A. Catchings for his service to the Council during the past six years.

Seventh Trustee District Resolution 106 to 1975 House of Delegates on "Guidelines for Hypertension Detection": (p. 106/Resolution 5; *Trans.* 1975:676) The Board carefully considered the report of the revision of the suggestions for dentists on hypertension detection as directed by the 1975 House of Delegates and concludes that the new suggestions are largely responsive to the House directive. However, the Board believes the suggestions could be further improved by changing item 2 (*Reports*:48) of the revised suggestions in order to make clear that it is "in-service" training that is being discussed, especially with respect to dentists, and to focus on the local chapters of the American Heart Association or other recognized authorities as a source for consultation. The amended item 2 would then read:

> 2. Dentists and dental auxiliaries desiring in-service training in the technique of taking blood pressure should consult with local chapters of the American Heart Association or other recognized authorities.

The Board of Trustees accordingly recommends that the following resolution be adopted.

5B. Resolved, that the *Suggestions for Dentists on Participating in the National High Blood Pressure Education and Screening Program* be approved as amended.

National Health Service Corps: The Board considered the *Statement on National Health Service Corps* (p. 115/Resolution 6) and believes that it will prove helpful to local and state dental societies making decisions on placement of Corps personnel, especially when used in conjunction with the guidelines being formulated by the Council. *Therefore, the Board recommends Resolution 6 be approved.*

Board of Trustee Resolution 91 on Guidelines on After Care for Denture Patients: The Council on Dental Health, responding to a recommendation of the ADA Special Study Commission on the Care of Fully and/or Partially Edentulous Patients, has drafted guidelines on the after care of denture patients, an essential part of denture care. The Board believes that the guidelines, which are appended to this report, should be adopted as Association policy.

91. Resolved, that *After Care Guidelines: Full Dentures* and *After Care Guidelines: Partial Removable Dentures* be adopted.

Federal Dental Services, Council on: (p. 137/Resolutions 7-8) *The Board of Trustees recommends approval of Resolutions 7 and 8.*

Hospital Dental Service, Council on: (p. 145) The Board of Trustees, in response to

the Council on Hospital Dental Service request, has included in its 1977 budget funds to implement a national survey of hospital dental practice. The survey is to be performed by the Council in cooperation with the Bureau of Economic Research and Statistics.

The Board noted with interest the Council's enhanced liaison with allied organizations. In particular, it noted the American Academy of Dental Group Practice request for Association support of Academy membership on the Joint Commission on Accreditation of Hospitals' Accreditation Council on Ambulatory Health Care. The Board of Trustees adopted a resolution expressing its strong belief that the Association's Council on Hospital Dental Service should remain the sole agency of the dental profession to seek participation with or membership within the JCAH. Also, the Board recommends that the Academy work cooperatively with the Council in studying the feasibility of establishing an approval program for dental group practice within the Council's patient care unit program.

International Relations, Council on (p. 155/Resolutions 9-10): The Board of Trustees shares the concern of the Council on International Relations regarding those United States dentists practicing overseas who cannot retain active membership in the Association under the existing *Bylaws*. In order to make such dentists eligible for direct membership, and to extend affiliate membership to those practicing where a national dental association does not exist, *the Board of Trustees recommends that Resolution 9* (p. 159) *be approved by the House of Delegates.*

The Board of Trustees agrees with the Council on International Relations that the significance of the Certificate of Recognition would be enhanced and the objectives of the program would be better served by the adoption of a minimum-service standard. Therefore *the Board of Trustees recommends adoption of Resolution 10* (p. 160).

Journalism, Council on: (p. 161/Resolution 11) The Board of Trustees approves of the revisions made by the Council on Journalism in the *Standards for Dental Publications*. However, the Board notes the need for a second resolving clause in Resolution 11 (p. 163) in order to rescind the *Standards* adopted by the House of Delegates in 1969 (*Trans.* 1969:312). Therefore *the Board of Trustees submits the following amended resolution and recommends its approval by the House of Delegates.*

> 11B. Resolved, that the revised *Standards for Dental Publications* be approved, and be it further
> Resolved, that the *Standards for Dental Publications* approved by the House of Delegates in 1969 (*Trans.* 1969:312) be rescinded.

Judicial Procedures, Constitution and Bylaws, Council on: (p. 167/Resolutions 12-22) The Board commends Dr. Elbert H. "Mike" Smith for his service to the Council.

The Board of Trustees recommends approval of Resolutions 12, 13, 16, 17, 18, 19, 20, 21 and 22.

Listing of Approved Specialties in "Principles of Ethics": (p. 178/Resolution 14) The Board of Trustees agrees with the Council that Section 18 of the *Principles of*

Ethics should specify the recognized areas of specialty practice and their proper designations. The Board recommends, however, that the parenthetical phrase "(or pediatric dentistry)" be stricken. *The Board, therefore, recommends that Resolution 14 as amended be approved.*

14B. Resolved, that Section 18 of the *Principles of Ethics* be amended by the addition of a new paragraph following the first paragraph to read as follows:

The specialty areas of dentistry approved by the American Dental Association and the designation for ethical announcements of limitation of practice are:

Endodontics
Oral Pathology
Oral Surgery
(or Oral and Maxillofacial Surgery)
Orthodontics
Pedodontics
(or Dentistry for Children)
Periodontics
Prosthodontics
Dental Public Health

Moratorium on Enforcement of Advertising Restrictions: (p. 178/Resolution 15) The moratorium on enforcing the ADA Principle against advertising was recommended by the Council on Judicial Procedures, Constitution and Bylaws in May. The kind of advertising that is excepted from the moratorium and thus subject to discipline as an ethical violation is patterned on a similar approach by the American Bar Association. Since May, the Justice Department has sued the ABA on its advertising restrictions despite the ABA's efforts to confine discipline to clear solicitation devices.

Also, the AMA, in protesting the Federal Trade Commission action challenging AMA's restriction on advertising by physicians, has defined its restrictions to apply only to advertising that is clearly aimed at soliciting patients. This explanation by AMA did not satisfy FTC.

The point of this commentary is to set aside the notion that the Council on Judicial Procedures, Constitution and Bylaws' recommended moratorium will necessarily deter Justice and FTC from challenging ADA's Principle on advertising. The moratorium does serve two purposes in the Board's judgment: (1) It presents a good faith showing that the Association is willing to look at its Principle on advertising to see if it is serving its essential purpose, that is to prevent lowering professional standards and thus disserving the public; and (2) of more immediate importance the moratorium is intended to alert component and constituent societies that enforcement of restrictions on advertising against dentists who, for example, send unusual announcements to other dentists or against dentists whose names are listed as available to beneficiaries of a third party plan may lead to costly law suits without adequate defense—the Association has already had a costly experience with a case involving a dentist's unusual announcements and the Bar Association had similar costly losing experiences in cases against lawyers whose services were advertised by unions to members.

It should be emphasized that the provision of the ADA *Principles of Ethics* restricting advertising by dentists (Section 12) is confined to "the use of advertising in any form to solicit patients. . . ." The Council's recommended moratorium, therefore, is in essence a detailed statement of what is meant by "advertising *to solicit* patients."

It should be emphasized again that a dental society disciplinary penalty based on advertising that can not clearly be shown to be a device to solicit patients is extremely vulnerable to court challenge. Again, the case previously referred to, namely the Northern Virginia Dental Society's costly experience in the Golec case, is illustrative of this vulnerability. Therefore, *the Board recommends that Resolution 15 be approved.*

Legislation, Council on: (p. 182) The Board commends Dr. Paul W. Kunkel, Jr. for his service to the Council for the past six years.

Board Report on "Guidelines for Dentistry's Position in a National Health Program": At its August 1975 session, the Board requested Association agencies to submit to the Board at its August 1976 session recommendations for revising the ADA "Guidelines for Dentistry's Position in a National Health Program" to update them, principally to conform the Guidelines to ADA policies adopted since 1971 (*Trans.* 1975: 516). The Board has developed a proposed revision of the Guidelines from the agencies' recommendations. The Board has deferred action on the proposed revisions until its November 1976 session in Las Vegas. But to insure that the House of Delegates will also have an opportunity to review the proposed revision of the 1971 "Guidelines for Dentistry's Position in a National Health Program," the Board transmits them to the House with the 1971 Guidelines for comparison. The Board requested the President to appoint a House reference committee to review the Guidelines. The Guidelines and proposed revisions are on pages 438 and 439 of this volume.

Relief, Council on: (p. 200/Resolution 23) *The Board recommends approval of Resolution 23.*

Licensure, Commission on: (p. 244/Resolutions 25-32) *The Board of Trustees recommends approval of Resolutions 25-32.* However, the Board wishes to point out that Resolution 30 (p. 256) is inaccurately stated. The phrase "to develop a mechanism for issuing active and inactive licenses" has been inadvertently omitted between the words "urged" and "to enhance public protection"; the Commission's resolution to reflect the correction should read:

> 30. **Resolved,** that each constituent society, in consultation with its state board of dentistry, be urged to develop a mechanism for issuing active and inactive licenses to enhance public protection.

In reviewing the *Guidelines for Licensure* (p. 256), the Board directed that all references to "he," "him" or "user" be asterisked and footnoted to imply either gender.

In summation, the Board of Trustees extends its sincere appreciation to members of the Commission on Licensure for a job well done. When the Commission was established by the 1974 House of Delegates, few would have anticipated that such a comprehensive approach to licensure issues could have been developed in only two years. Also, the Commission on Licensure takes a unique place in Association history by recommending its own demise. Both in the progress made in studying licensure and in the recognition that the Association cannot support an ever increasing number of separate agencies, the Board finds the Commission's actions commendable. A reference committee on licensure is scheduled for the 1976 House of Delegates.

Audiovisual Services, Bureau of: (p. 259) The Board of Trustees commends the Bureau for its increased services to both the public and the profession as evidenced by the continuing increase in the film circulation. The Board took special note of the increase in film rentals and the increased television audience.

Dental Health Education, Bureau of: (p. 267) The Board of Trustees reviewed the Bureau's extensive and comprehensive report and noted that the Bureau has cooperated with the American Society for Geriatric Dentistry which has entered into a contract with the Division of Long Term Care, Department of Health, Education, and Welfare in developing a seminar program on oral health care for geriatric nursing home residents. The Board was pleased to learn of the liaison among all Association agencies, such as the Council on Hospital Dental Services, particularly in regard to institutional programs.

Economic Research and Statistics, Bureau of: (p. 277) The Board of Trustees studied the report of the Bureau, documenting its considerable range of activities and projects. Particular note was made of progress on the *Price Index of Cost of Conducting a Dental Practice,* the manpower research activities and the project concerning redistribution of dentists.

Board of Trustees Resolution 230 (Res. 896) to 1975 House of Delegates on Economic Barriers to Dental Care: (p. 280; *Trans.* 1975:674) The Board reviewed detailed reasons for the general conclusion of the Bureau of Economic Research and Statistics that it is not feasible for the Association to undertake an economic barrier study at this time. The Bureau's feasibility study was directed by the 1975 House of Delegates to be reported to the Board of Trustees.

It was noted that recent activities of the Department of Health, Education, and Welfare indicate a renewed interest in funding, on a competitive basis, a study to determine the impact of dental prepayment in terms of health and cost benefits and that Association staff is considering possible responses to this request for research proposals. This indication from the federal government that funding of this type of research is potentially available does not materially affect the general recommendation of the Bureau, since a separate effort by the Association alone would still be too costly, time-consuming and duplicative of efforts currently being accomplished through other sources.

One limitation of Bureau research is, of course, the availability of funds. The Board observes that within existing fiscal constraints the intent of the resolution can be met through close cooperation of the Bureau with outside agencies performing research in this area.

Economic Research and Statistics, Bureau of, Supplemental Report 1 on Price Index of Cost of Conducting a Dental Practice: (p. 284) The Board of Trustees reviewed with interest the Bureau's report which presents the *Index,* which it believes will be a significantly useful tool for the profession. The Board notes that information derived from the *Index* was used by President Shira in testimony on July 20 before the Federal Council on Wage and Price Stability and that it provided valuable documentation for the Association's position. The Board understands that the *Index* will need continuous evaluation and at least yearly updates to keep it current. Since there are several specific indices that constitute the *Index,* it is the opinion of the Board

that the measurement will reflect a realistic, precise and comprehensive picture of the actual cost of operating a dental practice. The thoroughness of developing the *Index,* as explained in the Appendix, demonstrates the degree of validity the Association can attach to its use. The Board of Trustees looks forward to revision and evaluation activities during 1977 since the 1977 *Survey of Dental Practice* will provide additional data for use in the *Index.*

Advance Planning, Committee on: In 1975 the House of Delegates passed a California Dental Association resolution (*Trans.* 1975:632) which requested the Board of Trustees to study the feasibility of creating an Office of Immediate Past President and reevaluating the function of the Offices of First and Second Vice Presidents. The 1975 House of Delegates also passed a resolution, which originated in the Ohio Dental Association (*Trans.* 1975:639) that requested the Board of Trustees to study the feasibility of extending the terms of the First and Second Vice Presidents. Both resolutions were referred to the Board of Trustees Committee on Advance Planning. The Committee studied all aspects of these offices and the Board of Trustees has accepted the Committee's recommendations and submits the following resolution in order to (1) establish the Office of Immediate Past President, (2) dissolve the Office of Second Vice President and (3) change the name of the Office of First Vice President to Vice President. Adoption of the following resolutions, which are recommended by the Board of Trustees, would accomplish these three purposes and, because they will require *Constitution* amendments, will have to "lay over" until the 1977 House of Delegates.

78. **Resolved,** that the office of Immediate Past President be created and that the Immediate Past President be given a vote on the Board of Trustees.

79. **Resolved,** that the office of Second Vice President be eliminated.

80. **Resolved,** that the office of First Vice President be changed to Vice President and that the Vice President serve for a term of one year with a vote.

The Committee also recommends, and the Board of Trustees concurs, that officers and trustees not serve as Council members or voting members of the House of Delegates. Therefore *the Board of Trustees submits the following resolution to the House of Delegates with the recommendation that it be approved.*

81. **Resolved,** that Chapter V, Section 10 of the *Bylaws* be amended by deleting the third and fourth sentences as follows:

> The elective and appointive officers and past trustees of this Association shall be *ex officio* members of the House of Delegates without the power to vote unless designated as delegates. The trustees shall not serve as delegates but shall be *ex officio* members of the House of Delegates without the power to vote.

and substituting therefor the following two sentences:

> The elective and appointive officers and the trustees of this Association shall be *ex officio* members of the House of Delegates without the power to vote. They shall not serve as delegates. Past presidents of this Association shall be *ex officio* members of the House of Delegates without the power to vote unless designated as delegates.

to make the amended section read:

> Section 10. Composition: The House of Delegates shall be limited to four hundred seventeen (417) voting members. It shall be composed of the officially certified delegates of each constituent society and one (1) officially certified delegate from each federal dental service which is not organized into a constituent society. The elective and appointive officers and the trustees of this Association shall be *ex officio* members of the House of Delegates without the power to vote. They shall not serve as delegates. Past presidents of this Association shall be *ex officio* members of the House of Delegates without the power to vote unless designated as delegates.

and be it further

Resolved, that Chapter IX, Section 20, be amended by addition of the following sentence after the second sentence in paragraph A:

> The elective and appointive officers and the trustees of the Association shall not serve as members of Councils.

to make the amended section read:

> Section 20. Members, Nominations and Elections:
>
> A. All councils, except as otherwise provided for in these *Bylaws* shall be composed of five (5) members. Nominations for all councils shall be made by the Board of Trustees. Additional nominations may be made by the House of Delegates unless otherwise provided for in these *Bylaws*. Members of councils shall be elected by the House of Delegates in accordance with Chapter V, Section 140. The elective and appointive officers and the trustees of this Association shall not serve as members of Councils.

Annual Session, Special Committee on: In February 1975, the Board of Trustees appointed a Special Committee to Study the Annual Session, with Dr. James Kerrigan of Washington, D.C., as chairman. This Committee has conducted an excellent evaluation of the overall annual session and has submitted a variety of recommendations, many of which are now in force and have been used to shape this 1976 annual session. The following recommendations have been approved by the Board of Trustees and are referred to the Standing Committee of the House on Rules and Order.

Recommendation 1: Nominations for officers should be scheduled for the first meeting of the House of Delegates on Sunday. Further nominations would still be in order on Wednesday.

Recommendation 2: If officer nominations take place on Sunday, candidates need not receive lengthy introductions at the caucuses but should simply be presented thereby saving considerable caucus time, and each candidate shall be notified of this recommendation.

Recommendation 3: Chairmen of caucuses should be encouraged to help curb excessive debate by members of their delegation on the floor of the House of Delegates.

Recommendation 4: An attempt should be made to limit the number of speakers from the podium and the length of speeches on matters not directly related to the immediate business of the House of Delegates.

Delta Dental Plans Association: (p. 349) The Board reviewed with interest the annual report of Delta Dental Plans Association and noted the progress of DDPA as described therein. The Board commends DDPA for its efforts during its first decade of existence to educate and influence the profession, the public and third party carriers on prepaid dental care. Especially noted was DDPA's modification of its definition of Reasonable Fee to incorporate a concept under which a "usual" fee exceeding the 90th percentile limitation on the "customary" fee range may be accepted.

Arkansas Resolution on Amendment of "Standards for Dental Prepayment Programs": (p. 361/Resolution 54) The Board reviewed with interest the resolution submitted by the Arkansas State Dental Association which would amend the *Standards for Dental Prepayment Programs* (revised November, 1974– *Trans.* 1974:639) by adding a statement to the effect that schedules of benefits be as uniform as possible, particularly within a single state.

The Board notes the inequities which are caused by the improper implementation of a multi-level table of allowance plan on a national basis. Further, it observes that reported inequities in several states since implementation of the telecommunications prepayment program in January 1976 are being pursued by the Council on Dental Care Programs. While the Board questions the appropriateness of placing in the *Standards for Dental Prepayment Programs* the profession's concerns regarding what is essentially an administrative problem, it considers the concerns themselves central to the Council on Dental Care Programs' responsibilities. The Council has advised that any additional information regarding its activities in this regard will be reported to the Board at its November 1976 meeting. *The Board recommends that Resolution 54 be transmitted to the House of Delegates with the recommendation that it be referred to the Council on Dental Care Programs for action and report back in 1977.*

California Resolution on Guidelines for Dental Directories: (p. 363/Resolution 55) The Board of Trustees recommends approval of Resolution 55.

California Resolution on Clarification of Terminology in Pedodontics: (p. 362/Resolution 56) The Board of Trustees reviewed Resolution 56 submitted by the California Dental Association which proposes to recognize "pediatric dentistry" as an ethical designation for those specializing in children's dentistry. The Board is opposed to three approved designations for children's dentistry. The Board recommends that Resolution 56 be referred to the Council on Judicial Procedures, Constitution and Bylaws with direction to consult with the officials of the children's dentistry group to decide upon two acceptable designations for the specialty. Existing ethical designations are "pedodontics" and "children's dentistry". One of these should be eliminated if "pediatric dentistry" is to become an ethical designation. *The Board, therefore, recommends that action on Resolution 56 be postponed until the November 1976 session of the Board of Trustees. In the interim the Board proposes that Resolution 56 be referred to the Council on Judicial Procedures, Constitution and Bylaws for appropriate action.*

California Resolution on Military Dependent Care: (p. 364/Resolution 57) The Board of Trustees recommends approval of Resolution 57.

California Resolution on Remote Status Designations for Military Installations (p. 365/Resolution 58) The Board of Trustees recommends approval of Resolution 58.

California Resolution on Professional Exemption from Antitrust Legislation: (p. 364/Resolution 59) *The Board of Trustees* believes that the Association should take a strong posture in reference to the Federal Trade Commission edicts which weaken the status of our profession and compromise the enforcement of our principles and codes of ethics and therefore *recommends that Resolution 59 be approved.*

District of Columbia Resolution on Complete Utilization of Dentists in the Treatment of Patients: (p. 367/Resolution 33) The Board encountered difficulty in interpreting the exact intent of Resolution 33 submitted by the District of Columbia. For example, it is not clear whether the phrase "in all dental programs" is meant to include private dental practice. After some discussion, the Board agreed that the resolution endorses full utilization of dentists. Since this position is consistent with the position included in the Council on Dental Education's Special Report on Dental Auxiliary Utilization and Education (p. 234) the Board is of the opinion that the resolution should be amended to clarify its intent. Accordingly, *the Board recommends that the following resolution, as amended, be approved.*

> 33B. Resolved, that the American Dental Association urges and endorses the fullest utilization of dentists, before delegation of expanded functions to auxiliaries in the treatment of patients.

Florida Resolution on Study of the Dentist in All His Relationships: (p. 368/Resolution 45) The Board of Trustees considered at length the resolution submitted by the Florida Dental Association directing the Association to determine the feasibility of undertaking a sociological, medical, behavioral and environmental research project to investigate suicide, divorce and other stress signs related to occupational conditions of dentists.

It notes that the Association is currently pursuing joint activities with the Department of Health, Education, and Welfare to determine the validity of the existing research on which reports regarding the purportedly "high" rates of these conditions are based. The Board believes that consideration of the validity of existing research is a necessary first step prior to any commitment to determine the feasibility of undertaking additional research.

The Board notes that the scope of the feasibility study itself is such that associated costs could well amount to $10,000 or more. The larger research project in terms of data availability, measurement tools, methods of gathering additional data and personnel would result in costs and manpower efforts beyond the current capacity of the Association. The Association will continue to work with other private and public agencies on validation of existing reports. These activities may lead to the possibility of feasibility studies with outside funding. The Association will also continue to encourage researchers in other institutions to investigate these topics. The Board, however, does not consider the feasibility study to be a practicable undertaking by the Association at this time because of the existing heavy commitments of Association funds and staff. Therefore, *the Board recommends that Resolution 45 be postponed indefinitely.*

Illinois Resolution on Amendment of Section 20 of "Principles of Ethics": (p. 368/Resolution 46) The Board noted that the Illinois resolution would change Section 20 of the ADA *Principles* to permit the use of an assumed name to identify a dental practice. The Board is aware that the House of Delegates at two recent annual sessions has declined to approve the use of assumed names as an ethical designation of a dental practice. The House of Delegates was concerned with the great difficulty of determining when an assumed name connotes superiority or is otherwise misleading in describing the character of a dental practice. The Board believes that the concern expressed by the House of Delegates is still valid. The Board believes further that the use of "Dr. Smith and Associates" or "Dr. Smith, Brown, Jones and Associates" is an adequate means of identifying a large partnership or group practice. *The Board, therefore, recommends that Resolution 46 be postponed indefinitely.*

Illinois Resolution on Classification of Dental Laboratory Technicians: (p. 369/Resolution 47) In considering Resolution 47 submitted by the Illinois State Dental Society requesting that the Association recognize only the dental laboratory technician actually employed in the dental office as an auxiliary, the Board noted that both the Councils on Dental Education and Dental Laboratory Relations bave considered this issue. Both Councils agree, as stated in their annual reports (pp. 102, 116) that regardless of employer, the functions performed by the dental laboratory technician assist the dentist in his provision of patient care. Therefore, individuals providing that service are correctly identified as auxiliary to the dental profession.

Although *the Board recommends that Resolution 47 be postponed indefinitely,* it will give priority to a comprehensive study of the profession's relationship with the dental laboratory industry.

Illinois Resolution on Publication and Distribution of Fee Surveys: (p. 370/Resolution 48) Resolution 48, submitted by the Illinois State Dental Society, would rescind policy to limit "publication and distribution of fee surveys" and have such data published in *The Journal of the American Dental Association.*

The questions raised by the resolution are most substantive and require careful consideration by the House.

There are many situations in which data derived from such fee surveys are useful to the profession when dealing with Congress, other agencies of government, third party carriers, and the public. Without such data, the Association and many of its constituent and component societies would be in a most disadvantageous position in negotiations, testimony and in responding to numerous inquiries and requests for current estimates of the cost of dental services.

Owing to recent court decisions and the assertion of new areas of jurisdiction by federal and state regulatory agencies which are detailed later in this report, it does not appear advisable at this time to restrict the availability of such information to Association agencies and to constituent societies. Thus, if the Association wishes to collect and utilize such data at all, it will be necessary to provide accessibility to those who request it. This will not, in fact, be a massive change in the practical order since, from one source or another, various parts of the information have surfaced publicly on a regular basis in national magazines and other mass media publications. Yet, by forbidding appropriate Association agencies and spokesmen to directly release the data and furnish comment that places it into proper context, the risk of partial and misleading information being circulated is and has been greatly increased.

The present policy, restricting not only fee information but overhead costs, has also inhibited the Association from taking the fullest possible advantage of opportunities of informing the public, and state and federal agencies, that the cost of operating a dental practice has increased markedly at the same time as fee increases to patients have been most moderate.

The profession can, of course, decide to choose the option of denying itself this information in order to deny it to anyone else. The Board is not prepared to recommend that option. The net effect—since there is substantial data-gathering activity going on by others—is that the profession will become an island of ignorance with respect to practice management factors relating to private dental practice or, at best, have to passively rely on examining at second hand the data that others decide to gather or publish. This, in the Board's opinion, puts the profession at an intolerable disadvantage in attempting to state its case for private practice, fee-for-service to the nation in a compelling and candid manner.

The Board dealt initially with this highly complex question at its March 1976 session when, as a provisional measure, it took the following action:

> **Resolved,** that the Board of Trustees considers that in the best interest of the Association the Association's 1975 fee survey data should not be published or distributed until such time as such fee survey data no longer present a substantial, potential risk or until the 1976 House of Delegates, fully aware of the potential legal risk, formulates clear and concise direction as to its distribution (p. 618).

The Board was later advised that, in discussions between the Association's house counsel and its outside counsel, Peter M. Sfikas, the current attitudes of the United States Supreme Court concerning fee schedules and surveys were probed, particularly as contained in the Court's statements in its opinion in the *Goldfarb vs Virginia State Bar and Fairfax County Bar Association* (1975) suit. The Court stated, in effect, that if it were shown that a fee schedule or survey was purely advisory and merely an exchange of fee information and not an actual restraint on trade, this would present the Court with a different question than was presented in *Goldfarb*. However, the Court then cited three of its past opinions, which more or less stand for the proposition that, where the exchange of price or fee information is such that it has demonstrable impact on the setting of prices or fees, there is a violation of the antitrust laws. This means that, to the extent fee survey data would have an effect on the fees ultimately charged by dentists, there probably would be a violation of the antitrust laws.

In effect, what professional societies, such as the American Dental Association, may safely do is distribute somewhat dated national fee data that sets forth summary statistics for each procedure listed. Such fee information probably would have little or no impact on fees which individual dentists would charge. The nearer that published fee survey data reflects current fees, in narrow ranges, that are generally being charged in given communities, the closer the disseminator for the profession veers toward becoming involved in an antitrust violation.

To illustrate the point, the United States Department of Justice on March 18, 1976 issued a clearance (a "railroad release") to the Maryland State Bar Association to publish the results of an economic survey conducted among lawyers in Maryland during the summer of 1975. The fact that the survey purported to present the past

experience of a broad segment of the members of the Maryland Bar on various economic aspects of the practice of law and presented figures on fees and income in terms of an average range led the Justice Department to declare that it did not intend to take criminal action against the Maryland Bar. However, the Justice Department went on to state that it still reserved the right to take antitrust action if it found that the results of the survey were used to create an unlawful restraint of trade.

Before publication hy the Association of even this type of fee data, serious consideration needs to be given to the revocation of Resolution 60-1972-H which was adopted by the 1972 House of Delegates, reading as follows:

> **Resolved**, that in 1973 the Association's Bureau of Economic Research and Statistics implement a fee and overhead cost survey, and that this survey be repeated at least every two years, and be it further
> **Resolved**, that reports of surveys on dental fees and office overhead costs be published as monograph reports, rather than published in *The Journal* and then distribution of these reports be limited to members through constituent societies and to others when in the best interest of the Association.

The wider that fee data is distributed, the less danger there is of exposure to an antitrust complaint or indictment. A restriction on the publication could give rise to a suspicion that the membership intends using the data for less than pure purposes. Therefore, if the decision is made to publish information, such should be published in *The Journal of the American Dental Association* and then be freely made available to any member of the public.

In order to meet these various exigencies, the Board is recommending a substitute resolution to Resolution 48. It will, in the Board's view, fully meet the objectives of Resolution 48. The substitute resolution would accomplish the following purposes:

> —it will preserve the profession's ability to deal with economic data in an appropriate way in order to maintain dentistry's ability to speak out persuasively to the public about all aspects of private dental practice;
> —it will allow others equal access to the same information as is received by the public in a format, through direct report by the Association's Bureau of Economic Research and Statistics, that will permit the profession to place the matter in the fullest context;
> —it will separate the question of overhead costs and fee information and, by permitting speedy publication of data on overhead costs, materially aid the profession to make its case to the public about the notable, voluntary restraint individual dentists have exercised with respect to fees.

With these considerations in mind, *the Board of Trustees recommends that the following resolution be substituted for Resolution 48 and transmitted to the House of Delegates with the recommendation that it be approved:*

> **48B. Resolved**, that Resolution 60-1972-H adopted by the 1972 House of Delegates (*Trans.* 1972:680), concerning the conducting of fee and overhead cost surveys and restricting the publication of such data, is hereby revoked, and be it further

Resolved, that the 1975 fee survey data collected by the Association's Bureau of Economic Research and Statistics be published for historical information purposes only, showing national fee summary statistics for given dental procedures, as soon as feasible, in *The Journal of the American Dental Association* and thereafter be distributed to anyone on request, and be it further

Resolved, that the Association's Bureau of Economic Research and Statistics conduct fee and overhead cost surveys in 1977 and every two years thereafter, and be it further

Resolved, that the results of the overhead cost surveys be published in *The Journal of the American Dental Association* as soon as completed and thereafter be distributed to anyone on request, and be it further

Resolved, that the results of the 1977 and subsequent fee surveys be published in *The Journal of the American Dental Association* not earlier than one year after such data has been gathered for historical informational purposes only, showing only national fee summary statistics for given dental procedures, and then be distributed to anyone on request.

Indiana Resolution Commending Dr. Lloyd J. Phillips: (p. 371/Resolution 49) The Board of Trustees warmly joins with the Indiana Dental Association in saluting Dr. Lloyd J. Phillips and his outstanding service to the dental profession. *The Board of Trustees takes great pleasure in transmitting Resolution 49 to the House of Delegates with the recommendation that it be approved.*

Louisiana Resolution on Reaffirmation of Section 12 of "Principles of Ethics": (p. 374/Resolution 50) The Board of Trustees calls attention to Resolution 15 (p. 178) recommending a one year moratorium on enforcing Section 12 of the ADA *Principles of Ethics* against advertising except advertising designed to solicit patients. The Board has recommended approval of Resolution 15. The Louisiana resolution (Resolution 50) proposes reaffirmation of Section 12 of the ADA *Principles*. Since Section 12 is confined to advertising designed to solicit patients, *the Board recommends that Resolution 50 be approved.*

New Jersey Resolution on Amendment of "Bylaws" on Scientific Session: (p. 378/Resolution 34) and Rhode Island Resolution on Amendment of "Bylaws" on Scientific Session: (p. 385/Resolution 38) Since the resolution from the New Jersey Dental Association (p. 378) and the Rhode Island Dental Association (p. 385) are identical, the Board of Trustees considered them simultaneously. In its deliberations the Board of Trustees also considered a report from the Council on Scientific Session which stated that the Council opposes the creation of a new section on Oral Medicine. The Council points out, and the Board of Trustees concurs, that Oral Medicine touches virtually all of the 14 existing sections. It was noted by the Council that the objectives of the American Academy of Oral Medicine are:

> Oral Medicine is that area of special competence in the field of dentistry, relating to the management of the total health of the patient, which is concerned with the diagnosis and nonsurgical treatment of primary and secondary disease involving the oral and paraoral structures.

This subject matter is adequately covered by the existing sections and therefore *the Board of Trustees recommends that Resolutions 34 and 38 be postponed indefinitely.*

New York Resolution on Amendment of ADA "Standards for Dental Prepayment Programs": (p. 379/Resolution 35) The Board evaluated Resolution 35 submitted by The Dental Society of the State of New York calling for amendment of the *Standards for Dental Prepayment Programs* (revised November 1974—*Trans.* 1974:639) to consider as disadvantageous differentials in levels of reimbursement based on participating and non-participating classifications of dentists. The Board is persuaded by the reasoning of the Council on Dental Care Programs as expressed in Supplemental Report 3 (p. 57) that some reimbursement differential is justified because of the services provided by the participating dentist and the obligations he accepts. Therefore, *it is the Board's recommendation that Resolution 35 be postponed indefinitely.*

New York Resolution on Termination of TEAM Program: (p. 380/Resolution 36) The Board reviewed Resolution 36 which urges that the TEAM program be discontinued and that no further funding of this program occur. In considering the background material presented with the New York State resolution, it became clear to the Board that there still remains some confusion regarding the intent and purpose of the TEAM program and its byproduct development of expanded function auxiliaries. In order to clarify this matter for the House of Delegates, the Board offers this explanation to the House of Delegates.

The TEAM program refers *exclusively* to the training of *dentists* to deal effectively in the management of expanded function auxiliaries. The only principle upon which the program is based is that there is a need to acquaint graduating dental students with an ability to develop and manage a dental health care team that is appropriate for the type of practice, the type of auxiliaries utilized and the relevant legal restraints and requirements of dental practice. The goals of the program require that dental students, upon completion of the training, are able to: (1) demonstrate the ability to delegate duties commensurate with the skills of their auxiliaries and to insure the quality of their clinical performance and products; (2) demonstrate skills in personnel management; (3) demonstrate those skills and office management which relate to operating a TEAM practice; and (4) demonstrate an understanding of the basic principles of facilities and equipment design which are necessary for the implementation of TEAM dentistry in a private practice setting.

The TEAM program is *not* experimental and does not train for external practice purposes, expanded function auxiliaries. Every TEAM grant, however, contains *limited* grant monies which may be used to train auxiliaries in expanded functions to the extent that those auxiliaries are needed to function exclusively in the TEAM program. The program does not repeat the training of expanded function auxiliaries for the external work force.

Since dental education programs have an obligation to provide the best education possible for its potential graduates, and since the issue of greater utilization of auxiliaries has clearly been the direction in which dentistry has been moving it is incumbent upon the educational programs to provide a good education for graduates and the management of these auxiliaries. One of the greatest shortcomings of traditional dental education programs has been the aspects of practice management and the provision of an educational experience which would allow a recent dental graduate to feel comfortable in managing an effective and productive practice. Although the Board is aware of expressed abuses associated with the TEAM program, it believes that this program provides a valuable learning experience for students in managing dental auxiliaries.

The Board believes that although the Association supports the principle that dentists and their auxiliaries must perform services that are consistent with dental practice acts, the Association believes that dental education programs must still provide an adequate educational experience to insure the future practice potential of its graduates.

In considering the resolution, the Board concluded that it would be desirable to obtain basic information regarding training programs that teach expanded functions and noted that the Council on Dental Education, in the development of its comprehensive statement on the utilization of dental auxiliaries, prepared a compilation of information on research and experimental programs. The Board is of the opinion that additionally compiled information on other programs that deal with expanded functions would be helpful and informative. Therefore, the Board recommends that Resolution 36 submitted by the State of New York be divided. The Board does not believe that it is in the best interests of the profession or dental education to oppose TEAM programs and also recognizes that it has been Association policy since 1971 (*Trans.* 1971:500) to support dental schools in encouraging the expansion of this program.

The House also should be aware that Resolution 36a is defective in that the Association cannot terminate what it does not control, namely TEAM programs. Therefore, *the Board divides the resolution and recommends that the first resolving clause of Resolution 36 be postponed indefinitely.*

> **36aB. Resolved,** that all TEAM experimental programs and their financial support be terminated upon the expiration of existing contracts or grants.

In support of the contention that information regarding educational programs in expanded functions would be helpful, *the Board recommends that the second resolving clause in Resolution 36 be amended to provide clarity and transmitted to the House of Delegates with the recommendation that it be approved.*

> **36bB. Resolved,** that the results and conclusions of all TEAM and other expanded function auxiliary training programs be collected and collated by the ADA Council on Dental Education for distribution to all state boards for dentistry and all state dental societies for additional consideration and recommendations relative to implementation.

Oregon Resolution on Engagement of Actuary for ADA Insurance Programs: (p. 384/ Resolution 37) The Board has reviewed Resolution 37 submitted by the Oregon Dental Association recommending that the Association be directed to engage an independent actuary who is a Fellow of the Society of Actuaries to review the experience of the sponsored life, disability and health programs and, in addition, to engage an independent actuary who is a Fellow of the Casualty Actuarial Society, to review experience of the sponsored liability program. The Board is in agreement with the Oregon Dental Association that ADA insurance programs need to receive continuous and critical evaluation. This evaluation is an ongoing process by the Council on Insurance. The Association renegotiated the disability contract effective November 1975. In the negotiation process, the Association utilized the services of Marsh & McLennan, the administrator of the programs, and the actuarial resources available in that company. The results of that study were carefully analyzed by the Council. The result is a markedly improved contract.

The Council on Insurance has maintained similar vigilance in all other Association-sponsored insurance programs. The Council on Insurance, when it deems necessary, can request of the Board an independent actuarial study of any programs sponsored by the Association. In the past the Council on Insurance has made this request of the Board with subsequent approval. Therefore, while the Board recognizes the need for constant critical evaluation of Association-sponsored insurance programs, *it recommends that for the above-stated reasons Resolution 37 submitted by the Oregon Dental Association be postponed indefinitely.*

Pennsylvania Resolution on Identification of Dental Procedures by Scientific Term: (p. 385/Resolution 51) The Board examined Resolution 51 submitted by the Pennsylvania Dental Association which calls for all dental procedures to be identified by a strictly scientific term and that proprietary terms such as the manufacturers' trade names, personalized description and the like shall not be used to determine or identify a treatment or procedure or method of payment. The Board noted that no background material was furnished. Because an individual or manufacturer can secure a registered trademark without ADA approval and because some techniques, types of treatment and procedures are identified only by the originator's name it would not be possible to enforce such a resolution. In addition, the passage of such a resolution may have legal implications. However, the Board recommends the fullest use of the *ADA Procedure Code and Nomenclature.* Therefore, *the Board recommends that Resolution 51 be postponed indefinitely.*

Texas Resolution on Involvement of ADA Delegates with Third Party Programs: (p. 385/Resolution 52) In considering Resolution 52 from the Texas Dental Association to exclude dentists employed by third party companies from eligibility for election to the House of Delegates, the Board was concerned over a series of precedents that could potentially be set that would not, in the long view, be necessarily beneficial to Association members.

The resolution would, first of all, limit the freedom of judgment now exercised by component and constituent societies in deciding who they wish to elect to the Association's House of Delegates. It would, secondly, create a new and lesser class of membership of dentists who would otherwise be entitled to a fully privileged status. Finally, it makes a categorical and a prior judgment about the objectivity and sense of professional concern of a group of dentists based solely on their occupation. It sweepingly excludes them from participation in the Association's policy-making body not only on matters related to their occupation but on all matters. On the same basis, dentists who are educators or who are engaged in research could be excluded from the House because it takes up matters related to those subject areas or dentists who are members of the military could be excluded because the House deals with military dentistry from time to time.

The history of the House of Delegates, in the Board's view, makes clear that members listen carefully to the substance of debate and make judgments based on the soundness and pertinence of the arguments, not on the way in which the member offering those arguments makes his living. The Board believes, further, that it is in the best interests of the profession and the Association for component and constituent societies to continue to have as wide a latitude as possible in deciding who they wish to send to each meeting of the House . It is confident that the House, in the future, will deal responsibly with all questions and will continue to resolve matters based on

the merit of the positions expressed. Consequently, *the Board recommends that Resolution 52 be postponed indefinitely.*

Texas Resolution on Nomination for Offices of the ADA: (p. 386/Resolution 53) The Board of Trustees has been informed that the House Committee on Rules and Order will be considering an amendment to the "Rules of the House of Delegates" which would place nominations in the first meeting of the House of Delegates on Sunday. The Board supports this change. The Board commends the Texas Dental Association for its introduction of Resolution 53 but, since it would be superseded by the resolution of the House Committee on Rules and Order, *recommends that Resolution 53 be postponed indefinitely.*

Washington Resolution on Introduction of New Business in House of Delegates: (p. 386/Resolution 39) The Board of Trustees has reviewed Resolution 39 and strongly supports its intent and commends the Washington State Dental Association for submitting it. However, the Board believes that the resolution is too restrictive. If it were passed as written, it would cut off resolutions from several state dental societies which meet within 30 days of the annual session, and from caucuses which meet in the week prior to the annual session. The Board of Trustees is informed that the House Committee on Rules and Order will give consideration to amending the "Rules of the House of Delegates" so as to cut off introduction of new business at the close of the first meeting of the House of Delegates on Sunday afternoon. The Board of Trustees supports such a move, assuming that there will be some exception made, perhaps based on a three-fourths vote of the House of Delegates, for the introduction of new, urgent business following this cutoff time. Therefore, *the Board of Trustees recommends that Washington State Dental Association Resolution 39 be postponed indefinitely.*

Washington Resolution on Policy on Functions of Dental Auxiliaries: (p. 388/Resolution 40) The Board reviewed the background information accompanying Resolution 40 which requests amendment of Resolution 861, adopted by the 1975 House of Delegates, relating to the issue of auxiliary utilization and allowable expanded functions (*Trans.* 1975:701). The Board believes that the Council on Dental Education, in the preparation of its comprehensive report on auxiliary utilization, education and training, adequately considered the issue suggested by the Washington State Dental Association.

Although the Board concurs with the Washington State Dental Association's suggested revision of existing policy, it believes that the Council's comprehensive report on auxiliary utilization provides a preferable approach to establishing Association policy in this area. Further, it believes that the comprehensive statement of auxiliary utilization being proposed by the Council, while consistent with the intent of the Washington State resolution, is preferable to the approval of individual isolated policy resolutions. Therefore, *the Board recommends that Resolution 40 be postponed indefinitely.*

Washington Resolution on Position Statement on Advertising: (p. 389/Resolution 41) In the Board's consideration of Resolution 41 which has been submitted by the Washington State Dental Association, calling for the development of a position statement informing legislative and administrative agencies and the public of the

reasons why ethical dentists do not advertise, the Board was aware of the Federal Trade Commission's action against the American Medical Association, the United States Justice Department suit against the American Bar Association, the United States Supreme Court decision in the spring of 1976 finding that state boards of pharmacy could not proscribe the advertising of prescription drug prices by pharmacies, the threatened antitrust suit by the Arizona Attorney General concerning the advertising prohibitions contained in the ADA's "Principles of Ethics," and the clamor by consumer groups for the unfettered privilege of advertising by all professionals. In addition, the Board was also mindful that the Association's Council on Judicial Procedures, Constitution and Bylaws has recommended a moratorium against disciplinary actions involving advertising by dentists except advertising designed to solicit patients and that the Association's Executive Director has appointed a staff committee to develop recommendations to the Board of Trustees at its November 1976 session for possible consideration by the 1976 House of Delegates concerning the issuance of local dental directories by either component and constituent societies or consumer groups with the cooperation of such dental societies. Further, the Board just learned that two Arizona attorneys who placed blatant advertisements respecting their services in the public press recently were censured by the Arizona Supreme Court instead of having their licenses to practice suspended for two years as recommended by the Arizona Bar Association. Justice Rehnquist of the United States Supreme Court has stayed the censure, pending a decision by the United States Supreme Court whether or not to hear the matter. In this setting, the Board believes that the Washington State Dental Association resolution, if adopted, could be construed, because of its vigorous language, as a defiant challenge to enforcement agencies such as the FTC and the Justice Department. Therefore, *the Board recommends that the following resolution be transmitted to the House of Delegates with the recommendation that it be substituted for Washington State Dental Association Resolution 41 and then be adopted.*

> 41B. Resolved, that the Board of Trustees develop a national policy position on advertising by dentists.

Wisconsin Resolution on Reconsideration of 1974 Resolution 43 Regarding Modification of Membership Card: (p. 389/Resolution 42; *Trans.* 1974:603) The Board has reviewed Resolution 42 submitted by the Wisconsin Dental Association requesting that the House of Delegates approve the issuance of a standard-sized, multipurpose plastic membership card. The submitter contends that such a card would expedite registration at dental meetings and would accurately identify and record the attendance of members at continuing dental educational courses.

The 1974 House of Delegates referred the possible issuance of such a card to the Board of Trustees for study and implementation if feasible. The Board, among other reasons, learned at that time that the start-up costs to furnish a plastic membership card to each active, life and retired member would be as follows:

Cost of cards for 106,000 active, life and retired members @ 20¢ ea.	$21,200
Annual average of 24,000 address changes and new members	7,200

Postage (assuming bulk shipment to constituent dental societies)	2,000
Minimum of 600 imprinters @ $50 ea.	30,000
	$60,400

Wisconsin contends that these figures are in gross error. However, the Board understands that Wisconsin is actually talking about a five-line card while the ADA is required to issue a seven-line card, the additional two lines stating the member's constituent and component societies. Wisconsin's contemplated five-line card would cost 12¢ and the ADA's seven-line card 20¢. While the Board is unaware of any other estimated specific differences in cost projections, the Board was advised that the Association's Continuing Education Registry currently uses a prepunched IBM card and that the conversion from IBM to the plastic card would be a significant additional cost.

The Board, to set the record straight, points out that the 1975 Reference Committee on Budget and Administrative Matters had no resolution before it but merely the Board's informational report in which the Reference Committee concurred (*Trans.* 1975:644).

The Board notes that Wisconsin Resolution 42 is parliamentarily incorrect when it calls for reconsideration of a resolution that was acted on by a previous House of Delegates. The Board believes that it again could look into the feasibility of issuing a plastic membership card.

Therefore, *the Board recommends that the following resolution be transmitted to the House of Delegates with the recommendation that it be substituted for Wisconsin Resolution 42 and then be approved.*

> 42B. Resolved, that the Board of Trustees study the feasibility of issuing each active, life and retired member a plastic membership card and, if practicable, arrange for the issuance of such cards commencing in 1978.

Wisconsin Resolution on Redevelopment of Conference on Expanded Duties of Dental Auxiliaries: (p. 390/Resolution 43) In considering this resolution, the Board referred to the comprehensive report on dental auxiliary utilization and education submitted by the Council on Dental Education and specifically information on workshop participation. The Board believes that allocation of invitations for the workshop conformed to the 1975 House dictate that the majority of participants be full-time practicing dentists who utilize dental auxiliaries. Preregistration indicated that the mandate would be met. However, because a significant number of constituent society and state board representatives did not show, the final registration fell just short of a majority representation of full-time practicing dentists. The Board wishes to point out that 12 constituent societies and 23 state boards of dentistry did not participate in the workshop.

The Board believes that the Council was right in utilizing results of the workshop as one resource in developing its report to the House. A workshop is not a legislative body but provides opportunity for discussion of opinions on specific subjects. In the Board's opinion, no group represented at the workshop had undue influence on the report which is being submitted to the House. Further, the Board believes that it is not in the best interest of the Association to challenge the usefulness of the workshop. The Council's report should be considered on the basis of its merits irrespective of

the issue of workshop participation. Therefore, *the Board recommends that Resolution 43 be postponed indefinitely.*

Thirteenth Trustee District Resolution on Amendment of "Bylaws" on Disciplinary Penalties: (p. 418/Resolution 60) The Board of Trustees recommends that Resolution 60 be approved.

Delegate Paul J. McKenna (Mass.) Resolution on Amendment to Section 15 of "Principles of Ethics" on Use of Professional Titles and Degrees: (p. 434/Resolution 61) The Board examined Resolution 61 submitted by Delegate Paul J. McKenna, Massachusetts, and agrees with the principle of Dr. McKenna's resolution, namely, to permit use of earned degrees on letterheads, cards and other acceptable professional identification mechanisms. But the Board disagrees with Dr. McKenna's limitation to earned degrees "in health service areas." The Board believes that the privilege to use earned degrees should not be limited. The Board therefore recommends that Resolution 61 be amended by substituting "earned" for "additional advanced" wherever that phrase appears and by striking "earned in health service areas" wherever that phrase appears so that the Board's amended Resolution 61B will read as follows:

> 61B. Resolved, that Section 15 of the ADA *Principles of Ethics* be amended by inserting the words "any earned academic degrees" after the words "or D.M.D."; by deleting the words "a dentist who also possesses a medical degree may use this degree in connection with his name on cards, letterheads, office door signs and announcements"; and by deleting the words "if such usage is consistent with the custom of dentists of the community" to make the amended Section 15 read as follows:
>
> > **Use of Professional Titles and Degrees.** A dentist may use the titles or degrees, Doctor, Dentist, D.D.S. or D.M.D., and any earned academic degrees. A dentist who has been certified by a national certifying board for one of the specialties approved by the American Dental Association may use the title "diplomate" in connection with his specialty on his cards, letterheads and announcements. A dentist may not use his title or degree in connection with the promotion of any commercial endeavor.
> >
> > The use of eponyms in connection with drugs, agents, instruments or appliances is generally to be discouraged.

The Board recommends approval of Resolution 61B.

Odontological Society of Western Pennsylvania Resolution 79 to 1975 House of Delegates on Amendment of "Bylaws" on Dues of Members Elected After October 1: (Resolution 79-1975; *Trans.* 1975:629) The Board reviewed Resolution 79 which was introduced by the Odontological Society of Western Pennsylvania and received by the 1975 House of Delegates, proposing a bylaw amendment changing the dues obligation for active members joining after October 1. Since this Resolution 79, if adopted, would change the dues of some active members, the Speaker of the House referred it to the 1976 House for action.

As the Board of Trustees was advised at its December 1975 session, the submitter of Resolution 79 stated in support of the resolution that some prospective applicants in the latter quarter of the year choose to delay joining until the beginning of the fol-

lowing year rather than pay out one-half year's dues for less than a quarter of a year's active membership privileges (*Trans.* 1975:574). The submitter contended that, as a consequence, recruitment activities are hindered and young dentists are thus kept "from enrolling in the various insurance programs available."

Therefore, *the Board recommends that Odontological Society of Western Pennsylvania Resolution 79 to 1975 House of Delegates be transmitted to the House of Delegates with the recommendation that it be adopted.*

> 79-1975. Resolved, that Chapter I. Membership, Section 50, Dues and Reinstatements, Subsection H, Members Elected After July 1, be amended by adding the words "and October 1" to the subsection heading and by inserting after the words "current year's dues" in line 310* the words and punctuation, "; and who are elected after October 1, shall pay one-quarter (¼) of the current year's dues;" so that the subsection will read:
>
> > H. Members Elected After July 1 and October 1. Active members elected to active membership in this Association for the first time, and who are elected after July 1, shall pay one-half (½) of the current year's dues; and who are elected after October 1, shall pay one-quarter (¼) of the current year's dues; except that a student member, upon his classification as an active member by a constituent society shall pay no further dues for the remainder of the calendar year in which he was entitled to the benefits of student membership.

Board of Trustees Resolution 82 on Amendment of "Bylaws" on Composition of House of Delegates: The Board of Trustees recommends the *Bylaws* be changed to grant voting privileges to the American Student Dental Association representative to the American Dental Association House of Delegates. The Board takes notice of the fact that there are currently 14,952 members in the ASDA. This represents a significant number of future ADA members. The future leadership of the ADA is in the hands of these student members. The student consultants to the various councils have made significant contributions to these councils. Therefore, *the Board recommends that the following resolution be transmitted to the House of Delegates with the recommendation that it be adopted.*

> 82. Resolved, that Chapter V, House of Delegates of the *Bylaws* be amended as follows:
>
> I. Amend the first sentence of Section 10 by substituting the number "four hundred eighteen (418)" for the number "four hundred seventeen (417)" to make the amended sentence read as follows:
>
> > The House of Delegates shall be limited to four hundred eighteen (418) voting members.
>
> II. Delete the second sentence of Section 10 and substitute therefor the following:
>
> > It shall be composed of the officially certified delegates of each constituent society, one (1) officially certified delegate from each federal dental service which is not organized into a constituent society, and one (1) student member of the American

*Editorially corrected from reference to "line 303" to reference to "line 310" as a consequence of the revised edition of January 1, 1976, of the *Constitution and Bylaws*.

Dental Association who is an officially certified delegate from the American Student Dental Association.

III. Delete the first sentence of Section 20 and substitute therefor the following:

The secretary of each constituent society, the ranking administrative officer of each federal dental service, and the secretary of the American Student Dental Association shall file with the Executive Director of this Association, at least sixty (60) days prior to the first day of the annual session of the House of Delegates, the names of the delegates and alternate delegates designated by his society, service or association.

Board of Trustees Resolution 83 on Recision of Res. 24-1972-H on Publication of Business Referred to Councils by House of Delegates: (*Trans.* 1972:620) The Board considered at some length the recommendation of the Executive Director that the general membership be in some manner informed of important issues that have been referred by the House of Delegates for study and report back to a subsequent session of the House. The Board noted that the 1972 House of Delegates adopted the following restrictive resolution:

Resolved, that all business referred to councils or other agencies of the ADA by the House of Delegates, with explicit instruction to be returned to a future meeting of the House, be submitted back to the House before implementation or publication outside of the officers, Board of Trustees, delegates and alternate delegates of the Association and officers of constituent societies.

and recommends that the prohibition against publication be somewhat relaxed. The Board recommends that, after a matter has been reported back to the House, for example, through promulgation in an issue of *Annual Reports and Resolutions,* the Board of Trustees then be given permission to authorize publication, using its discretion, in reports or articles directed to other interested parties, particularly the general membership. Therefore, *the Board recommends that the following resolution be transmitted to the House of Delegates with the recommendation that it be adopted:*

83. **Resolved,** that Resolution 24-1972-H, adopted by the 1972 House of Delegates (*Trans.* 1972:620) be rescinded, and be it further
Resolved, that all business referred to councils or other agencies of the ADA by the House of Delegates, with explicit instructions to be returned to a future meeting of the House, be submitted back to the House before implementation and that publication outside the officers, Board of Trustees, delegates and alternate delegates of the Association and officers of constituent societies be left to the discretion of the Board of Trustees.

Board of Trustees Resolution 84 on Veterans Administration Reimbursement Arrangements: The Board of Trustees noted the Council's concern that V. A. reimbursement arrangements reflect accurate and timely data on usual and customary fees in each state. Therefore, *the Board submits the following resolution to give appropriate emphasis to this concern and recommends that it be approved.*

84. **Resolved,** that the ADA encourage the Veterans Administration to improve its efforts to obtain timely and accurate data on the cost of dental services in

states and localities before entering negotiations on reimbursement arrangements with constituent dental associations.

Board of Trustees Resolution 85 on Amendment of Res. 53-1953-H on Dental Services in Veterans Administration Hospitals: A major revision of the Veterans Administration health care program is proposed in pending legislation. One provision would authorize dental care for veterans with conditions that aggravate medical conditions regardless of the basis for the veteran's admission to a V. A. hospital or domiciliary institution. Existing policy approves such care only where the veteran is admitted for a "service-connected" condition. *The Board recommends that veterans admitted for either service connected or non-service connected medical conditions be entitled to receive dental care for conditions aggravating a medical condition.*

85. **Resolved,** that the third resolving clause of Resolution 53-1953-H (*Trans.* 1953:232) be amended to strike "service-connected" wherever it appears, the amended resolution to read as follows:

> **Resolved,** that nothing in this statement of policy should be construed to apply to the present system for providing dental services in Veterans Administration hospitals and domiciliary institutions or to the present system for providing outpatient dental care (1) to veterans whose dental conditions have been professionally determined to be aggravating a medical condition; and (2) to veterans whose conditions have been determined to be disabling and compensable.

Board of Trustees Resolution 86 on Veterans Administration Emergency Outpatient Care for Non-Service Connected Dental Conditions: A second provision of the pending V. A. bill would authorize emergency dental care on an outpatient basis. The Board of Trustees believes that a veteran faced with a dental condition requiring emergency treatment should be entitled to V. A. outpatient dental services necessary for relief of pain and control of infection. To support this position, *the Board submits the following resolution and recommends that it be approved:*

86. **Resolved,** that the Association encourage the Veterans Administration to approve the following extension of dental benefits by the Veterans Administration: emergency outpatient dental care for a non-service-connected dental condition but only to the extent required to relieve pain and/or control infection. Major restorations, therapy or prostheses would not be included.

APPENDIX

AFTER CARE GUIDELINES: FULL DENTURES

Introduction: Changes in the environment of dental practice underline the necessity for the dental profession to continue its concern for denture practice and, moreover, to demonstrate continued concern for this portion of the potential patient population. An increasing proportion of the population will be in the age category likely to need full or partial dentures, and the extension of third party programs suggests that more patients will be able to obtain more comprehensive care through lowering of financial obstacles. Other pertinent changes in the socioeconomic background of practice are the demands of third parties and consumer advocates for the health professions to demonstrate and maintain their accountability for such costly and irreversible procedures as provision of

dentures. Accordingly, to underline the profession's continued concern for the after care of denture patients, the following guidelines are presented:

1. The dentist should recognize that successful after care and denture satisfaction begin with the initial contact between dentist and patient and continue through the entire process of constructing and fitting the dentures. Acknowledging the limitations of denture therapy, the dentist should impart only realistic expectations to the patient and be willing to seek aid from other professionals as necessary.

2. The patient must be prepared for a period of adjustment and should be informed of potential problems that are normal and to be expected, such as bulkiness, slight change in appearance, increased saliva flow, minor speech difficulties, and a period of decreased masticatory efficiency.

3. The dentist or auxiliary should instruct the patient on home care; e.g., removing the appliance for a few hours during each 24 hour period, cleaning and massaging the oral tissues, and rinsing the mouth. Instruction should cover cleaning, brushing and storage of the appliance.

4. The patient should be warned against self-adjustment or self-relining of the denture and should be informed of the prospective need for fitting adjustments in the dental office. The dentist will make these adjustments if necessary.

5. The patient should be instructed regarding any changes in eating habits necessitated by the dentures.

6. A sequence of recall visits should be outlined for the patient, including regular visits during the adjustment period, followed by periodic recall as deemed advisable by the dentist. The need for continuing dental attention should be emphasized.

7. A major priority of the recall visit should be examination of the oral tissues for clinical signs of change, including changes that might affect denture fit. The dentist should be alert for pathological changes in the oral tissues, including pre-cancerous and cancerous lesions.

8. Continuing recall appointments should reinforce past instruction on continuing oral hygiene and care of dentures. The patient should be encouraged to note possible signs of difficulty and to return to the dental office for examination of oral tissues.

AFTER CARE GUIDELINES: REMOVABLE PARTIAL DENTURES

1. The dentist should recognize that successful after care and partial removable denture satisfaction begin with the initial contact between dentist and patient and continue through the entire process of constructing and fitting the appliance. Acknowledging the limitations of partial removable denture therapy, the dentist should impart only realistic expectations to the patient and be willing to seek aid from other professionals as necessary.

2. Proper maintenance of the appliance and of supporting structures is imperative for successful partial denture treatment. Particular emphasis must be given to abutment teeth.

3. The dentist or auxiliary should instruct the patient on home care; e.g., removing the appliance for a few hours during each 24 hour period, cleaning and massaging the oral tissues, and rinsing the mouth. Instruction should cover cleaning, brushing, and storage of the appliance.

4. The patient should be warned against self-adjustment or self-relining of the denture and should be informed of the prospective need for fitting adjustments in the dental office. The dentist will make these adjustments if necessary.

5. The patient should be instructed regarding any changes in eating habits necessitated by the appliance.

6. A sequence of recall visits should be outlined for the patient, including regaular visits during the adjustment period, followed by periodic recall as deemed advisable by the dentist. The need for continuing dental attention should be emphasized.

7. A major priority of the recall visit should be examination of the oral tissues for clinical signs of change, including changes that might effect denture fit. The dentist should be alert for pathological changes in the oral tissues, including pre-cancerous and cancerous lesions.

8. Continuing recall appointments should reinforce past instruction on continuing oral hygiene and care of the appliance. The patient should be encouraged to note possible signs of difficulty and to return to the dental office for examination of oral tissues.

Sppplemental Material

The dentist should examine recall patients who have received full or partial removable dentures for the following:

1. Oral cancer and pre-cancerous lesions
2. Periodontal condition of remaining teeth
3. Changes in edentulous areas
4. Muscle changes
5. Maxillomandibular changes
6. Temporomandibular changes
7. Occlusal changes
8. Caries
9. Condition of the prosthesis

Each recall examination also should include a review of preventive measures for oral health.

REPORT 3 OF BOARD OF TRUSTEES TO HOUSE OF DELEGATES: FINANCIAL AFFAIRS AND RECOMMENDED BUDGET FOR FISCAL YEAR 1977

Introduction: The Board of Trustees, in accordance with its duties assigned under the *Bylaws,* presents Board Report 3 on Financial Affairs and the Recommended Budget for 1977.

Review of Financial Operations for 1975: The Association's income for 1975 reached $15,075,721, an increase of $451,421 over the approved budget of $14,624,300. The largest increases in income were from Membership Dues $80,191, Underwriting Income $99,608, Subscription Income $110,163 and Testing Fees $98,099. A corresponding decrease is reflected from Advertising Income amounting to $153,095. Expenses and nonoperating disbursements, excluding depreciation, in 1975 were $14,418,258, resulting in a surplus of $657,463. This surplus was $632,813 greater than the budgeted figure of $24,650 primarily due to the Association receiving $451,421 more revenue than was anticipated.

Review of Association Headquarters Building Operation for 1975: In 1975 the Headquarters Building produced income of $1,135,659, and incurred expenses, excluding depreciation, in the amount of $1,707,223. However, if the 138,500 gross square footage which the Association occupied were valued at $7.50 per gross square foot and added to building income, the building income would have exceeded expenses, excluding depreciation, by $467,186.

Review of Financial Operations for First Five Months of 1976: The Association's income for the first five months of 1976 reached $11,524,310, an increase of $361,282 over the comparable period in 1975. Operating expenses and nonoperating disbursements for the first five months of 1976 totaled $5,030,544 as compared to $6,034,072

for the same period in 1975, a decrease of $1,003,528. The biggest declines in the payment of expenses at this stage of the calendar year were in Administrative expenses ($316,714) and Grants to Related Health Groups ($801,850), but these two declines do not represent true savings since the budgets representing these items are expected to be spent before the end of 1976.

Report on Association Headquarters Building Operations to May 31, 1976: For the five-month period ended May 31, 1976, Headquarters Building operations produced income of $485,933 and incurred expenses, excluding depreciation, of $682,014. The space occupied by the Association increased recently from 138,500 to 139,450 gross square feet to accommodate a relocation of the Bureau of Audiovisual Services, the Council on Scientific Session and the Council on Hospital Dental Services. The estimated rental value of this space when priced at a very conservative annual rate of $7.50 per gross square foot, amounted to approximately $435,779, and when added to the income produced from building operations of $485,933 totals $921,712. Operating expenses, including mortgage interest of $94,940, amounted to $682,014 for the first five months of 1976 which was $18,550 more than the operating expenses paid in the comparable period in 1975. The excess of building income over expenses, excluding depreciation, was $239,698 for the first five months of 1976 as compared to $226,079 for the same period in 1975. The mortgage payments made in 1976 which apply to principal amounted to $152,228 and therefore, reduced the mortgage liability at May 31, 1976 to approximately $4,510,000.

Financial Reserves: The securities held in the portfolio of the Reserve Division, exclusive of the investment in Dental Service Plans Insurance Company and cash on hand, was shown at May 31, 1976, on the records of the Association as having a cost value of $4,447,925 and a market value of $4,627,868 for an appreciation of $179,943 (or 4.05 percent) above cost.

However, the foregoing reflects only the cost of the current securities and does not include prior capital gains and losses and interest and dividend income realized during Wright Investors' Service management for the period January 2, 1970–May 31, 1976. To get a true picture of Wright's management, one must first take the net amount that was turned over to Wright, namely $4,587,540 ($2,919,703 of which was deposited with Wright in 1975-1976), and subtract that figure from the investment in DSPIC stock but includes cash on hand of $356,165. This approach reveals an investment return of $396,493 (after deduction of all expenses including bank charges and management advisor fees). Further, the portfolio value increased in market value from $4,984,033 on May 31 to $5,199,057 on June 30, 1976, for an investment return of $611,517. This represents a 200 percent paper increase over the investment return of $210,609 at December 31, 1975.

PROPOSED 1977 BUDGET

The Board of Trustees proposes a modified cash flow budget with income of $16,507,750 and operating expenses and nonoperating disbursements of $16,479,950. As a consequence, the 1977 budget as presented reflects a modest surplus of $27,800.

Estimated Income for 1977: The Board of Trustees proposes an estimated income budget for 1977 of $16,507,750. This estimated income for 1977 is $1,146,800 higher than the income predicted for 1976. Some of the largest increases are predicted from Advertising $183,000, Membership Dues $300,000 and sale of Underwriting materials $306,850.

Estimated Operating Expenses for 1977: An operating expense budget of $14,744,750 is proposed for 1977. This amount is an increase of $1,292,300 over the amount budgeted for 1976.

Estimated Nonoperating Disbursements Budget for 1977: The nonoperating disbursements budget includes funds for capital appropriation requests, grants to related health groups and the reduction of the Headquarters Building mortgage loan liability. The total nonoperating disbursements budget for 1977 is projected at $1,735,200 which is $177,650 more than the 1976 budget. Included in the 1977 budget is $388,000 toward the reduction of the mortgage loan liability. This reduction is $18,800 more than was budgeted in 1976 and reflects the steadily increasing shift in the percentage of the mortgage payments that are credited to the principal amount of the mortgage instead of interest expense. As of December 31, 1977, the mortgage loan liability will be approximately $3,905,000. Purchase of furniture and fixtures, typewriters, research equipment, library books and films are included in the 1977 budget at $264,200. Grants to related health groups are budgeted for $1,083,000 which is $20,800 more than in 1976. The Research Institute and the Research Unit at the National Bureau of Standards, both agencies of the American Dental Association Health Foundation, are included in this grant budget for support in the amount of $885,150. Delta Dental Plans Association has again indicated that it is self-sufficient and, therefore, neither a grant nor a loan is provided for it in 1977. Other substantial grants are proposed for the American Dental Political Action Committee $118,300, and the American Fund for Dental Health $58,300 ($25,000 of which is designated as a contribution to the American Association of Dental Schools).

The Board of Trustees transmits the following resolution to the House of Delegates with the recommendation that it be approved:

> 87. **Resolved,** that the 1977 Annual Budget of Income, Expense (excluding depreciation) and Nonoperating Disbursements be approved, and be it further **Resolved,** that building and building furniture and equipment depreciation in the amount of $286,000 and depreciation on other furniture and equipment of the American Dental Association in the amount of $166,000 be approved.

SUMMARY OF BUDGET RECEIPTS AND DISBURSEMENTS ON A MODIFIED CASH FLOW BASIS FOR THE YEAR 1977

	Audited 1975 Actual Income	1976 Approved Budget	1977 Board Proposal
Income:			
Advertising			
ADA News	$ 157,146	$ 175,000	$ 175,000
Dental Abstracts	—	—	—
JADA	831,236	875,000	1,050,000
Journal of Dental Research	—	—	—
Journal of Oral Surgery	24,523	22,000	30,000
Oral Research Abstracts	—	—	—
Rental Fees			
Audiovisual Services	17,210	20,000	27,500
Data Processing Services & Membership Records	107,974	95,000	110,000
Library Services	5,493	5,000	6,000
Testing Fees			
Dental Education—Division of Educational Measurements	425,729	450,000	490,000
National Board of Dental Examiners	397,370	370,000	400,000
Earnings on Investments	188,554	150,000	150,000
Exhibit Space Sales	669,000	600,000	675,000
Headquarters Building	1,135,659	1,202,800	1,247,200
Membership Dues	9,180,191	9,450,000	9,750,000
Miscellaneous Income	26,583	20,000	26,000
Overhead on Government Grants	190,324	142,000	190,000
Underwriting Income	977,808	997,500	1,304,350
Sale of Advances Series	40,313	60,000	70,000
Registry Program	14,345	18,000	52,200
Subscriptions:			
ADA Leadership Bulletin	1,250	1,700	1,850
ADA News	2,090	1,950	2,100
Dental Abstracts	124,804	122,250	135,300
JADA	123,625	101,700	125,000
Journal of Dental Research	132,030	176,500	150,400
Journal of Endodontics	79,824	75,000	78,750
Journal of Oral Surgery	124,133	138,000	150,250
Oral Research Abstracts	98,507	91,550	110,850
Total Income	$15,075,721	$15,360,950	$16,507,750

	Audited 1975 Actual Expense	1976 Approved Budget	1977 Board Proposal
Expense:			
Advertising Review, Office of	$ 40,665	$ 39,950	$ 44,250
Annual Session	403,596	210,250	225,250
Bureaus and Departments	1,944,980	2,203,150	2,321,950
Business Affairs	682,843	748,750	785,850
Central Administrative (Excludes depreciation expenses of $233,000 for 1976 and $166,000 for 1977)	1,201,316	1,263,750	1,319,500
Councils and Divisions	2,695,739	3,072,080	3,213,500
Elected Officers and Trustees	310,854	330,550	304,850
Executive Director	118,204	129,800	166,500
Executive Director Emeritus	5,576	10,700	7,650
Headquarters Building (Excludes depreciation expenses of $300,000 for 1976 and $286,000 for 1977)	1,707,223	1,790,350	1,933,100
House of Delegates	101,819	112,100	114,150
Licensure, Commission on	15,410	24,000	—
Memberships	54,480	49,200	49,200
Publications	1,682,676	1,845,100	1,951,600
Public Education Program	925,001	700,000	700,000
Student Affairs, Office of	8,764	7,300	7,650
Treasurer	4,691	6,650	5,950
Underwriting	660,601	608,300	827,500
Washington Office	248,246	291,850	286,300
Sub-Total	$12,812,684	$13,443,830	$14,264,750
Contingent Fund	—	8,620*	480,000
Total Expenses	$12,812,684	$13,452,450	$14,744,750
Nonoperating Disbursements:			
Reduction of Mortgage Loan Liability (Interest expense of $205,200 is included in the Headquarters Building budget)	$ 351,274	$ 369,200	$ 388,000
Capital Appropriations	244,178	126,150	264,200
Grants to Related Health Groups	989,185	1,062,200	1,083,000
Loans to Related Health Groups	20,937	—	—
Total	$ 1,605,574	1,557,550	1,735,200
Total Expenses and Nonoperating Disbursements	$14,418,258	$15,010,000	$16,479,950
Excess of Income over Expenses and Nonoperating Disbursements	$ 657,463	$ 350,950	$ 27,800

*Contingent Fund — Summary

Original amount approved by the House of Delegates	$400,000
Plus amount returned from agencies	45,500
	$445,500
Less amount allocated to agencies	436,880
Amount remaining in Contingent Fund	$ 8,620

SUMMARY OF BUDGET RECEIPTS AND DISBURSEMENTS ON A MODIFIED CASH FLOW BASIS FOR THE YEAR 1977

	Audited 1975 Actual Expense	1976 Approved Budget	1977 Board Proposal
Advertising Review, Office of	$ 40,665	$ 39,950	$ 44,250
Annual Session:			
Annual Session	$ 396,533	$ 204,950	$ 219,850
General Committee on Local Arrangements	7,063	5,300	5,400
Total	$ 403,596	$ 210,250	$ 225,250
Bureaus and Departments:			
Audiovisual Services	$ 246,174	$ 260,050	$ 282,200
Convention Services	51,644	57,050	61,250
Data Processing Services and Membership Records	302,198	322,950	343,050
Dental Health Education	245,091	275,250	300,150
Dental Society Services	115,603	149,350	97,600
Economic Research and Statistics	135,149	302,400	352,700
Library Services	253,422	272,250	303,300
Public Information	308,565	266,850	279,200
Sales and Advertising	287,134	297,000	302,500
Total	$ 1,944,980	$ 2,203,150	$ 2,321,950
Business Affairs:			
Accounting	$ 137,645	$ 151,150	$ 162,000
Assistant Executive Director — House Counsel	83,414	89,350	90,050
Comptroller	42,528	46,700	49,800
Duplicating	70,429	81,550	84,900
Order	56,011	62,650	68,450
Personnel	102,460	110,350	112,000
Purchasing	33,911	34,100	35,250
Shipping and Receiving	108,734	118,900	125,200
Subscription	47,711	54,000	58,200
Total	$ 682,843	$ 748,750	$ 785,850

	Audited 1975 Actual Expense	1976 Approved Budget	1977 Board Proposal
Central Administrative	$ 1,201,316	$ 1,263,750	$ 1,319,500
Councils and Divisions:			
Coordinating Committee on Preventive Dentistry	$ 3,251	$ —	$ —
Dental Care Programs	253,177	366,050	307,450
Dental Education	739,004	742,700	754,450
Educational Measurements	245,685	335,100	333,550
Continuing Education	—	—	66,450
Dental Health	103,229	110,750	110,050
Dental Health — Assistant Executive Director	—	—	55,550
Dental Laboratory Relations	38,629	112,350	96,100
Dental Materials and Devices	222,120	238,550	258,350
Dental Research	71,312	54,100	74,150
Dental Therapeutics	185,332	194,400	214,450
Education and Hospitals — Assistant Executive Director	65,589	81,080	73,500
Federal Dental Service	19,967	22,000	27,150
Hospital Dental Service	99,493	119,750	161,550
Insurance	17,435	22,450	21,850
International Relations	59,623	56,800	59,450
Journalism	64,882	63,450	54,250
Judicial Procedures, Constitution and Bylaws	17,774	36,750	22,800
Legislation	96,582	97,500	102,800
National Board of Dental Examiners	265,890	271,600	275,700
Scientific Affairs — Assistant Executive Director	61,129	69,950	75,500
Scientific Session	65,636	76,750	68,400
Total	$ 2,695,739	$ 3,072,080	$ 3,213,500
Elected Officers and Trustees:			
Board of Trustees	$ 217,174	$ 247,550	$ 201,850
President	59,016	55,000	65,000
President-Elect	34,664	28,000	38,000
Total	$ 310,854	$ 330,550	$ 304,850

	Audited 1975 Actual Expense	1976 Approved Budget	1977 Board Proposal
Executive Director	$ 118,204	$ 129,800	$ 166,500
Executive Director Emeritus	$ 5,576	$ 10,700	$ 7,650
Headquarters Building	$ 1,707,223	$ 1,790,350	$ 1,933,100
House of Delegates	$ 101,819	$ 112,100	114,150
Licensure, Commission on	$ 15,410	$ 24,000	$ —
Memberships	$ 54,480	$ 49,200	$ 49,200
Publications:			
Editorial Office	$ 272,070	$ 289,200	$ 317,600
Editorial Office — ADA News	189,418	210,700	244,950
Dental Abstracts	63,982	74,450	74,350
JADA	784,677	826,250	879,250
Journal of Dental Research	86,956	132,600	122,800
Journal of Endodontics	27,802	52,000	51,500
Journal of Oral Surgery	96,214	110,700	93,350
Oral Research Abstracts and Advances Series	161,557	149,200	167,800
Total	$ 1,682,676	$ 1,845,100	$ 1,951,600
Public Education Program	$ 925,001	$ 700,000	$ 700,000
Student Affairs, Office of	$ 8,764	$ 7,300	$ 7,650
Treasurer	$ 4,691	$ 6,650	$ 5,950
Underwriting Expense	$ 660,601	$ 608,300	$ 827,500
Washington Office	$ 248,246	$ 291,850	$ 286,300
Total Expenses	$12,812,684	$13,443,830	$14,264,750

Future Financial Planning: During the course of its deliberations over the financial affairs of the Association, the Board was concerned by and constantly reminded of the lack of funds necessary to implement programs vital to the continued progress and well being of organized dentistry. While reviewing the 1977 agency requests and Finance Committee recommendations, the Board was cognizant of cutbacks in existing programs and the inhibition of necessary growth in contemplated future program activities. The Board approved reductions in the agency askings in the amount of $1,789,650, of which $1,096,000 was a reduction in the request for the Public Education Program. In some instances, such as reduced travel budgets, no adverse effect on Association activities is contemplated. However, the full impact of reductions in other areas of the budget cannot be predicted at this time.

The Board of Trustees firmly believes that a major Public Education Program is necessary. The Board has given thorough consideration to the report of the Advisory Committee to the Public Education Program, a committee that has done an outstanding service for the Association and membership. The Board urges every delegate to read this report carefully. It concludes: "if PEP is to have real impact in urgently communicating the story of private practice, fee-for-service, if PEP is to compete for the attention and the support of the public, of legislators, of business and union leaders, then sufficient funds must be provided. The need to communicate our story is too urgent to delay." Having agreed with the urgency of the need, the Board was then forced to turn to the reality of available funds. A Public Education Program of $1,796,000, as requested by the PEP Advisory Committee, simply could not be accommodated within the 1977 budget without throwing it into deficit by more than $1,000,000.

Also of great concern to the Board is the fact that dramatic changes have taken place and continue to take place in the public's attitude toward the professions. Regulatory agencies such as the Justice Department, Federal Trade Commission, Internal Revenue Service, Food and Drug Administration and state attorneys general have all reacted to the age of consumerism with greater involvement in the affairs, both external and internal, of professional associations. Prepaid dental care programs, peer review, manpower legislation, public education, dental students' financial needs, and the illegal practice of dentistry are but a few of the challenges dentistry is facing. It is critical to understand that these challenges are part of the present. They are here now and must be faced here and now. Delays in meeting these issues for financial reasons could be calamitous since the future of each and every member of the Association is at stake. It must be recognized that those groups whose interests are incompatible with those of organized dentistry will not declare a moratorium on their activities until such time as dentistry deems fit to meet the challenges. While reasonable minds may differ over the best means to meet the challenges, reasonable minds cannot differ over the necessity of meeting them now.

The Board is of the opinion that additional funds are necessary to conduct vital programs that are not included in the 1977 proposed budget. No doubt discussion will be had on the merits of some of these programs. Modifications and alterations may be suggested. Nevertheless, it is the opinion of the Board that in whatever final form the programs are cast the funding will be necessary. To think otherwise would result in modifications to programs to fit financial constraints rather than providing the necessary revenues to meet program obligations. The resulting tokenism may prove detrimental to membership interests.

After careful review of the average inflationary growth experienced by the Associa-

tion for the years 1970-1975, the Board is projecting a conservative seven percent inflationary growth for the years 1978-1980. In addition, the Board anticipates an additional seven percent growth for projected expansion of programs. The projected growth in Association expenditures needed for the three-year period 1978-1980 to meet the above challenge is anticipated to be approximately $24,000,000.

A fully detailed explanation of programs and costs to substantiate the seven percent growth projection will be forthcoming in early 1977.

For the above-stated reasons and because it is charged with anticipating the fiscal requirements of the Association, the Board submits the following resolution to the House of Delegates with the recommendation that it be received and referred to the 1977 House of Delegates for action.

88. Resolved, that Chapter I, Section 50A of the *Bylaws* be amended by the deletion of the words and figures "one hundred dollars ($100.00)" and insertion in lieu therefor of the words and figures "one hundred seventy-five dollars ($175.00)" to make the amended section read as follows:

> A. Active Members. The dues of active members shall be "one hundred seventy-five dollars ($175.00)" due January 1 of each year.

and be it further

Resolved, that increased active members dues become effective January 1, 1978.

REPORT 4 OF BOARD OF TRUSTEES TO HOUSE OF DELEGATES: FURTHER RECOMMENDATIONS ON REPORTS AND RESOLUTIONS

The following are the comments of the Board of Trustees on resolutions and reports which will be considered by the House of Delegates.

Dental Care Programs, Council on, Supplemental Report 5: (p. 70) The Board of Trustees reviewed with interest Supplemental Report 5 on the Council's activities investigating, monitoring and taking appropriate action on fourth party closed panel programs as directed by the 1975 House of Delegates. The Board recognizes that this report comprises data from an initial investigation only. It agrees that the Council must continue its collection of information and action in this area and report appropriate findings to future Houses of Delegates.

The Board fully concurs with the Council's recommendation that Association policy regarding closed panels (*Trans.* 1972:670) be pursued vigorously. The Board observes that, while modifications of this policy are being proposed in its Report 9 (p. 599) these modifications, if adopted, will not negate the substance of the Council's recommendation.

Dental Care Programs, Council on, Supplemental Report 6: (p. 76) The Board of Trustees reviewed the progress report on Diverse Prepayment Policies which provides information on further activities on the project since the Board meeting in August, 1976.

The Board made particular note of a statement on the status of the project from the Council Chairman in his correspondence to Dr. Robert T. Maberry, president of the Texas Dental Association (p. 82).

> The Council feels an obligation to the House of Delegates, and the profession at large, to discharge the duty given it. Our purpose is not to vindicate existing policy of this or any other association. Neither is it our purpose to attack, directly or indirectly, any such policy. What the Council wishes to obtain is factual information concerning the personal attitudes and behavior of individual dentists, chosen through appropriate random sampling techniques and on the basis of confidentiality. The summary statistical information received would, of course, be shared through the House with the full profession. We believe the information elicited will prove most helpful.

The Board commends the persistence of the Council in attempting to carry out the intent of the House. Considering the general evolutionary movements in policies related to prepayment as well as other activities and projects of the Council, the Board feels that the pursuance of a specific survey in selected states no longer has the same high priority in implementing the intent of the 1975 House resolution. The Board recommends that the Council continue to investigate the effects of diverse policies on the practice of dentistry by utilizing existing resources such as national survey data from the Bureau of Economic Research and Statistics.

The Board of Trustees believes that the Council and the Bureau are involved in activities that will continue to provide information to further the understanding of the prepayment experiences of dental practices in states with diverse policies and passes the report to the House with a recommendation not to pursue further the specific survey. Accordingly, the following resolution is transmitted to the House of Delegates with a recommendation that it be *adopted.*

> 126. **Resolved,** that the Council on Dental Care Programs pursue its study of the effect of diverse policies on dentists' practices through normal administrative channels without the use of a special purpose survey.

Position Statement on the Commercial Dental Laboratory Industry: The Board of Trustees submits for approval by the House of Delegates a policy statement giving appropriate recognition to the dental laboratory industry. The Board's statement is a refinement of a proposed statement from the Council on Dental Laboratory Relations' Supplemental Report 1 to the Board of Trustees. The Board agrees with the first portion of the Council's position statement, namely that "All personnel associated with the dentist in the delivery of health care are properly termed 'auxiliary' in the sense of aiding the dentist to properly serve the public; however, the laboratory technician who performs a supportive function in an environment outside the dental office is not only an auxiliary to the dental profession but may also be properly termed a supportive or allied member of the dental health team." The Board believes, however, that the preceding quotation from the Council's statement is already ADA policy and, furthermore, may detract from the impact of a statement mainly intended to recognize the industry. The Board, therefore, submits the following policy statement with accompanying resolution for *adoption* by the House of Delegates.

> 127. **Resolved,** that the "Position Statement on the Commercial Dental Laboratory Industry" be approved.

Position Statement on the Commercial Dental Laboratory Industry

The commercial dental laboratory industry is comprised of independent, for-profit businesses whose services are exclusively dependent upon dentists who provide the laboratory with work authorizations for the processing of prosthetic or other dental appliances.

Economic Research and Statistics, Bureau of, Supplemental Report 2: (p. 299) The Board of Trustees reviewed the report on the historical patterns of movement of dentists and the discussion of current legislative and licensing restrictions and encouragements of this mobility (p. 299) as called for by the 1975 House of Delegates (*Trans.* 1975:674).

The Board gave particular attention to the comments in the report that note the complexity of the issues affecting mobility that could not be accounted for within the framework of this analysis. It is emphasized by the Board that this report provides information regarding past trends. It should not be used to project future trends.

The Board agrees fully with the caution in the report that it is not possible to project future conditions under national reciprocity because of the many complex factors other than reciprocity agreements that affect this movement.

Board of Trustees Resolution 230 (Resolution 896) to 1975 House of Delegates on Economic Barriers to Dental Care: (p. 280; p. 484; *Trans.* 1975:674) The Board of Trustees is pleased to inform the House of Delegates that, subsequent to its comments in Board Report 2 on the proposed study of the economic barriers to dental care, funds have been made available from the Department of Health, Education and Welfare to study the impact of dental prepayment on the oral health of beneficiaries. Research Triangle Institute (RTI) of North Carolina, a research institute established by joint action of University of North Carolina, North Carolina State and Duke University, was awarded a $571,000 contract from which RTI has awarded a subcontract to the Association to assist in all stages of the project, particularly study design and data analysis.

The Board made special note of the advantage of this working relationship in strengthening the Association's position in monitoring research involving dentists and dental patients and in primary participation in data analysis, interpretation and reporting of this type of research funded by outside agencies.

California Resolution on Clarification of Terminology in Pedodontics: (pp. 362, 487/ Resolution 56): The Council's recommendation reflects the wishes of the American Academy of Pedodontics to have an opportunity to make an official decision on the proper designation of the specialty. The Board concurs with the recommendation of the Council on Judicial Procedures, Constitution and Bylaws that *Resolution 56* be *referred to the Council for report to the 1977 House of Delegates.*

California Resolution on Committee on Advance Planning: (p. 363/Resolution 106): The Board reviewed the purpose of California Dental Association Resolution 106 (p. 363) and pointed out that the request was already being met. The report of the Advance Planning Committee is being submitted to the House of Delegates for its approval. In light of this fact, the Board recommends that Resolution 106 be *postponed indefinitely.*

District of Columbia Resolution on Definition of "Denturism": (p. 368/Resolution 98) The Board of Trustees recommends that Resolution 98 be *adopted.*

District of Columbia Resolution on Announcement of a Specialty: (p. 367/Resolution 99) The Board believes that Section 18 should prohibit the use of the word "exclusive" in describing a limited practice whether the dentist limits his practice to one special area or more than one special area. This belief is based on the fact that "exclusive" may be interpreted to connote superiority and is confusing to the public. The Board, therefore, recommends that Section 18 of the *Principles of Ethics* be amended to delete the word "exclusive" in the first sentence thereof. The Board recommends, therefore, that Resolution 99B be substituted for Resolution 99, and that it be *adopted.*

99B. Resolved, that Section 18 of the American Dental Association *Principles of Ethics* be amended to delete the word "exclusive" in the first sentence thereof, so that Section 18 as amended will read as follows:

> **Section 18**
>
> **Announcement of Limitation of Practice.** Only a dentist who limits his practice to the special areas approved by the American Dental Association for limited practice may include a statement of his limitation in announcements, cards, letterheads and directory listings (consistent with the custom of dentists of the community), provided at the time of the announcement, he has met in each specialty for which he announces the existing educational requirements and standards set by the American Dental Association for members wishing to announce limitation of practice.
>
> In accord with the established ethical ruling that dentists should not claim or imply superiority, use of the phrases "Specialist in _____" or "Specialist on _____" in announcements, cards, letterheads or directory listings should be discouraged. The use of the phrase "Practice limited to _____" is preferable.
>
> A dentist who uses his eligibility to announce himself as a specialist to make the public believe that specialty services rendered in his dental office are being rendered by ethically qualified specialists when such is not the case, is engaged in unethical conduct. The burden is on the specialist to avoid any inference that general practitioners who are associated with him are ethically qualified to announce themselves as specialists.

Florida Resolution on Study of the Dentist in All His Relationships: (pp. 368, 488/Resolution 45) The Board is pleased to inform the House of Delegates that the Bureau of Economic Research and Statistics has received $4,700.00 from the Division of Dentistry, Department of Health, Education, and Welfare, to convene a meeting of expert consultants to assist in determining the reliability of data on which research of this kind is based.

The group of consultants and Association representatives will meet January 13 and 14, 1977. A summary report will be prepared, including proceedings and summary recommendations for future research activities of major interested organizations. This activity is to consider the status of past and current research, is not a feasibility study for future research and in no way alters the Board's previous comment that recommended that a full feasibility study funded by the Association is not fiscally advisable at this time (p. 488).

Illinois Resolution on Reconsideration of Funding for Dental Editors Seminar: (p. 370/Resolution 93): The Board has reviewed Illinois State Dental Society Resolution 93

(p. 370) and reaffirms its previous action in temporarily suspending the editors' seminar for *one year.* The Board members pointed out that it is not a question of the value or the popularity of the seminar. The decision to temporarily suspend it, along with many other effective conferences and programs, was made purely on the basis of economic necessity which had to be faced in balancing the 1977 budget. The Board, therefore, recommends that Resolution 93 be *postponed indefinitely.*

Indiana Resolution on Nondiscriminatory Policy for Accepting Dental Students: (p. 371/Resolution 109) The Board reviewed Resolution 109 submitted by the Indiana Dental Association, concurs with the intent of the resolution and notes that the Council on Dental Education adopted a similar policy in the conduct of its accreditation program. National policy required all accrediting agencies to adopt policy standards supporting nondiscrimination in admission of students and employment of faculty and staff and, therefore, in May 1972, the Council on Dental Education adopted the following statement:

> The Council on Dental Education supports the principle which prohibits discrimination in educational programs on the basis of sex, race, creed, religion or national origin related to the admission of students or the employment of faculty and staff.

When the Commission on Accreditation of Dental and Dental Auxiliary Educational Programs assumed *Bylaws* authority to approve educational standards in 1975, it adopted the Council's statement which then became an accreditation policy for all areas within the Commission's purview. The policy statement was appended to the *Requirements and Guidelines for Dental Education Programs* and transmitted to all educational programs. Since the House of Delegates transferred the *Bylaws* authority for the approval of educational requirements to the Commission on Accreditation, the Board believes that Resolution 109 should be amended to conform to Association *Bylaws.* Therefore, the Board recommends that the following *resolution, as amended, be adopted.*

> 109B. Resolved, that the Commission on Accreditation of Dental and Dental Auxiliary Educational Programs be requested to amend the *Requirements* for an Accredited School of Dentistry (*Trans.* 1970:54, 437) by adding the following words to the third paragraph under "Admissions":
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> > and that nondiscriminatory policies will be followed in admitting students
>
> to make the paragraph read as follows:
>
> > It is the opinion of the Commission that the selection of students for admission to dental schools should be based on estimates of their capacity for success in the study of dentistry as determined by evaluation of all available and significant information. Consideration of the qualifications of applicants for admission should include information regarding their character, the quality of their preprofessional education, health status and aptitude for and interest in a career in dentistry. The Commission emphasizes that the admission committee has the major responsibility for determining the qualifications of prospective students in the light of educational aims and objectives of the profession and that nondiscriminatory policies will be followed in admitting students.

Indiana Resolution on Rejection of Supplemental Report 2 from Council on Dental Care Programs: (p. 372/Resolution 110) In its consideration of Resolution 110 submitted

by the Indiana Dental Association, the Board concluded that it presents two entirely separate questions and, consequently, has appropriately divided this resolution.

With respect to the recommendation that the report on Delta Dental Plans Association produced by the Council on Dental Care Programs at the direction of the 1975 House of Delegates (p. 32) be rejected, the Board is of the view that this would be unwise. In its Board Report 2 to the 1976 House of Delegates (p. 472), the Board of Trustees commended the Council "for its thorough study" and noted that the report "will be of particular value to all members of the profession when dealing with this issue." It believes these expressions to be as valid now as they were in August. As Board Report 2 also points out, the delegates themselves will have ample opportunity to evaluate the contents of this report during reference committee hearings and on the floor of the House. For these reasons, the Board recommends that the call for rejection of the report in the first clause of Resolution 110 be *postponed indefinitely* and appends an appropriate resolution to that effect at the conclusion of these comments.

With regard to the second matter raised by Resolution 110, the Board would agree that such an overview is both appropriate and prudent. It notes, for the information of the House of Delegates, that steps in this process are already well underway at the Board's request. In the view of the Board the intent of the second and third clauses of Resolution 110 can be fully met by a resolution drafted in a more compact manner and therefore offers a substitute resolution. In summary the Board recommends that Resolution 110aB be *postponed indefinitely.*

> 110aB. **Resolved,** that the Council on Dental Care Programs Supplemental Report 2 not be accepted.

The Board recommends that Resolution 110bB be *adopted.*

> 110bB. **Resolved,** that the Board of Trustees arrange for a study of potential antitrust questions involved in the relationship between the American Dental Association and Delta Dental Plans Association and report to the 1977 House of Delegates.

Kentucky Resolution on Commendation to Dr. Charles D. Carter: (p. 373/Resolution 92): The Board fully and warmly supports Resolution 92 (p. 373) submitted by the Kentucky Dental Association. The Board considers itself privileged to recommend that Resolution 92 be *adopted.*

Michigan Resolution on Amendment to "Guidelines on the Use of Radiographs": (p. 375/Resolution 111) The Board of Trustees reviewed Resolution 111, which would amend Guideline 11 on the use of radiographs (*Trans.* 1974:653) to permit transmittal of these records to peer review bodies without the written consent of the dentist furnishing them. The Board understands that the intent of this resolution is to assist constituent and component societies in the effective operation of their peer review mechanisms. Nevertheless, it is the Board's position that the controlling agent in all decisions on the use of radiographs must remain the attending dentist, the owner of these records. The Board believes existing Guideline 11 properly protects the practicing dentist's prerogatives without imposing any unreasonable administrative requirements upon others. Accordingly, the Board of Trustees transmits Resolution 111 with the recommendation that it be *postponed indefinitely.*

Michigan Resolution on Insurance Programs for ADA Members: (p. 376/Resolution 112): The Board has carefully reviewed Resolution 112 submitted by the Michigan Dental Association (p. 376) requesting the Council on Insurance to distribute the experience statistics by state, relative to the Professional Protector Plan, 90 days before renewal dates of the program for analysis and discussion with that constituent society, prior to a rate increase and further requiring the Council to forward all information pertaining to proposed changes in coverage to constituent societies for their input prior to definitive action on those changes. While the Board is sympathetic to intent of the Michigan resolution, the Board must point out that the establishment of premium rates for professional liability and casualty coverages on a national level is a highly technical and complex procedure requiring consideration of many factors. In order to have the program operate in the best interest of all plan participants a balance in premium rates is required. The Council on Insurance is currently undertaking a study for the purpose of determining the most equitable method of applying rate increases.

The Board would also point out that the Professional Protector Plan is not a true group program. It does not have a single contract with a common expiration date, but rather each participant is issued an individual policy, as required by individual state law, with policy expirations taking place throughout the year. The Board also takes notice of the changed climate in professional liability and casualty insurance. The insurance industry, as a result of severe financial losses resulting from these coverages, is no longer freely writing this business. Indeed, on any large scale basis, the number of companies willing to write this business at all has dwindled to no more than a handful. The implementation of Resolution 112 without a thorough study of its implications and ramifications could prove to be detrimental to the entire program. Therefore, the Board recommends that Resolution 112 be *referred to the Council on Insurance for study and report back to the 1977 House of Delegates.*

New Jersey Resolution on Formation of Self-Insured Malpractice Program: (p. 378/Resolution 100): The Board has carefully reviewed Resolution 100 submitted by the New Jersey Dental Association (p. 378) requesting that a study be made of the feasibility of the Association forming a self-insured malpractice program. The Board was made aware of the fact that the Council on Insurance has already undertaken such a study. The magnitude of such a study was pointed out, and the Board was advised that it will be kept informed on the progress of the study. Therefore, the Board recommends that Resolution 100 be *adopted.*

Ohio Resolution on Opposition to Preceptor Dental Hygiene Training Programs in All States and Territories (p. 381/Resolution 95) and Fifth Trustee District Substitute for Resolution 4: (p. 398/Resolution 4S-1) The Board reviewed Resolution 95 submitted by the Ohio Dental Association which urges the ADA to oppose efforts seeking to train and qualify individuals to practice dental hygiene through methods other than accredited educational programs. The Board noted the similarities between Resolution 95 and Resolution 4 submitted by the Council on Dental Education. It believes, however, that the second resolving clause of the Ohio resolution, with the deletion of the word "actively", clarifies and strengthens the intent of the Council's position. In its discussion of the profession's support of educational standards for dental hygienists, the Board also considered the Fifth Trustee District's Resolution 4S-1 to substitute the word "preferred" for "essential." The substitution would change completely the intent of the resolution and would reverse Association policy which historically has

supported formal education and the educational qualifications established by the profession for dental hygienists' licensure and employment. The serious ramifications of such an action will be, in the Board's opinion, clear to the House.

The Board believes that the Association should take the strongest possible position in support of the Association's formal education standards for dental hygiene.

With these considerations in mind, the Board recommends that the following *substitute resolution for Resolutions 4, 95 and 4S-1 be adopted.*

> 4B. **Resolved,** that graduation from a dental hygiene program accredited by the Commission on Accreditation of Dental and Dental Auxiliary Educational Programs is the essential educational eligibility requirement for dental hygiene licensure examination, and be it further
>
> **Resolved,** that the American Dental Association oppose efforts to train and qualify individuals to perform dental hygiene functions who have not completed an accredited dental hygiene education program.

Ohio Resolution on Continued Development of Criteria for Curriculum and Development of an Accreditation Mechanism for Expanded Function Dental Auxiliary Education Programs (p. 382/Resolution 96) Resolution 96 submitted by the Ohio Dental Association suggesting that the House direct the Council on Dental Education to develop criteria for curriculums of expanded function dental auxiliary educational programs and that the criteria be utilized by the Commission on Accreditation of Dental and Dental Auxiliary Educational Programs in designing and implementing an accreditation program was considered by the Board. The Board discussed the fact that the *Commission currently has criteria for evaluating instruction in expanded functions when such instruction is included in curriculums of dental assisting and/or dental hygiene programs.* The Board also made note of recommendations in the *Special Report on Dental Auxiliary Utilization and Education.* Two recommendations relate to what the Board interprets as the intent of Resolution 96. Those recommendations are that the Association direct immediate attention to studying and identifying appropriate mechanisms for credentialing auxiliaries for performance of the expanded functions (Recommendation 2) and that the Association develop comprehensive educational guidelines for education and training in expanded functions for use by states and educational institutions where need exists (Recommendation 4).

In the Board's view, adoption of Resolution 96, as it is worded, would, in effect, create a new category of auxiliary, as it calls for development of educational standards for an expanded function dental auxiliary program. Currently, it is the Association's position that if expanded functions are delegated, they should be delegated to dental assistants or dental hygienists and that new categories of auxiliaries will not be recognized. Eligibility for accreditation by the Commission on Accreditation does not extend to programs that do not meet the educational standards which have been approved by the Association and the Commission. In the area of dental auxiliary education, three programs are recognized: dental assisting, dental hygiene and dental laboratory technology. The Commission evaluates expanded functions instruction only when it is provided as part of the curriculum in an accredited dental assisting or dental hygiene program.

The Board shares the Ohio Dental Association's concerns and believes that attention must be directed to those concerns to assure that the profession is doing everything possible to maintain the quality of dental care and provide appropriate assurances of

quality to the public. However, the Board believes extensive study is required before the Association can make a decision regarding educational programs that will, in effect, establish a new category of auxiliary. The Board believes that, as suggested in the *Special Report on Dental Auxiliary Utilization and Education,* there is need for the Association to study its position on categories of personnel and consider the question of whether an expanded function dental auxiliary should be identified. *In the Board's view it would be unwise to adopt the Ohio resolution without thoroughly studying the ramifications of such an action,* including the effect on dental care delivery, the dental practitioner and dental assisting and dental hygiene; and the cost of a new accreditation program. Therefore, the *Board recommends that Resolution 96 be referred to the Council on Dental Education* for study with the directive that a complete report on this matter be submitted to the 1978 House of Delegates. That report should include information on the ramifications of identifying an expanded function dental auxiliary, establishing a separate accreditation program and educational standards; and information on the effect of such action on delivery of dental care, dental practitioners, and existing auxiliaries; and statements of cost which would be incurred in launching a new accreditation program.

Ohio Resolution on Sharing and Coordination of Legal Expertise: (p. 382/Resolution 97) The Board recognizes the need for the program for sharing and coordination of legal expertise as proposed in Resolution 97 of the Ohio Dental Association. The Board also recognizes that this action will require a supplement to the proposed 1977 budget in order to provide for additional legal services, supporting personnel and facilities. A preliminary estimate is that the minimum cost of the program will be $100,000 per year. In order to dispel any assumption that additional ADA funds will be made available for regular legal expenses of constituent societies, the Board recommends deletion of the words "and legal resources" from the first resolving clause of Resolution 97. The Board believes that constituent societies should bear the costs of legal expenses needed for carrying on their regular programs and activities. If Resolution 97 as amended is approved by the House of Delegates, legal staff will report to the March 1977 session of the Board of Trustees on progress in implementing the program reflected in Resolution 97. The Board of Trustees, therefore, recommends that *Resolution 97, as amended, be adopted.*

> **97B. Resolved,** that the American Dental Association, through its legal department, develop a means by which its high level of legal expertise can be shared with constituent societies and their respective legal counsels when deemed appropriate, feasible and in the best interests of the dental profession, and be it further
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> **Resolved,** that the American Dental Association legal department establish a mechanism whereby the legal counsel of the various constituent societies may better coordinate and share expertise and information with respect to their common legal problems.

Wisconsin Resolution on Reinforcement of 1975 Resolution 861: (p. 391/Resolution 107) The Board considered Resolution 107 submitted by the Wisconsin Dental Association which supports Resolution 861 adopted by the 1975 House (*Trans.* 1975: 701). The Board believes that the *Special Report on Dental Auxiliary Utilization and Education,* emanating from the special workshop conducted at the direction of the 1975 House, thoroughly addresses the subject of expanded functions. Further, the

Board is of the opinion that a comprehensive statement on auxiliary utilization, as presented in the *Special Report,* is preferable to the approval of individual isolated policy resolutions. The Board is aware that one resolving clause of the 1975 resolution specifically opposes delegation of certain expanded functions. However, the Board believes that the *Special Report* with Resolution 24 will provide the Reference Committee on Auxiliary Utilization with appropriate information for discussion of specific functions. Therefore, the Board recommends that Resolution 107 be *postponed indefinitely.*

Second Trustee District Resolution on Problems Existing Between Medicine and Dentistry in the Hospital: (p. 391/Resolution 113) In studying Resolution 113 submitted by the Second Trustee District the Board reviewed background correspondence from which the problem first arose. It became readily apparent that this situation is closely related to the request of the American Society of Maxillofacial Surgeons presented in Resolution 94 on use of the term "maxillofacial surgery." Indeed, it was a Trustee of the ASMS who initially raised the question of legality in relation to the practice of oral surgery in the hospital. In addition, the Board noted that it was the same ASMS trustee who requested that the New York Board of Medical Examiners be consulted in this regard.

The Board does not believe that physicians, nor boards of medical examiners, should impose arbitrary and capricious restrictions on the scope of practice of dentistry or its specialty of oral surgery. The scope of practice should be consistent with educational training and the established nature of patient care provided.

The Board believes that the impetus for implementing undue restrictions on the practice of dentistry is based upon economic rather than professional considerations and are, therefore, entirely indefensible. The Board strongly believes that the potential implications are of such a nature that the Association must consider amelioration of this problem a high priority. However, because the phrase, "with all available resources" is subject to various interpretations, the Board recommends that the resolution be amended by the deletion of that phrase. Accordingly, the Board recommends that the following *resolution, as amended, be adopted.*

> 113B. Resolved, that the American Dental Association is strongly urged to assist The Dental Society of the State of New York to ameliorate jurisdictional disputes between medicine and dentistry in the State of New York in order to allow appropriately licensed dentists to practice dentistry within the parameters of their training, experience and demonstrated competence.

Fifth Trustee District Substitute for Resolution 8: (p. 398/Resolution 8S-1) The Board of Trustees recommends that Resolution 8S-1 be *substituted for Resolution 8 and that the substituted resolution be adopted.*

Fifth Trustee District Substitute for Resolution 24: (p. 403/Resolution 24S-2) The Board considered Resolution 24S-2 submitted by the Fifth Trustee District which recommends amendment of the *Statement on Expanded Function Dental Auxiliary Utilization and Education.* The Board considered lines 13-18 (p. 234) when it reviewed the *Special Report* in August and recommended a clarification of that section of the statement on philosophy and principles.

The Board believes that its restatement of lines 13-18 meets the intent of the first resolving clause of the Fifth District's substitute resolution by deleting the clause

". . . functions should be identified and delegated to dental auxiliaries when the demand for specific services exceeds the capacity of dentists to provide them. . . ."

The 1975 House directive to the Council on Dental Education (*Trans.* 1975:697) specified that a position statement on functions which should be delegated to dental auxiliaries be prepared and that those functions which would require formal education be identified. The Board believes that the *Statement* would not comply with this directive if the section on "Expanded Functions Which Could be Delegated to Dental Assistants and/or Dental Hygienists" and the section on "Educational Requirements for Expanded Functions Which Could be Delegated to Dental Assistants and/or Dental Hygienists" were deleted (lines 75-216) (pp. 235-238).

The Board reiterates its position that progress cannot be made in resolving the issues related to auxiliary utilization and in identifying appropriate credentialing mechanisms without a specific list of functions and educational requirements. Specific Association policy which specifies designated functions and educational requirements is necessary to provide states with guidance in determining local policy. Therefore, the Board recommends that Resolution 24S-2 be *postponed indefinitely.*

Fifth Trustee District Substitute for Resolution 25: (p. 399/Resolution 25S-1) The Board considered the resolution suggesting that the words "and opposes use of licensure for any other purpose" be deleted. The Board believes that the intent of this clause is implied in the initial portion of the resolution which states that licensure is solely for the protection of the public, and therefore the phrase is not needed. For this reason the Board recommends that the Fifth Trustee District's resolution be *adopted.*

Fifth Trustee District Substitute for Resolution 26: (p. 403/Resolution 26S-1) The Board considered Resolution 26S-1 submitted by the Fifth Trustee District and agrees that sound moral character is essential for a member of a profession and should be considered in licensure. It, however, does not share the concern of the Fifth Trustee District that the original wording of Resolution 26 circumvents the sound moral character requirement for licensure. Further, the substitute offered is, in the Board's view, unnecessarily restrictive. There are data not listed in the substitute which would be objectionable on a licensure application. An example would be national origin. It would be unproductive to develop a complete list of all information that would be objectionable on a licensure application. The Board views asking state boards to review their applications to determine why each data item requested is related to qualifications for licensure to be a better approach. Therefore, the Board recommends that Resolution 26S-1 be *postponed indefinitely.*

Fifth Trustee District Substitute for Resolution 28: (p. 404/Resolution 28S-1) The Board considered the amendment to Resolution 28 proposed by the Fifth Trustee District as containing two separate issues. First, the amendment proposed elimination of guidelines related to licensure by examination. The Board opposes this change. For a state board to accept current, valid results from examinations conducted by other appropriate agencies would have advantages for both applicants and the state board. State boards are encouraged to use only results of examinations of at least comparable quality and difficulty to their own examination. *Guidelines for Licensure* propose ethical and practice requirements before outside examination results would be accepted. With these restrictions, the Board viewed the section of *Guidelines for Licensure* that relates to licensure by examination as appropriate.

The second aspect of Resolution 28S-1 involves not recognizing teaching experience for documentation of either current theoretical knowledge or of current clinical skill. Because more dental educators could probably qualify under other proposed provisions, the Board did not view this proposed change as being significant. Nevertheless, for reasons listed in the Commission's report, the Board favors retention of guidelines on teaching experience as originally presented. Therefore, the Board recommends that Resolution 28S-1 be *postponed indefinitely.*

Fifth Trustee District Substitute for Resolution 36aB (p. 405/Resolution 36(aB)S-1 and **Fifth Trustee District Substitute for Resolution 36bB:** (p. 406/Resolution 36(bB)S-1) The Board considered Resolutions 36(aB)S-1 and 36(bB)S-1 of the Fifth Trustee District to amend Resolutions 36aB and 36bB on the TEAM programs together as they are interdependent. The Board believes the position it took on the New York resolution on termination of TEAM programs during its August 1976 meeting upholds the Association's longstanding position that the individual practitioner ultimately makes the decision in accordance with dental practice acts on functions which will be performed by dental auxiliaries in his employment. Further, the Board's position upholds the principles often reiterated by the profession that dentists should be prepared to utilize effectively auxiliaries in accordance with the dental practice act in the jurisdiction of their practice. While some may not agree with the functions dental auxiliaries are performing in TEAM programs which are designed to prepare dentists to utilize effectively auxiliaries, those functions are permissible in a number of states. To deprive the dental student of experience in utilizing dental auxiliaries in roles that reflect dental practice acts in jurisdictions where he may elect to practice is contrary to the philosophy of education and advancement that denotes a profession. The Board believes that its position that information on TEAM and expanded function dental auxiliary training programs should be provided to state boards of dentistry and dental societies for their consideration and recommendation on implementation is sound and reflects the profession's commitment to obtaining all available information, studying that information and determining whether it indicates action or rejection. To adopt a resolution that the Association would not consider any information on methods of dental practice and dental auxiliary utilization would be parallel to adopting a resolution that the profession did not want to consider information on research in any other area. For these reasons, the Board recommends that Resolutions 36(aB)S-1 and 36(bB)S-1 of the Fifth Trustee District be *postponed indefinitely.*

Fifth Trustee District Substitute for Resolution 41: (p. 407/Resolution 41S-1) The Board of Trustees recommends that Resolution 41S-1 be substituted for Resolution 41 and that the substituted resolution be *adopted.*

Fifth Trustee District Substitute for Resolution 58: (p. 399/Resolution 58S-1) The Board recommends that Resolution 58S-1 be substituted for Resolution 58 (p. 000) and that the substituted resolution be *adopted.*

Fifth Trustee District Resolution on Commendation to Commission on Licensure: (p. 401/Resolution 108) The Board of Trustees recommends that Resolution 108 be *adopted.*

Delegate Joseph A. Devine Resolution on Financial Tabulation of Cost of Proposed Programs: (p. 422/Resolution 102) The Board of Trustees was informed that Delegate

Joseph A. Devine, after submitting his proposed Resolution 102 (p. 422), advised that he in no manner wishes by way of his proposal to invade or impinge on the managerial responsibilities of the Board of Trustees concerning the preparation of the annual budget for submission to and approval by the House of Delegates. He stated that he merely wishes to implement a practical mechanism that will keep the House informed at all times of the total strain that new programs approved by the House are placing within the framework of the budget. With this understanding, the Board calls attention to the resolution adopted by the 1975 House requiring that resolutions calling "for creation of new programs, special committees or studies" be accompanied by cost estimates and the potential source of funds (*Trans.* 1975:631). In addition, the Board points out that, if the approval of the annual budget were held as the last order of business before the House, the Board fears that a call for a quorum might leave the Association in the embarrassing, untenable predicament of having no approved budget for the coming year. Further, hastily formed estimates of cost, which had not undergone the benefit of agency and Board scrutiny, would become more or less fixed costs, depending on precipitate Board decisions amending the budget for House consideration and culminating in unanticipated and possibly non-emergency dues increases for active members. For these reasons, the Board recommends Resolution 102 be *referred to appropriate Association agencies for further study.*

Delegate Harry W. F. Dressel, Jr. Resolution on Terminology Used to Describe Duties Performed in the Mouth by Dental Auxiliaries: (p. 425/Resolution 104) The Board carefully considered Resolution 104 submitted by Delegate Harry W. F. Dressel, Jr., Maryland, regarding the need for substituting a new term for "expanded" or "extended" functions, and the reasons for change presented with the resolution. In the Board's view, legislators, consumers, dental auxiliaries, dental educators and dental practitioners have over the past 15 years become familiar with the meaning of the term "expanded" or "extended." They have a specific connotation which is important in communication. While the term "intraoral" has merit, it is not as precise. Historically the functions performed by dental hygienists have been "intraoral" and thus the term would not differentiate between those functions and the new functions which have been delegated to dental hygienists in recent years. As the resolution is stated, "intraoral" duties would also include some that chairside assistants have performed historically. The dental assistant has in carrying out chairside responsibilities used her hands and some instruments in the mouth particularly in four-handed dentistry procedures.

In the Board's view, a change in terminology would not reduce, but could create, confusion as it merely replaces one term for another. The problem is not with the term "expanded" but with the lack of definition of the term. A substitution of terms would not negate the need for a definition of the functions. The Council on Dental Education's *Special Report on Dental Auxiliary Utilization and Education* presents a definition or listing of the functions for consideration by the House. The Position Statement if adopted by the House will define the term. For these reasons, the Board recommends that Resolution 104 be *postponed indefinitely.*

Delegate Harry W. F. Dressel, Jr. Resolution on Classification System for Traditional and Nontraditional Duties: (p. 423/Resolution 105) The Board considered Resolution 105 submitted by Delegate Harry W. F. Dressel, Jr., Maryland, and discussed at some length whether it would be feasible and beneficial to classify traditional and

nontraditional dental assisting and dental hygiene functions. It was noted that prior to 1970 there was significant difference in practice acts throughout the country. Some acts included a list of functions which could be delegated or a list of functions which could not be delegated; some did not identify functions and some included rules and regulations provisions and lists of functions.

It would be necessary for each state to interpret the practice act in effect in 1970 and provide a list of functions which were delegatable at that time. Development of such information has been attempted, but data are inaccurate. The Board could not identify a need for such a classification which in its view introduces still another term for expanded functions.

The Board believes there is general understanding of what historically has been delegated to the dental assistant and the dental hygienist and again notes that the problem is not the term that is used but the lack of identification of the functions which are considered "expanded" or "nontraditional." The Board is of the opinion that developing an additional classification system which could not be accurate would make any discussion of expanded functions unnecessarily complex and create the need to refer to several definitions and classifications in discussing matters related to utilization and education of dental assistants and dental hygienists. The position statement developed by the Council on Dental Education defines what is meant by expanded functions and the House will determine, ultimately, what that definition will be. The position will be on record and will establish a common language for communication. Therefore, the Board recommends that Resolution 105 be *postponed indefinitely.*

Delegate Eugene J. Fortier, Jr., Resolution on Model State Dental Practice Act: (p. 428/Resolution 103) The Board understands that Resolution 103 is directed only to those dental law provisions that are affected by recent federal court cases and related actions that touch upon advertising by professionals. Typically, dental laws have a section that prohibits dentists from advertising and from using other commercial tactics in the announcement of their practices. The Board, therefore, has recommended an amendment to Resolution 103 to remove any implication that a complete model of a dental law is contemplated. The Board's proposed amendment would delete from Resolution 103 reference to a model state dental practice act and insert in its place the following: "the feasibility of recommending changes in state dental practice acts as they pertain to advertising and related sections of the acts." The Board of Trustees, therefore, recommends that *Resolution 103, as amended, be adopted.*

> 103B. Resolved, that the appropriate agency of the American Dental Association investigate the feasibility of recommending changes in state dental practice acts as they pertain to advertising and related sections of the acts, and be it further
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> Resolved, that the results of this study be presented to the Board of Trustees at the earliest time for implementation and funding, if feasible.

Delegate Eugene J. Fortier, Jr. Resolution Amending Resolution 24: (p. 426/Resolution 24S-1) In considering Resolution 24S-1 submitted by Delegate Eugene J. Fortier, Jr., Louisiana, to amend the *American Dental Association Statement on Expanded Function Dental Auxiliary Utilization and Education,* the Board did not find justification for changing the position taken during its August 1976 meeting. The *Statement* was developed by the Advisory Committee and Council on Dental Education

on the basis of extensive background and intensive study. The workshop was *only one source* of information and the opinions of the minority of participants were recorded in proceedings of the workshop. The Advisory Committee, Council and Board have been fully aware of the opinions of the minority in development of their recommendations.

The Board has made a recommendation for amendment of Principle 2 (lines 34-35) (p. 479) which, in the Board's view, meets the intent of the revision of that principle proposed by Delegate Fortier.

The Board believes that deletion of the word "expanded" and substitution of "additional" would only cause confusion. The problem in use of the word "expanded" has been that it has not been defined in terms of functions. The *Statement* presented by the Council on Dental Education identified expanded functions. A change in term would, in the Board's view, introduce a new word for one that has universal connotation.

The *Special Report* includes extensive background and rationale which the Board believes justifies their recommendations on sections of the statement related to educational requirements and functions which could be delegated. Justification for changes are not presented in Resolution 24S-1, therefore the Board finds no reason to change the recommendations it made in August. It believes, however, that there will be opportunity for complete discussion of the *Special Report* and presentation of reasons for the resolution and other proposed revisions in the Reference Committee hearing.

For these reasons the Board recommends that Resolution 24S-1 be *postponed indefinitely.*

Minority Report to "Proceedings, Workshop on Dental Auxiliary Expanded Functions": (Delegate Fortier, et al) (p. 239) In its consideration of the Minority Report on the "Proceedings, Workshop on Dental Auxiliary Expanded Functions," the Board found that the report relates to representation of dental practitioners and to opinions of workshop participants on functions which could be delegated to dental assistants and/or dental hygienists. The Board considered both of these matters in August 1976 in its study of the *Special Report on Dental Auxiliary Utilization and Education.* It has taken a position in support of the Council on Dental Education on the question of representation at the workshop and believes the "Proceedings" of the workshop accurately represent the deliberations and decisions.

The Minority Report represents opinions which were heard during the workshop and recorded in the "Proceedings." The workshop was only one source of information for the Advisory Committee and Council in development of the *Special Report.* The report is based on information developed over the past 15 years.

In making its recommendations to the House in August, the Board carefully studied the report and stated its belief that the Council has adequately defended its position on workshop representation and those functions which can be delegated to dental auxiliaries.

Delegate Ronald I. Maitland Resolution on Training in Cardiopulmonary Resuscitation: (p. 431/Resolution 101) The Board of Trustees agrees with the intent of Resolution 101 which calls attention to the need for the availability of continuing education in cardiopulmonary resuscitation (CPR). It notes that the resolution as presented is consistent with existing policy (*Trans.* 1964:275). After hearing comments on the

CPR training that now is a part of the dental school curriculum, the Board concluded that a substitute resolution urging dental societies to make such programs available would be more conducive to accomplishing the intent of the original resolution. Additionally, the Board of Trustees is requesting the Council on Dental Health, in concert with other agencies, to study the limits of dental practice responsibilities as they relate to and overlap with medical conditions that are traditionally and by law the usual responsibility of the physician. It appears to the Board that the dental profession needs to address the dimensions of the dentist's responsibilities on matters that can relate to dental diagnosis and treatment but are not the normal concern of the dentist.

The Board presents the following *substitute resolution* that, it believes, will best implement the intent of Resolution 101 and recommends its *adoption.*

> 101B. **Resolved,** that constituent and component societies be encouraged to make regularly available to their members continuing education in cardiopulmonary resuscitation.

Delegate Alex J. McKechnie, Jr. Resolution on Reevaluation of Dental Claim Form: (p. 433/Resolution 89) The Board of Trustees reviewed Resolution 89 (p. 433) calling for the reevaluation and redesign of the uniform claim form to reduce repetitious and unnecessary information.

The Board is sympathetic to the intent of this resolution. The seeking of the means to reduce administrative demands brought about by dental prepayment upon the practicing dentist and his staff is a basic function of the Council on Dental Care Programs. It was in the fulfillment of this responsibility that the Council cooperated with major dental prepayment representatives in achieving agreement on a uniform claim form. The Board notes that the primary objective of this agreement was uniformity for the purpose of ensuring the widest possible acceptance of the form. While the Council on Dental Care Programs continually evaluates this approved form, the Board understands that the objective of uniformity remains paramount.

In the view of the Board, universal acceptance of a single claim form is the key to simplified administration for the dentist in that it affords him the opportunity to utilize any of a variety of preprinting techniques in the furnishing of repetitive information. As a consequence, the *Board offers the following substitute resolution for Resolution 89 and recommends that it be adopted.*

> 89B. **Resolved,** that the Council on Dental Care Programs continue to evaluate the currently approved dental claim form, while actively pursuing the goal of uniform acceptance by all third parties, and be it further
>
> **Resolved,** that the Council on Dental Care Programs provide to practicing dentists information on preprinting techniques in connection with the uniform claim form for the purpose of reducing the administrative workload in dental offices.

Delegate Alex J. McKechnie, Jr. Resolution on Use of Procedure Codes: (p. 433/Resolution 90) The Board of Trustees examined with care Resolution 90 which specifies that procedure codes not be required on dental forms submitted by dentists. The Board observes that the *Code on Dental Procedures and Nomenclature* was originally developed by the Council on Dental Care Programs to promote improved, sim-

plified methods of administering dental prepayment programs (*Trans.* 1969:317). While the Board believes these codes represent a concise, effective means of identifying dental services on claim forms, no requirement exists that dentists provide these codes in addition to a description of the procedure. Further, the Board would point out that narrative descriptions of procedure not specifically identified in the *Code on Dental Procedures and Nomenclature* are always appropriate. For these reasons, the Board transmits Resolution 90 to the House of Delegates with a recommendation that it be *postponed indefinitely.*

Board of Trustees Recommendation Regarding Office of Treasurer: The Board of Trustees at its August 1976 session appointed Dr. Jack H. Pfister to serve as Treasurer of the Association for a one rather than three year term commencing November 19, 1976, with the thought of proposing to the House of Delegates that the office of Treasurer be strengthened by permitting the Board of Trustees to provide in its *Organization and Rules* to have the Chairman of the Committee on Finance and Investments, who is always an elected, voting member of the Board, also serve as Treasurer. However, to accomplish this objective an amendment to the *Bylaws* must first be enacted by the House. Therefore, the Board recommends that the following resolution, amending the *Bylaws,* be *adopted:*

> 128. **Resolved,** that Chapter VIII, Appointive Officers of the *Bylaws* be amended by the deletion of Section 20, Appointments, and the substitution therefor of the following new section:
>
> > Section 20. Appointments: Any active, life or retired member in good standing may be appointed to an appointive office by the Board of Trustees in accordance with its rules and regulations.

Board Resolution on Fraud and Abuse in Medicare and Medicaid: The Board of Trustees is concerned with reported fraud and abuse in the Medicare and Medicaid programs.

In the Board's view, a formal expression of the Association's position is the appropriate mechanism to make known the concerns of the dental profession. Therefore, the Board submits the following resolution to the House of Delegates and recommends that it be *adopted.*

> 129. **Resolved,** that the American Dental Association pledges its cooperation in the elimination of fraudulent and other illegal practices associated with the Medicare and Medicaid programs.

Report of the American Dental Hygienists' Association: (p. 355) The Board read with interest the report of the American Dental Hygienists' Association and recommends that it be transmitted to the House of Delegates for information. The Board compliments the ADHA on its growth and appreciates the opportunity to learn more about that Association's programs and activities. Further, it wishes to acknowledge its appreciation for the cooperation shown by ADHA in matters relating to space requirements in the Washington complex. The Board noted that at the request of ADHA, additional office space was provided that Association in the Headquarters Building to accommodate its expansion program. The Board is hopeful that if and when ADHA's space requirements escalate, the ADA will again be able to meet the office needs of that Association.

In reviewing the report, however, it was noted that some information is incomplete. The report includes a statement that the Council on Dental Education has "decided to discontinue the meeting of the Committee on Auxiliaries twice a year." While the Commission on Accreditation and Council have determined that the Committee on Auxiliaries, which is comprised of the review committees on dental assisting, dental hygiene and dental laboratory technology, should not be convened at each of the semi-annual Commission/Council meetings, they have not discontinued the joint meeting of the three review committees. Policy matters related to each of the three disciplines which previously have been discussed in the meeting of the Committee on Auxiliaries will be included on the agendas of the semi-annual meetings of the respective review committees. *The three committees will meet together when there are matters of direct interest to all three occupational areas.*

Thus, the liaison between the American Dental Association and the American Dental Hygienists' Association which has existed through the Committee on Auxiliaries will be retained and hopefully enhanced. *The change in convening committees will result in the involvement of a proportionately greater number of hygienists in formulation of recommendations for ADA policy on dental hygiene matters.* All agencies were informed at the time of the Council's and Commission's decision that they would be invited to participate in that part of the agenda of the respective review committee which relates to policy matters in which they have an interest.

In reaching its decision to convene a joint meeting of the three review committees when indicated, rather than at each semi-annual meeting, the Council and Commission are of the belief that the size of the committee, which is between 30 and 35 individuals, including representatives of the American Dental Hygienists' Association, American Dental Assistants Association and Certifying Board of the American Dental Assistants Association, has inhibited discussion. Also, members have been reluctant to comment on issues that do not relate to their area and the majority of agenda items to date have related directly to only one of the auxiliary fields.

The Board also noted in the report that the ADHA has developed criteria for selecting individuals to recommend as consultants to the Council and Commission, and the statement that the ADHA has urged the Council to adopt similar standards. The Board is aware, as are other agencies, that the Council on Dental Education has from the time of its inception utilized standards for selecting consultants. These criteria have been conveyed periodically to the ADHA to assist that agency in making recommendations for accreditation consultants. The Council and Commission historically have considered it important that dental hygiene consultants have experience in dental hygiene education and are recognized for their expertise. Recommendations have been accepted on the basis of curriculum vitae which indicate that the individual's qualifications justify recommendation to the ADA Board of Trustees for appointment. The number and distribution of consultants appointed in any given year is based on the accreditation load. That load does not always warrant appointment of all individuals who are recommended. The Board would oppose appointment of consultants when there is no need. Further, the American Dental Association has the right and responsibility to make the final decision on the selection of individuals who will serve as consultants for various accreditation activities. In seeking individuals with the highest qualifications, it is wise and necessary to solicit recommendations from a variety of sources. The Board believes that while the Association values and places the highest priority on recommendations received from the American Dental Hygienists' Association, it still must reserve the right to make decisions on consultant appointments.

The American Dental Hygienists' Association's concern about the Workshop on Dental Auxiliary Expanded Functions representative selections is one that the Board seriously questions. In initial letters of invitations to the ADHA, the number of representatives was limited to 15 to assure that the ADA House mandate would be met. At the request of the ADHA, representation of that Association was increased to include two additional staff observers. The Council on Dental Education honored the request from the ADHA because it agreed with that Association that it was important for their staff to be informed. It was unfortunate that this concession contributed to the concern that practicing dentists were not in the majority at the workshop as directed by the ADA House. However, the Board believes the Council would, under the same circumstances, again honor such a request from the American Dental Hygienists' Association because the ADA believes it is important for those who are affected by decisions to participate in deliberations leading to the decisions. Further, the ADA believes it important to provide opportunity for staff of related organizations to be fully informed so that they may convey complete and accurate information to their membership. The Board was particularly disappointed that the comments questioning selection of the workshop representatives appeared in the ADHA report in view of the fact that the issue was discussed at length during the special meeting of the Board of Trustees Committee on Inter-Agency Affairs with ADHA representatives in March 1976. Further, it is difficult to understand why such statements would be made when the ADHA was aware of the stipulations of the ADA House. The Council was certain that individuals selected by the ADHA would be well versed on workshop discussion topics. Finally, the Board noted that all workshop participants had opportunity to consider and revise reports prepared by group chairmen and recorders—a unique procedure which provided a review mechanism beyond that usually found in workshops.

The Board believes that comment on the section of the ADHA report related to continuing education is indicated. The ADHA questions the fact that the Council decided to study the feasibility of establishing a national continuing education evaluation program without including an official representative of the American Dental Hygienists' Association on the special study committee. The Council has had several communications with ADHA on this matter and has stated repeatedly that it was charged by the 1975 House of Delegates to study the feasibility of developing a national continuing education evaluation system *for dentists*. The ADHA's position that they should have designated a representative for dental hygiene would have merit if the charge to the committee had been to develop a continuing education program to encompass dental hygienists. If that had been the case, the American Dental Hygienists' Association would have been invited to designate a representative.

In carrying out its charge the Council believed it important to include individuals with expertise in providing continuing education and it happened that a dental hygienist who is a past president of the American Dental Hygienists' Association and recognized for her abilities and leadership was selected. The Board believes the Association must continue to exercise its prerogative of appointing individuals of its choice, including dental auxiliaries to committees, just as the American Dental Hygienists' Association has exercised its prerogative in appointing dentists to committees without requesting official representation from the American Dental Association.

The Board again noted that the March 1976 meeting of the Board of Trustees Committee on Inter-Agency Affairs, which included American Dental Association and American Dental Hygienists' Association representatives, was positive. The questions raised in the ADHA report were discussed at some length during that meeting. The

Board looks forward to continued improvement of liaison and communication between the two organizations and exchange of complete information on all activities of mutual interest and concern through the Inter-Agency Committee.

During its meeting, the Board was apprised of the fact that arrangements have been made this year to provide identifiable space for ADHA officers in the ADA's House of Delegates. In the spirit of mutual cooperation, which has guided both Associations during the past years, the Board is hopeful that similar accommodations will be extended to the ADA during ADHA sessions.

American Society of Maxillofacial Surgeons (A medical-dental association) Resolution on Amendment of "Principles of Ethics" Regarding Oral and Maxillofacial Surgery: (p. 435/Resolution 94) In carefully studying Resolution 94 submitted by the American Society of Maxillofacial Surgeons (ASMS), the Board reviewed background correspondence and positions of various organizations involved in this issue. The ASMS defines "maxillofacial surgery" to be the practice of medicine and not within the scope of training, experience or practice of educationally qualified oral surgeons. In addition, the ASMS states that "maxillofacial surgery" is a specialty of medicine.

The Board is of the opinion that the American Society of Maxillofacial Surgeons has misinterpreted the intent and actions of the American Dental Association House of Delegates adoption of a revised definition of oral surgery and the provision for the ethical announcement of limitation of practice in oral and maxillofacial surgery.

In 1952, the House of Delegates authorized the Board of Trustees to appoint a special committee for the purpose of studying and making recommendations on the topics covered in a special report on the problem relating to oral surgery, hospital dental service and interprofessional relations (*Trans.* 1952:171). The report of the special committee to the 1953 House indicated in part that despite the provisions of dental practice acts and despite the accumulation of many years of surgery, a frequent cause of misunderstanding was the lack of a clear definition of terms and the desire of some to solve all problems at the national level without regard for local conditions and customs. One of the specific factors leading to the establishment of the special committee was an effort on the part of the House of Delegates of the American Medical Association to place unilateral and national limits and interpretations on the practice of oral surgery. As a result of the study, the Committee recommended and the House subsequently approved the following definition for the area of oral surgery.

> The specialty of oral surgery is that part of dental practice which deals with the diagnosis, the surgical and adjunctive treatment of the diseases, injuries and defects of the human jaws and associated structures.
>
> The scope of the specialty of oral surgery shall include the diagnosis, the surgical and adjunctive treatment of the diseases, injuries and defects of the human jaws and associated structures within the limits of the professional qualifications and training of the individual practitioner and within the limits of agreements made at the local level by those concerned with the total health care of the patient (*Trans.* 1953:143).

The adoption of a revised definition is a result of a Board of Trustees directive that each of the eight dental specialty definitions be reviewed. The definitions have been under discussion for several years; specifically, however, the revised definition of oral surgery was presented to and adopted by the 1975 session of the House of Delegates. The current definition of the specialty of oral surgery is not designed to change the traditional practice of oral surgery. Rather, it was an attempt to represent and clarify the legitimate, current scope of clinical activity.

The definition as adopted by the 1975 House of Delegates is as follows:

> Oral surgery is that part of dental practice which deals with diagnosis, the surgical and adjunctive treatment of diseases, injuries and defects of the oral and maxillofacial region (*Trans.* 1975:691).

The Association believes that the special area of practice in which a dentist announces himself should be consistent with the identification of the specialty and the established nature of patient care provided. Educational requirements do and have required extensive training and experience in surgery of the oral and maxillofacial region. In addition, Association policy related to ethical announcement of limitation of practice was revised in 1971 to assure that all dentists announcing in the area of oral surgery, have successfully completed an accredited education program of at least three years duration.

The *Essentials of an Advanced Educational Program in Oral Surgery* state that a resident's training must include operations such as removal of teeth; corrective hard and soft tissue surgery; biopsy and excision of lesions; open and closed reduction of fractures of the mandible, maxilla and zygomatic complex; condylectomy; arthroplasty of the temporomandibular joint; intra and extraoral incision and draining of odontogenic infections; sequestrectomy and saucerization of osteomyelitis; sialolithotomy; peripheral neurectomy, closure of oral-antral and oro-nasal fistulae; and the surgical correction of congenital, developmental, and acquired deformities of the mouth and jaw regions. Certainly, these procedures fall within the oral and maxillofacial region. By permitting utilization of the term "oral and maxillofacial surgery," the Association permits a suitably trained specialist to more accurately describe the services which he is legally, ethically and professionally qualified to provide to the public.

The Board also noted the claim of the American Society of Maxillofacial Surgeons that "maxillofacial surgery" is a specialty of medicine and is being usurped by the dental profession. It should be emphasized that the House of Delegates has never authorized oral surgeons to identify themselves as "maxillofacial surgeons." Nor has any report been received that this identification has been used by oral surgeons. Rather, members of the specialty of oral surgery may announce that their practice is limited to oral surgery, or "oral and maxillofacial surgery."

The Board believes that the ASMS confuses the recognition of medical specialties with the manner in which limitation of medical practice may be announced. In medicine, there exist 22 specialty certifying boards recognized by the American Medical Association. However, the medical profession identifies some 65 acceptable forms of announcement of limitation of practice. Announcement of limitation of practice in an area of medicine does not connote, necessarily, specialization in a special area recognized by the American Medical Association. Furthermore, dentistry has more specifically delineated the manner in which limitation of practice may be announced than has the medical profession. The specialty areas of dentistry approved by the American Dental Association and the designation for ethical announcement of limitation of practice are: endodontics; oral pathology; oral surgery, or oral and maxillofacial surgery; orthodontics; pedodontics, or dentistry for children; periodontics; prosthodontics; dental public health. Resolution 14 to the 1976 House of Delegates proposes that pedodontics be further recognized as pediatric dentistry.

The ASMS states that "maxillofacial surgery" is a specialty of medicine requiring a medical degree and five years of postgraduate training. The American Medical Asso-

ciation is not supportive of this claim. "Maxillofacial surgery" is not recognized by the AMA as a specialty of medicine; there is not an AMA approved residency in "maxillofacial surgery," nor are there AMA recognized examining boards in medical specialties or subspecialties limited to "maxillofacial surgery."

The ASMS proposes that the House of Delegates rescind its previous actions amending the *Principles of Ethics* and the definition of oral surgery, and suggests that such action would eliminate public confusion and would continue to allow for the medical and dental professions to provide optimal care. The Board does not believe the ASMS to be correct in its position. The Board is not persuaded by the background to Resolution 94 that the 1975 House action should be reversed. Such action would, in fact, adversely affect the dental profession and its specialty of oral surgery and, furthermore, would confuse the public and denigrate the oral surgeons' established right to appropriately identify the nature of services they provide to the American public.

The Board understands that ADA and AMA officials have discussed the convening of a series of conferences, alternately sponsored, to address the several problems existing between medical and dental specialties. Although "maxillofacial surgery" is not a recognized specialty of medicine, the Board believes it might be advantageous for the ASMS to seek participation during the proposed meetings. The Board strongly believes that the only appropriate arena in which to address these issues of dispute between medicine and dentistry is in that forum.

The Board therefore recommends that Resolution 94 be *postponed indefinitely.*

Amendments to 1977 Annual Budget of Income, Expense (Excluding Depreciation) and Nonoperating Disbursements: After the proposed 1977 Budget was submitted by the Board of Trustees, the Association's Editor was advised that the American Association of Dental Research, a division of the International Association of Dental Research, was terminating the agreement appointing and engaging the ADA as the publisher of the *Journal of Dental Research,* effective January 1, 1977. As a consequence of this termination, the Board of Trustees has revised the 1977 Budget proposed in Board Report 3 as follows:

	Original Budget	Revised Budget
Income	$16,507,750	$16,364,750
Total Expenses and Nonoperating Disbursements	16,479,950	16,348,000
Excess of Income Over Expenses and Nonoperating Disbursements	$ 27,800	$ 16,750

The following resolutions and their estimated respective costs are being presented in compliance with the 1975 House of Delegates resolution requesting estimates of costs for the creation of new programs, special committees or studies.

Resolution 36 (p. 380)—estimated cost $1,000
Resolution 41S-1 (pp. 389, 496)—estimated cost $25,000
Resolution 43 (p. 390)—estimated cost $45,000
Resolution 45 (p. 368)—estimated cost $12,000
Resolution 55 (pp. 363, 487)—estimated cost $5,000
Resolution 59 (pp. 364, 488)—estimated cost $25,000

Resolution 77 (p. 476)—estimated cost $3,000
Resolution 89 (p. 433)—estimated cost $10,000
Resolution 93 (p. 516)—estimated cost $18,000
Resolution 96 (p. 520)—initial estimated cost $18,500; annual cost $50,000
Resolution 96B (p. 521)—estimated cost $8,500
Resolution 97B (p. 521)—estimated cost $100,000
Resolution 110bB (p. 518)—estimated cost $2,500

REPORT 5 OF BOARD OF TRUSTEES TO HOUSE OF DELEGATES: ILLEGAL DENTISTRY

The events signaling the approach of "denturism" in the United States are occurring with increasing and alarming frequency.

The immediacy and seriousness of this modern-day form of health charlatanism are unmistakable in the following direct quotations, all related to events that have occurred since the adjournment of the 1975 House of Delegates.

FTC investigation

"The Federal Trade Commission has by unanimous vote directed its San Francisco Regional Office to conduct an investigation into the effects of state regulations which prohibit dental laboratories from selling complete dentures directly to consumers and require that dentures be purchased only through dentists."—News release issued by the Federal Trade Commission.

FTC has authority, U.S. Senator says

"The courts have recognized the power of the Commission, at least in some instances, to promulgate TRRs (trade regulation rules) which have the force and effect of law and which take precedence over inconsistent state law."—Senator Warren G. Magnuson (D-Wash.), chairman of Senate Commerce Committee, in a letter responding to an inquiry from ADA President Robert B. Shira.

Illegal operators organize

"About 160 denture manufacturers from 19 states gathered Friday and Saturday at the Showboat Hotel for the National Denturist (*) Association's first annual convention and talked about revolution. According to the chairman, the convention signals 'the birth of a new profession.' "—News article in Las Vegas *Sun*.

Newspaper wire service report

"Technicians who make false teeth for Americans have begun a national fight to break up the family dentist's monopoly on selling dentures . . . To press their case, denture-makers in more than a dozen states have formed a National Denturist Association, hired a lawyer and launched advertising campaigns."—*Associated Press* wire story .

*The term "denturist" and "denturism" are used and defined in various ways in these quotations originating outside the profession. It should be noted that the American Dental Association defines the term "denturist" as a person who illegally holds himself out as qualified to practice dentistry. "Denturism" is the fitting and dispensing of dentures illegally to the public.

Denturist "degree" urged

"Join your National Denturist Association and be a proud part of the future. Upgrade your profession by adding D.D.P. (Doctor of Denture Prosthetics) following your name."—From a four-page advertising supplement in an industry periodical announcing a nationwide membership drive by the National Denturist Association.

Denturists' dues $600

"I am interested in becoming a member of the Denturist Association and am enclosing a check in the amount of $600 for my original membership cost. If for any reason my membership is disapproved by the Board of Directors, I understand I shall receive a reimbursement check for the full $600."—From the *Membership Application Form,* California chapter, National Denturist Association.

"Denturist" definition

"A denturist is a dental technician specializing in the diagnosing, manufacturing and fitting of dentures. It is an accepted dental practice in eight of Canada's provinces and, according to all reports, dentists, technicians and consumers are very happy."—News article in Quincy (Mass.) *Patriot Ledger.*

Oregon to be first

"If the denturist movement succeeds in getting organized locally, Kansas will become the 20th state in which an attempt is presently being made to change the laws to allow denturists to operate. Oregon is expected to become the first state to legalize denturism and set up for control and supervision guidelines of the profession when the Oregon legislature convenes early next year."—News article in the Wichita *Sun.*

Legislator's views

"We need someone to make teeth. We don't care if it is a blacksmith as long as they (voters) get teeth. . . . I want to license them (denturists), bring them out in the open so people will know who they are. If this bill isn't correct, I am willing to work out some amendments."—Statement by Representative James T. Dudley (D-Enfield) during floor debate on a denturist licensing bill in the Maine House of Representatives.

Newspaper's warning

"This defeated denturism bill is doubtlessly a signal of what's to come. So it would behoove the professional dentists to get involved in initiative programs which would make professional dental care more easily accessible to Maine people of limited means."—Editorial in the Bangor *News.*

Lobbyist's recommendation

"I strongly recommend that the Association move forward with deliberate speed to address the issue of the availability of dentures for low income people. . . . The dental association was, in essence, given one 'free shot.' That was this year. Next year we will have had notice that the matter is one which deserves serious consideration by the professionals providing dental health care in Maine and alternatives to a 'denturist' proposal should not only be reviewed and proposed but, if meritorious, initiated."—Letter to the Maine Dental Association president from that Association's lobbyist after the defeat of a denturist bill.

In 1977, as many as 20 states may have "denturism" bills introduced in their legislatures. The Federal Trade Commission is expected to complete its study of the free-trade implications of state laws restricting denture care to licensed dentists and numerous instances of overt illegal dental practice will be litigated. Despite the profession's best efforts, dentistry will continue to receive large doses of "bad press."

This report to the House of Delegates concerns steps for resolving this serious and rapidly accelerating illegal dentistry problem—both the national level steps that have already been taken by the Board of Trustees, as well as those steps that yet need to be

taken. It also presents the Board's recommendation on what the constituent and component levels of organized dentistry need to do in order to proceed in a coordinated manner to eliminate from their jurisdictions this threat to public health and to the profession of dentistry.

Background: In August 1974, the Board of Trustees commissioned a one-year study of the growing illegal dentistry phenomenon in the United States and its recurring successes in obtaining statutory recognition in Canada.

A distinguished six-member Commission, appointed by then-President Carlton H. Williams, conducted on-site investigations in both countries and, at the conclusion of the study, presented a comprehensive report tracing the history of the illegal dentistry movement, its probable causes and the steps that might be taken to prevent its further spread in this country. (That report and a summary of the study Comission's 20 recommendations for action by the American Dental Association were published in the April 1976 edition of *The Journal of the American Dental Association.*)

It is noteworthy that one of the members of the Commission was a dental laboratory technician nominated by the laboratory industry.

The Board of Trustees in August 1975 adopted the Commission's 20 recommendations in their entirety and assigned them to various Association agencies for implementation. At the same time the Board extended the tenure of the Commission for one additional year to monitor the progress of Association agencies in responding to the recommendations and to present evaluations and further recommendations at intervals through that year.

As a result of the highly competent work of the Commission and equally skilled efforts on the part of several of your Association's Councils and Bureaus, the Board of Trustees is now able to report that specific, reasoned steps are being taken to deal with the underlying causes of illegal dentistry. But these are *preliminary* steps against a burgeoning problem, and much more remains to be done before the challenge can be considered met.

Nature of the Problem: Illegal dentistry poses a genuine health threat to the edentulous and the partially edentulous public. The organized illegal operators today are quite different from the individual offenders many of us have observed in the past. The organized illegal operators are using sophisticated legislative, legal and public relations personnel and tactics in a bid for public approval and statutory recognition. They have achieved their objectives in most Canadian provinces. Their efforts in the United States are accelerating month by month.

As the special study Commission has accurately pointed out, the final decision as to whether the "denturism" movement survives will not be made by the dental profession; it will be made by the general public through elected legislators based on the type of evidence that has been presented.

To gain public support and successfully prevent the victimization of patients by illegal operators, the profession must demonstrate its own responsiveness to public needs. This can be accomplished by better meeting certain health needs of the public. Groups of Americans who have not gained access to the excellent quality of dental care that is available in this nation must be given assistance in gaining full entry to the dental care system so that they will not be inclined to seek substandard forms of care.

Nature of the Solution: Since the fundamental characteristic of the problem is one of economic barriers to full access to dental care, the long-term solution must be found in reduction of those barriers. This can be accomplished through one or a combination of the following: (1) denture care cost reductions, (2) public assistance programs that subsidize lower-income denture care patients or (3) private prepayment programs capable of helping patients obtain an adequate standard of professional denture care with the limited financial resources they have available. By insuring that all persons have ready access to dentists' offices at what they perceive as a reasonable cost, the market for the illegal operator will largely cease to exist.

To accomplish significant progress in any of the three areas listed above may require hard rethinking on some policies and traditions of practice that our Association has espoused over many years.

There are other parts of the solution to illegal dentistry which also need full attention and dedication of resources: (1) educating the public about the important health aspects of dental care, (2) improving the general dentist's abilities and interest in denture prosthetics, (3) encouraging preventive law enforcement, (4) fostering innovations in denture care delivery, (5) promoting a higher level of awareness in the public and among legislators of the needs of the edentulous patient and the hazards of treatment by unqualified operators and (6) improving the dental laboratory technician's abilities in denture fabrication.

Unfortunately, the profession's greatest obstacle to success is internal apathy. For whatever reasons, many in the profession will remain ill-informed and many others will remain unconcerned until the denturism problem arrives in their community. This has been observed repeatedly.

Association Actions: The Association has passed through three succeeding steps in approaching the illegal dentistry problem: first the in-depth study of the problem, then the recommendations for solutions and, most recently, the planning of how to implement those recommendations. These have been accomplished through administrative directives of the Board.

The Association has now arrived at a pivotal point in deciding its commitment to implementing those plans and solving the problem. Commitment will be measured in manpower, energy and dollars. The course the Board has charted includes the following specific activities:

1. In March this year the Board joined with the executive council of the Oregon Dental Association in authorizing a two-year pilot program for increasing access to denture care in that state. Bills to legalize "denturism" have been introduced in the 1973 and 1975 biennial legislatures in Oregon, and it is certain that legislation will be attempted again in 1977. It is expected that the Oregon program, as a pilot project dealing directly with the issues of illegal dentistry at the state level, will be a valid experiment in the development of materials and procedures that will be of benefit to all states.

   The project, which the Oregon dentists have named "POW! Project Open Wide," includes among its features: a survey instrument for measuring dentists' and dental laboratory technicians' attitudes about denture care and illegal dentistry; a training program for dental society spokesmen; a state-level public forum on oral health needs to open dialogue with important leaders outside the profession and to develop in concert with the community programs for increas-

ing access to dental care; a follow-up series of public "town meetings" on community dental health care needs; a task force on exploring new possibilities for providing private prepaid and postpaid dental care to the elderly and low-income persons in the state; a similar task force on public programs for financing denture care; a research committee studying procedures of reducing denture care cost and conducting seminars for dentists and their dental laboratory technicians on cost-reduction procedures; a series of component society "rap sessions" to discuss the issues of illegal dentistry, to keep the individual member informed and to offer suggestions on how the individual dentist can help; a speaker's bureau to enable dentistry to take its position to the public; a task force for tightening compliance with the state's dental practice act with regard to work authorizations and the proscription on referral of patients to dental laboratories; a legislative information packet on denture care.

A newsletter for "POW! Project Open Wide" has been started and is being sent regularaly to all ODA members and to persons outside the profession who have an interest in oral health care. It is also being mailed to all constituent dental society offices.

The ADA Board of Trustees allocated $67,000 from 1976 contingency funds in March to begin the Oregon project. The Oregon Dental Association is contributing an additional $15,000 and enormous numbers of man-hours to make the project a success. The second year of the two-year project is expected to cost $42,500, and that expense is to be shared equally by the ODA and the ADA.

In August this year the Board initiated these additional activities:

2. The Council on Dental Research was directed to assemble an ad hoc committee of experts in denture care, practice administration and dental economics to study the feasibility of new forms of ethical denture care delivery. The committee will operate under the auspices of the Council. It will be able to propose research in areas where research is indicated and may seek financial support for that research. The Board approved the allocation of $20,000 for this committee's activities in the 1977 proposed budget.

3. The Bureau of Dental Health Education was directed to proceed immediately in the selection of key groups who represent large numbers of edentulous persons, such as senior citizen organizations, and to make personal visits to those organizations to discuss matters of dental health education, publicly funded assistance programs, nursing home care, illegal dentistry and other concerns. An allocation of $2,000 from the 1976 contingency fund was provided to pay for the costs of the personal visits.

4. The Bureau of Dental Health Education was also directed to proceed with the development of a comprehensive legislative package of materials on oral health care for edentulous patients and on the necessity of that care being provided by a trained and qualified health professional. The Board approved an allocation of $7,600 in the 1977 proposed budget for the development of the legislative package.

5. The Board accepted two statements of guidelines on the after care of denture patients which were drafted by the Council on Dental Health in consultation with the Federation of Prosthodontic Organizations. These statements,

After Care Guidelines: Full Dentures and *After Care Guidelines: Partial Removable Dentures,* are being transmitted to the 1976 House of Delegates with the Board's recommendation that they be adopted as expressions of Association policy. The Council on Dental Health has been directed that upon their adoption the guidelines should be promoted widely to the profession.

6. The Council on Dental Laboratory Relations was directed to work in conjunction with other appropriate agencies of the Association to convene a workshop in early 1977 devoted to solutions to problems of access to comprehensive oral health care for lower income adults and families where Medicaid monies are not available. The Board approved the allocation of $7,500 for this conference in the 1977 proposed budget.

7. The Council on Dental Laboratory Relations was directed to begin work, immediately after the workshop on access is completed, on the development of a compendium of initiatives that may be taken by organized dentistry at the local, state and national levels to increase access to comprehensive oral health care for lower income adults and families where Medicaid monies are not available. The Council was instructed to work with other appropriate Association agencies in the development of the compendium.

8. The Council on Dental Laboratory Relations was directed to proceed with plans it submitted for a three-day conference on dental law enforcement in 1977 and a one-day dental examiner seminar on law enforcement which will precede this year's annual session on November 13 in Las Vegas. The Board approved the allocation of $2,300 for the three-day conference in the 1977 budget.

9. The Council on Dental Health was directed to survey the appropriate cancer research and treatment centers to determine what information may exist demonstrating a cause-and-effect relationship between oral cancer and ill-fitting dentures. The Council is to report its findings to the March 1977 session of the Board.

10. The Council on Dental Education was directed to seek a meeting between representatives of the American Association of Dental Examiners and the American Dental Association for the purpose of determining the best ways to encourage state dental boards to evaluate the sections of licensure examinations which test the applicants' proficiency in the technical aspects of removable denture prosthetics and to increase that emphasis where appropriate. The Council is to report to the Board in March 1977 the progress of the discussions with the American Association of Dental Examiners.

11. The Council on Dental Education was directed to adopt the most effective course for urging state boards of dentistry to provide on an ongoing basis summaries of examination results to the Council. The Council is to report on its progress in this matter to the Board in March 1977.

12. The Council on Dental Education was directed to study the problems of dental schools finding sufficient numbers and varieties of denture patients for clinical instruction. The special study Commission had presented to it the incredibly ironical problem of a shortage of full denture patients at many dental schools. The Council is to report to the Board in March 1977 its findings and its proposed solutions for this highly dismaying problem.

13. The Council on Dental Laboratory Relations was directed to implement its

proposal to continue after August 1976 the activities of the expired special study Commission on denture care with regard to (1) the continuous monitoring of illegal dentistry activities; (2) the continuing consideration of long-term solutions to denture care problems, particularly as they relate to the activities of laymen not trained or otherwise qualified to practice dentistry; and (3) the coordination of activities of other Association agencies to the extent that those activities concern the illegal practice of dentistry. The Board approved the allocation of $1,900 in the 1977 proposed budget for expenses of bringing to the Council meetings expert consultants on matters related to denture care and illegal dentistry. The Board also approved an allocation in the 1977 proposed budget for the creation of a new position of assistant secretary of the Council on Dental Laboratory Relations to coordinate and conduct activities related to denture care.

The Board of Trustees also received in August, in response to an earlier request, a proposal for a health education project in denture care. The Bureau of Dental Health Education presented the multi-faceted program— one phase of it directed to the general public, and the other phase directed to the profession.

The professional education component would include an after-care program kit containing materials for the dentist which would suggest ways in which he can inform his patients about denture care, suggest a method of patient recall to facilitate continuing care for the edentulous and offer resources and methodology for successful patient education. Also included in the kit would be a 16mm continuing education motion picture on comprehensive oral health care for edentulous patients.

The public education component would include pamphlets to explain the various aspects of comprehensive denture care, including the care of dentures, new dentures, immediate dentures and the need for regular oral health examinations; radio and television public service announcements on how to maintain a healthy mouth and how to avoid the hazards of oral neglect; a 16mm motion picture designed to emphasize prevention and oral health of the edentulous and a publicity campaign to alert the dental profession and allied health professionals of the availability of special health education materials on care for the edentulous patient .

The total estimated cost of this health education campaign was $326,000. This high priority activity had to be postponed because of severe constraints in the Board's effort to present a balanced 1977 budget to the House of Delegates, and because of uncertainties about the outcome of upcoming national conferences and a pilot program in Oregon. It will be taken up again by the Board in 1977 after there has been a chance to evaluate the results of the national conference on access to dental care for lower income persons and the progress in the pilot program on increasing access to denture care in Oregon. However, it must be emphasized that no provision for funding this health education campaign is made in the proposed 1977 budget.

Constituent Society Actions: The activities listed above are appropriate for the national association in solving the problems of denture care. There is much, however, that can be accomplished at the state and local levels. Illegal dentistry is a national problem that strikes at the state level but occurs at the local level.

Members of the House of Delegates can be influential and instrumental in seeing that their constituent and component societies are working in concert with the ADA in solving denture care problems. It is important, first, that every one of your con-

stituents is aware of the significance of illegal dentistry to both them and their patients' health.

It is important that each constituent society has a blue ribbon committee dealing with denture care problems. The committee, ideally, will have representatives of the state board of dental examiners, the state dental political action committee and the state dental laboratory association, as well as the state dental association. Committees that are already established can move more quickly against illegal operators to stop them at an early stage.

It is essential that dentists at the local-community level have the trust of members of their state legislature. Legislators should be kept well informed of the illegal inroads by unqualified and unlicensed personnel. Highly effective lobbyists are essential at the state level if dentistry is to effectively convey its concerns about public health to the lawmakers.

There is great merit in the state board of dental examiners and the state dental society issuing joint notices to all licensees to stress the need for *full* conformance with state's dental law requirements for written work authorizations. And it is equally important for state boards to inform licensees who ever refer a patient to a dental laboratory for any service whatsoever that they are breaking the law as surely as are the "denturists." Appropriate ethical and legal penalties should be swift for those failing to comply.

The same type of joint effort between the state board and the state dental association can be used to inform dental laboratories that compliance with the dental law is mandatory and carries an obligation upon the dental laboratory to refuse any patient referral by a dentist, as well as direct service requests from the public.

Full support of the state political action committee is essential. That means every dentist should make a contribution each year. The dental PACs must have dentists' financial backing to accomplish their function of helping to elect legislators who are sympathetic to the health needs and protection of the public.

Finally, and most importantly, the problem of access to denture care must be addressed at the state and local levels as it is being addressed at the national level. In the words of the special study Commission, the long-term solution lies in "helping the patient obtain an adequate standard of professional dental care, including denture care. By insuring that all persons have ready access to dentists' offices, the market for the illegal operator will largely cease to exist."

It is with respect to this statement of philosophy--that professional dental care should be accessible to all Americans--that a resolution is presented for House consideration at the end of this report. The resolution expresses the Association's firm opposition to substandard dental care provided by inadequately trained persons. It also urges state and local dental societies to join in eliminating barriers to the full accessibility to professional dental care. The Board of Trustees recommends adoption of the resolution as a statement of policy of the American Dental Association.

Future Programming: The special study Commission and the Council on Dental Laboratory Relations were asked to present to the Board of Trustees examples of the types of projects that might be needed if the denturism problem continues its present course. In addition to the postponed $326,000 health education campaign, the list the Council and Commission presented included:

> Detailed investigation of the characteristics of the status of legalized denturism in Canada

Regional conferences on illegal dentistry

Development of spokesmen training programs

Legislative assistance to as many as possible of the 20 states slated to receive denturism bills in 1977

More intensive research on new forms of ethical denture care

Exhibits for use by constituent dental societies for demonstrating the health hazards of illegal dentistry to the public and demonstrating the importance of complete and accurate work authorizations to the dentist

The Commission advised the Board in its final report that it was conceivable that as much as $2 or $3 million would be needed over the next three years as denturism reaches the prominence as a public issue that it did in Canada.

In fulfilling its responsibilities to administer effective programming on behalf of the dental profession, the Board of Trustees finds itself continually having to retreat from full commitments because of fiscal realities. A total of $76,000 was allocated from the 1976 contingency budget for illegal dentistry-related activities described earlier in this report. The cost of activities included in the 1977 budget, including the second executive staff position within the Council on Dental Laboratory Relations, totals $66,150.

In terms of the individual dentist member of the Association, the commitment is about $.72 per fully privileged member in 1976 and $.62 per fully privileged member in 1977. To undertake the health education program on denture care that has been postponed would cost approximately $3.04 per member beyond that now budgeted.

The Association's overall fiscal problem is one of stretching the dollars across the dozens of vitally essential care-taking activities the Association is obligated to perform if the profession is to maintain its self-governing independence, yet still having at its command the necessary funds to have an impact on the numerous serious and complex issues that are challenging our profession: illegal dentistry, Federal Trade Commission activities, public education, prepayment, federal legislation including national health insurance, HMOs, PSROs, to name but a few.

Meanwhile, the members of the newly formed, so-called National Denturists Association contribute $250 for their 1976 national dues and have set $600 for their 1977 dues. The single objective of that organization, which is urging its members to assume the title D.D.P., Doctor of Denture Prosthetics, is to propagandize our state legislators, the courts, the public, even our patients. Their goal is to replace natural teeth. Their means to that goal is to undermine public confidence in the dentist's role as the person solely responsible for all of oral health care.

The self-proclaimed "denturists" are not to be expected to withhold their efforts until such time as dentistry deems fit to respond fully to their challenge.

The Board of Trustees would welcome any House policy statements or directives for action on the problem of access to denture care or any of the other of the secondary facets of the denturism problem.

Therefore, the Board transmits Resolution 114 to the House of Delegates with the recommendation that it be *adopted.*

114. **Resolved,** that all Americans should have access to dental care provided by adequately trained and fully competent health care professionals, and be it further

Resolved, that the responsibility for the provision of denture care rests with the dentist, and the provision of substandard care solely through individuals of lesser training and competence is firmly opposed, and be it further

Resolved, that the American Dental Association and its constituent and component dental societies should take immediate steps to identify the economic and other barriers to full access to professional care within their jurisdictions and to seek remedies that will remove those barriers.

REPORT 6 OF BOARD OF TRUSTEES TO HOUSE OF DELEGATES: CONSUMER DIRECTORIES OF PRACTICING DENTISTS

Background: The learned professions are being challenged increasingly to provide more consumer information, whether this be facts which will enable the consumer to select a dentist, a physician or a lawyer, or fee information which will enable the consumer to judge whether the bill he has received is fair. The basic reasoning behind these pressures appears to be that if more information is provided to the consumer, competition will be increased between practitioners and health care costs will be lowered.

These pressures come from such diverse sources as the Federal Trade Commission, the Justice Department and a variety of consumer groups. The range of demands is quite broad: At one end of the spectrum are agencies which ask that the health professions advertise fully in all media, providing full fee information; at the other end of the spectrum are groups which ask for consumer directories of dentists and physicians which provide basic information on the types of practice, the waiting time for appointments, office hours, and, perhaps, fee ranges for the geographic area.

Several component and constituent societies of the American Dental Association have cooperated with local consumer groups to develop consumer guides or directories of practicing dentists. Currently, the American Dental Association has no specific policy on such consumer directories nor has it provided any formal guidelines on how constituent or component dental societies might operate if they wish to develop a directory with or without the help of a local or state consumer organization.

Staff Study and Board Recommendations: In July, the Executive Director appointed a staff committee to study all aspects of consumer directories. This report contains the findings of that committee and the resultant recommendations of the Board of Trustees to the House of Delegates. The committee consisted of the assistant executive director for Communications as chairman, the assistant executive director for Dental Health, the assistant executive director for Legislation and Legal Affairs, the assistant executive director for Business Affairs-House Counsel, the Associate House Counsel, the associate director of the Bureau of Public Information, and the secretary of the Council on Judicial Procedures, Constitution and Bylaws.

Based on this study, and the discussions of the Board of Trustees, the Board recommends:

1. that constituent and component dental societies be encouraged to produce or cooperate in producing ethical "consumer directories" of dentists in their

areas which will provide meaningful information to the public,

2. that constituent and component societies consider cooperating with responsible state or local consumer organizations in the production of such directories,

3. that appropriate agencies of the Association develop guidelines and report these guidelines to the March 1977 session of the Board of Trustees for consideration and promulgation.

The reasons for these recommendations are outlined in the following report: however, it should be noted throughout that if this resolution passes it would still be entirely voluntary on the part of each society as to whether they participated or not.

Practical Implications: The Justice Department and the Federal Trade Commission have taken strong steps to weaken the codes of ethics of the learned professions. Clearly, it is impossible to know the full reasoning behind these actions. However, it is the belief of the Board of Trustees that if state and local dental societies are persuaded to issue effective consumer directories, it will vitiate the essence of the governmental complaints: that the public is unable to obtain essential information in selecting and patronizing practitioners. Further, if dental societies cooperate in publishing such directories, it will be an explicit display of good faith by the profession and will provide a very solid platform from which to defend against further encroachment on professional ethics.

Governmental and Legal Pressures on the Profession: During this past year, a variety of legal and regulatory steps have been taken that, if successful, would seriously weaken the traditional codes of ethics of the learned professions.

1) The Federal Trade Commission in December 1975 filed an antitrust complaint against the American Medical Association. The complaint charged that the AMA's *Principles of Medical Ethics,* because it restricted physician advertising, was in violation of federal law by restraining competition among physicians. The matter was scheduled to come before an FTC trial examiner—an administrative judge—on October 26. A finding for AMA would end the matter. A finding for the FTC will likely move the case to the U.S. Circuit Court of Appeals for review. It may eventually go to the Supreme Court.

In May 1976 the AMA Judicial Council stated that its *Principles of Medical Ethics* "do not proscribe advertising; they proscribe the solicitation of patients." The AMA Judicial Council defined solicitation as attempts to obtain patients by persuasion or influence using statements or claims that contain testimonials, self-laudatory remarks or misrepresentations. The Judicial Council's statement said that physicians could furnish information to the public through "the accepted local media of advertising or communication which are open to all physicians on like conditions." Office signs, professional cards, dignified announcements, telephone directory listings and reputable directories were designated as acceptable media. The statement said physicians could supply the following types of information: name, type of practice, office location, office hours and other information that will "enable people to make a more informed choice of physician."

In addition, physicians who wish to supply fee information to a reputable directory can publish charges for a standard office visit or fees or fee-ranges for specific services, provided factors and conditions affecting the amount of the fee are fully disclosed.

2) The U.S. Department of Justice in June 1976 filed a civil antitrust suit against the American Bar Association charging ABA with conspiring to prohibit lawyers from engaging in advertising the availability and cost of legal services. In February 1976 the ABA changed its *Code of Professional Responsibility* to permit lawyers to advertise specified information in reputable consumer directories, law directories published by official legal publishers and local bar associations, and display ads in the yellow pages. In addition to name, office location and telephone number, the new advertising ethic permits lawyers to advertise such information as areas of specialty, office hours, any foreign languages spoken, school of graduation, and initial consultation fees.

3) In early October 1976 the U.S. Supreme Court agreed to hear a test case on lawyer advertising by two Arizona law partners. The case was appealed from the Arizona State Supreme Court which in July upheld the Arizona Bar's ethical restrictions on lawyer advertising. The two lawyers, who had advertised fees for legal services in a statewide newspaper, are challenging advertising restrictions on grounds that they violate federal antitrust laws and Constitutional guarantees of free speech.

Ethical Considerations: Section 19 of the American Dental Association *Principles of Ethics* states:

> Directories: A dentist may permit the listing of his name in a directory provided that all dentists in similar circumstances have access to a similar listing and provided that such listing is consistent in style and text with the custom of the dentists in the community.

Section 12 of the *Principles of Ethics* concerns advertising and it states:

> Advertising reflects adversely on the dentist who employs it and lowers the public esteem of the dental profession. The dentist has the obligation of advancing his reputation for fidelity, judgment and skill solely through his professional services to his patients and to society. The use of advertising in any form to solicit patients is inconsistent with this obligation.

After the issuance of a directory of dentists by a consumer group in 1975, Dr. Elbert H. Smith, then chairman of the Council on Judicial Procedures, Constitution and Bylaws, was asked to comment on the ethical questions involved and the likely consequences of a dental society bringing charges against a dentist who did participate. He stated in part:

> Recent activities by the Federal Trade Commission and the Justice Department, especially concerning the listing of pharmaceutical prices by pharmacies, suggest that a disciplinary action based on the listing of procedures and fees would ultimately be unsuccessful and probably be damaging to the public esteem of dentistry. An unfavorable precedent is also applicable in that the listing of procedures and fees by dentists was recently required under the Economic Stabilization Program. In addition, under recent U.S. Supreme Court decisions (and consequently not subject to a private group's ethical constraints) sponsors of third party plans may freely disclose fees for various procedures to their subscribers.
>
> Under these circumstances and for these reasons, I would suggest that this and similar directories may be legally protected. I would rather see our efforts directed toward the dissemination of more useful information to the consumer.

Finally, as the House of Delegates is aware, the ADA Council on Judicial Procedures, Constitution and Bylaws has submitted Resolution 13 (p. 178) proposing a moratorium on disciplinary actions against dentists for ethical violations involving advertising, except that which is designed to solicit patients.

Fee Information: The question of whether information on fees should be included in such consumer directories is complex and involves many legal ramifications.

The Board of Trustees has commented on the distribution of fee information nationally in relation to Illinois Resolution 48 (p. 489). In the context of this report it can be said simply that if fee information is included in a consumer directory, that fee information should be collected and disseminated by a consumer group and not by the dental society.

Bureau of Economic Research and Statistics Information: The results of the 1975 Survey of Dental Practice have been placed on computer and the Bureau of Economic Research and Statistics will soon be able to make basic information available to component societies on the practicing dentists in each area. That information will include the dentist's name and office address, his year of birth, his year of graduation, the school from which he graduated, the character of his practice and his telephone number. This material can be provided to the component society as a computer readout. Thus, with very little additional effort of the component, it would be able to provide this basic information to consumers.

Final Comment: In summary, then, the Board of Trustees believes that it would be beneficial to the public, and to the ultimate goals of the profession, for dental societies to participate in the publication of effective consumer directories.

This activity could weaken or eliminate the pressures on the profession to enter into mass advertising, and it could greatly enhance communications between the profession and the public. For these reasons, the Board of Trustees submits the following resolution to the House of Delegates with the recommendation that it be adopted.

> 115. **Resolved,** that constituent and component dental societies be encouraged to produce or cooperate in producing ethical "consumer directories" of dentists in their areas which will provide meaningful information to the public, and be it further
>
> **Resolved,** that constituent and component societies consider cooperating with responsible state or local consumer organizations in the production of such directories, and be it further
>
> **Resolved,** that appropriate agencies of the Association develop guidelines and report these guidelines to the March 1977 session of the Board of Trustees for consideration and promulgation.

REPORT 7 OF BOARD OF TRUSTEES TO HOUSE OF DELEGATES: REPORT OF COMMITTEE ON ADVANCE PLANNING

As the House of Delegates is aware, the Committee on Advance Planning of the Board of Trustees has been active for several years in studying a number of matters related to the future direction of the Association. The Board notes that the California Dental Association has submitted a resolution (p. 363) requesting that the activities of this Committee be reported to the House of Delegates. It has been, in fact, the intention of the Board of Trustees to do so.

The main concern of the Committee on Advance Planning during 1976 has been an examination of the organizational structure of the Association with a view to modifying it as necessary to enhance the Association's effectiveness in carrying out its duties. A report of its findings and recommendations has been submitted to the Board of Trustees. The Board has considered it at length and is convinced that the proposed plan, which is appended, is sound and well considered. The Board has formally adopted the report and all of the restructuring proposals contained therein. It is forwarding it to the 1976 House of Delegates for its approval.

In presenting it, the Board notes that most of the changes proposed can be implemented under the existing authority possessed by the Board of Trustees and the Executive Director to manage and administer the affairs of the Association.

However, one group of recommendations, those relating to changes in the number and compositions of councils, bureaus and commissions, require amendments to the *Bylaws* and thus action by the House of Delegates. Because of the interrelationship between the managerial restructuring and proposed *Bylaw* changes, it is the Board's view that the entire report should be presented to the House of Delegates so it may take cognizance of the full context of the changes being recommended.

The Board is concerned that the House of Delegates be satisfied that the actions being proposed are those best suited to dentistry's pressing modern needs. The Board is convinced that the appended *Proposal of the Committee on Advance Planning on Structure of American Dental Association Agencies* will indeed fulfill that function. The Board calls particular attention to the comments in the *Proposal* pointing out that it deals with the structure of the Association and not personnel considerations which are, of course, under the purview of the Executive Director. It is the Board's belief that decisions concerning the proper structuring of the Association must first be decided upon and personnel considerations can then be arranged in accordance with those structural decisions. However, the Board wishes the House to know that, in its view, the proposals will not materially effect, one way or the other, the staffing needs of the Association.

With respect to the proposed organizational chart which is part of the *Proposal*, it should be understood that it displays a separation between a council itself and the staff assigned to provide administrative support to that council in order to make clear that the councils are creations of and responsible to the House of Delegates, while the administrative support structure is the concern of the Executive Director.

The Board is convinced that today's needs are so urgent and pressing that movement toward a more effective structure cannot be inordinately delayed. Time is a luxury we cannot afford. While the Board fully understands that it is asking the House to add to an already heavy agenda a matter of considerable complexity, it is confident that the House shares this feeling of urgency and will make every effort to complete its part of the task as swiftly as it deems commensurate with the need for prudent deliberation.

Accordingly, the Board transmits its report to the House of Delegates with the following resolution:

> 116. **Resolved,** that the *Proposal of the Committee on Advance Planning on Structure of American Dental Association Agencies* be approved.

REPORT OF COMMITTEE ON ADVANCE PLANNING

Background: At the August 1975 session, the Board of Trustees adopted the following resolution:

> Resolved, that the Committee on Advance Planning be directed to formulate a plan with costs to perform a study of the structure, management, operation and function of the Association utilizing both an in-house evaluation as well as outside expertise and report to the March 1976 session of the Board of Trustees (*Trans.* 1975:446).

At the March 1976 session the Committee reported on the progress of its study of the present council and bureau structure of the Association. The Committee also requested and received authorization to select an outside management firm, if needed, at a cost not to exceed $35,000.

At its meetings in May and July, the Committee studied a proposal for restructuring the Association which was developed by the Committee's Chairman, the Executive Director and several members of the staff. The proposal was reviewed in detail and several modifications were recommended. The Committee also adopted the following *Statement of Purpose*, which was, in turn, adopted by the Board of Trustees at its August 1976 session:

> 1. To shape Association agencies in such as way as to relate most effectively a..d efficiently to the actual problems facing the profession.
>
> 2. To facilitate the most cost-effective use of available funds and personnel.
>
> 3. To eliminate as far as possible overlapping or duplicative or uncoordinated activities of agencies in order to administratively identify with precision where responsibility for an activity is located (and to be better able to judge performance standards of agencies) and to insure uniform responses to essentially the same challenge or problem by all agencies.
>
> 4. To assure that the Association is structured in such a way as to address itself with dispatch and excellence to the many problems confronting dentistry today and to relate to the membership in such a way as to assure and impress on each member that his Association is indeed effectively representing him in these areas of concern.

The Committee agreed at its July meeting that a staff committee be appointed to consider the initial proposal and recommended modifications and to develop a formal, comprehensive proposal. Accordingly, the Committee requested the Executive Director to appoint a committee, of which he would be chairman, to develop a restructuring proposal for the Committee's consideration at its October 11, 1976 meeting.

The Executive Director then appointed the following staff members to the Staff Committee on Structure of the Association: Mr. Bernard J. Conway, vice-chairman, Mr. Eric M. Bishop, Dr. John M. Coady and Mr. John P. Noone.

On October 11, 1976, the Committee on Advance Planning considered and modified the proposal developed by the Staff Committee. The proposal as adopted by the Committee on Advance Planning is presented in *Appendix I* and is submitted for the consideration of the Board of Trustees.

APPENDIX I

Proposal of the Committee on Advance Planning on Structure of American Dental Association Agencies

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I. Introduction: Today, and for the foreseeable future, the dental profession is facing a broad range of intense challenges, some of which would, if brought to fruition, greatly distort the historic dental health system to the detriment of patients and dentists alike.

The forces involved in these challenges are of such strength and diversity that it is not always possible for the profession to dictate solutions. The profession must, through negotiation and demonstration, persuade others to its point of view and have them join dentistry in offering mutually agreeable solutions.

Ideally, the profession's point of view will largely prevail. If it does not, the profession should at least be able to know that it has focused on the fundamental issues.

The present structure of the Association--however appropriate to the past—is inadequate to the present and to the future. Appropriate revision will enable the Association to focus more effectively on these fundamental issues and bring its available resources into a framework that will facilitate coordinated and aggressive programming.

This proposed restructuring is offered as a tool to accomplish these goals.

The proposed restructuring has four fundamental purposes, as set forth in the *Statement of Purpose* adopted by the Committee on Advance Planning. To accomplish these purposes, those councils whose activities today are no longer central to the modern purposes of the Association are eliminated. In every instance, the necessary functions being carried out by those councils are located somewhere within the proposed restructuring and will be described later.

The number of bureaus has been reduced from eight to seven and modifications proposed in order to locate closely related activities within one agency and thus enhance the possibility of greater coordination, allow for better based future planning and permit cost-effective use of each dollar.

This proposal is not primarily intended to be a cost-cutting device. It is doubtful that initial savings of any size will be realized. *Appendix I-A* presents a *Comparison of Costs Between Existing and Proposed Councils,* based on the proposed 1977 Budget, and *Reasons for Cost Differences Between Existing and Proposed Councils.*

The proposal does, however, have dollar significance in two ways. First, it will facilitate the allocation of available resources in proportion to priority by more precisely aligning the structure to the needs. Second, once implemented, it will far more readily than at present allow ongoing identification of areas that are over- or under-staffed and will allow, through personnel transfers and other administrative steps, the evening of the workload throughout the structure and better demonstrate to membership that each area has the proper and necessary mix of people, expertise and funds.

In constructing the proposal, no direct attention was paid by the Committee to present personnel. The Association's interests are served best by first identifying the structure that will serve dentistry's purposes and, only secondly, examining the need for personnel to staff that new structure. Nonetheless, a preliminary judgment is possible that this proposal lends itself better to effective use of existing personnel than it does to extensive additions or layoffs.

However, the Committee believes there will be a need to add, in the not too distant future, executive staff in some areas of activity in order that the restructured Association can be effective in the future. For example, experience indicates that serious consideration should be given to the creation of a high level executive position, such as the position of Associate Secretary to the Council on Dental Education in order that it can meet the needs of an ever increasing workload. The growth of activities requiring staff support, including the Commission on Accreditation of Dental and Dental Auxiliary Educational Programs, which was created in 1975, appears to dictate this need. Likewise, the growth of the specialty and auxiliary organizations has necessitated increased executive time being spent on matters of liaison and policy with these related groups.

It should be noted that much that is contained in the proposal is a compilation of initiatives and suggestions that have been current for some time and are not original to this proposal. This is not said in an effort to spread the blame but to give appropriate credit to the many officers, trustees and staff members who have, in past months, been giving serious thought to the urgent needs of the Association.

Finally, the Committee believes that the Executive Director and appropriate members of the staff should be called upon to review the Association's "structure, management, operation and function" on a continuing basis. This continuing evaluation should include not only modifications of the administrative organization and structure, which is the responsibility of the Executive Director, but also the policy-making structure which obviously requires consideration by the Board of Trustees and approval of the House of Delegates.

II. Organizational Designations: The organizational chart that accompanies this proposal (*Appendix I-B*) creates three levels of support to assist the officers, trustees and House of Delegates in carrying out Association responsibilities reflected in its *Constitutional* objective. One level of support is the policy recommending and policy implementing role of the councils. A second level of support is the policy implementing role of commissions. The chart in *Appendix I-B* shows two commissions: one is the existing Commission on Accreditation and the other is the Commission on Relief and Disaster Fund Activities, which the Committee recommends replace the Council on Relief. The third level of support is the administrative structure under the Executive Director that includes all staff agencies.

The Committee believes that the new chart better illustrates the place of the councils and their relation to the House of Delegates and the Board of Trustees than do existing charts. The following designations are used in the body of this proposal and are reflected in the new organizational chart:

Council: A standing committee of the Association established by the House of Delegates, composed of Association members elected by the House of Delegates, with specified *Bylaw* responsibility in a subject area of intrinsic importance to the purposes of this Association and with authority to recommend and implement policy. Councils report annually and directly to the House of Delegates with the reports being reviewed and commented upon by the Board of Trustees. Councils are assisted by staff members assigned by the Executive Director.

Commission: Usually a *Bylaw* agency authorized by the House of Delegates to carry out studies or to implement policies in areas of special expertness. (From time to time the House of Delegates or the Board of Trustees has appointed commissions for special purposes that are more properly special committees.)

Bureau: A permanent agency of the Association established by the House of Delegates, composed of staff members assigned by the Executive Director, which has specified *Bylaw* responsibilities designed to provide supportive services in areas of intrinsic importance to the purposes of this Association, the House of Delegates, Board of Trustees and councils. Bureaus report annually and directly to the House of Delegates with the reports being reviewed and commented upon by the Board of Trustees.

Department: An agency created administratively by the Executive Director to assist the Association in carrying out necessary functions common to all associations and composed of staff members assigned by the Executive Director to whom departments report as necessary.

Division: An area of activity administratively created by the Executive Director and supervised under his direction by an Assistant Executive Director. Divisions are composed of council staffs, bureaus, departments and other Association agencies.

III. Comparison of Council Activities with Bylaw Responsibilities: The descriptions of council functions within the *Bylaws* are purposely concise in defining broad categories of responsibility. This pattern for flexibility is essential to each council's obligation to recommend and implement measures for achieving *Bylaw* functions. But the *Bylaw* description of functions should also reflect all major objectives and activities of councils. The following evaluations are based upon material submitted by each council secretary to identify existing programs and activities in relation to its *Bylaw* responsibilities.

The evaluations concentrate mainly on *Bylaw* functions reflected in council activities and programs as well as activities and programs that are not included in *Bylaw* functions. Materials submitted by each council also commented on the direction of council programs, that is, whether they are primarily directed to the public or the membership. Also submitted were comments on each council's involvement in the formation of Association policies.

A. Council on Dental Care Programs: This Council is charged by the *Bylaws* with responsibilities related to planning, administration and financing of dental care programs. Activities of the Council, however, are intimately related to programs of insurance companies and other sponsors of third party dental plans including governmental agencies. The amendment to the *Bylaws* (*Appendix I-C*) defining the Council on Dental Care Programs responsibility for relations with these outside organizations would make the *Bylaws* compatible with all major programs and activities of the Council.

The programs of the Council are directed to both the public and the membership. The Council is heavily involved in the formation and implementation of Association policies. The Council submits several resolutions to the House of Delegates each year and receives from the House at least one major new assignment each year, usually based upon a recommendation or recommendations from constituent societies.

B. Council on Dental Education: This Council has several *Bylaw* assignments. In general, the Council on Dental Education is responsible for dental education policies and guidelines, extending to dental auxiliary education and specialty education as well as education toward the D.D.S. and D.M.D. degree. The Council's programs and activities are adequately covered in its *Bylaw* assignments.

The programs of the Council on Dental Education are of significant importance to the public, the membership and all elements of the health education complex. Like the Council on Dental Care Programs, the Council on Dental Education is heavily involved in the formation and implementation of Association policies and must respond to at least a few House of Delegates directives or assignments each year.

C. Council on Dental Health: The Council's *Bylaw* functions relate to policies and guidelines governing dental practice, preventive dentistry and public health. The Council's function in the area of dental practice presents several problems. Dental practice responsibilities are shared by the Council on Dental Care Programs and, to a limited extent, the Bureaus of Economic Research and Statistics and Dental Health Education. The Council's *Bylaw* function in the field of dental public health extends to all public health agencies, including state dental public health units and similar local units. The Council's activities, however, do not reflect significant attention to the many activities carried on by state and local public health units.

The Council on Dental Health might function effectively by concentrating on preventive health measures and public health activities. A more precise role for the Council in the area of dental practice is also indicated. This will be especially critical if a new Council on Practice Administration is established.

The Council on Dental Health's activities are directed to both the public and the membership with emphasis upon dentists engaged in public health endeavors. The Council has a moderate role in the formation of Association policy, but does receive assignments from the House of Delegates periodically, which are mainly concerned with the annual conferences sponsored by the Council.

D. Council on Dental Laboratory Relations: This Council is charged by the *Bylaws* with responsibility for maintaining the dental profession's legal as well as professional obligation for providing prosthetic dental services to the public. The Council has a second critical *Bylaw* function: to maintain effective relations with the dental laboratory industry and craft.

The Council's programs and activities are in keeping with its *Bylaw* responsibilities. Because of the recent serious threat posed by persons practicing dentistry illegally and their determination to obtain legal recognition to perform prosthetic dental services for the public, the Council has expanded its activities in combating illegal dentistry.

The programs of the Council on Dental Laboratory Relations are directed mainly to the membership and to ethical dental laboratory owners and technicians. The Council has a moderate role in the formation of Association policies. Its main goal is developing resourceful programs to help stem illegal dental practice and to fortify relations with dental laboratories and technicians.

E. Council on Dental Materials and Devices: The Council's prime function is to insure that the materials and devices used by dentists in practice are safe and effective. The Council's pro-

grams and activities are adequately designed to carry out that *Bylaw* function. The Council works closely with the ADA Research Unit at the National Bureau of Standards in the development and improvement of dental materials and devices, another critical *Bylaw* responsibility of the Council.

While the programs of the Council on Dental Materials and Devices are directed mainly to the membership, the public obviously is served by programs concerned with safety and effectiveness of dental materials and devices. The Council is periodically involved with formation of Association policies. The Council publishes biennially a volume that lists and describes the materials and devices that meet the Council's specifications.

F. Council on Dental Research: The Council's *Bylaw* functions call for identification and promotion of research opportunities relating to dental practice and the evaluation of the efficacy of concepts and techniques used in the treatment of patients. The activities of the Council are closely related to its *Bylaw* functions. In the past five years especially, the Council has concentrated on the evaluation of new techniques, such as acupuncture and myofunctional therapy. A new assignment accepted by the Council is a study of methods for providing less expensive but professionally acceptable denture services.

The activities of the Council on Dental Research are directed mainly to the membership. The Council has only a small role in shaping Association policy.

G. Council on Dental Therapeutics: This Council's principal *Bylaw* functions are evaluating dental therapeutic agents used by dentists or members of the public and encouraging research in the field of dental therapeutics. The Council's programs and activities are fully responsive to its *Bylaw* responsibilities. Like the Council on Dental Materials and Devices, the Council on Dental Therapeutics publishes a biennial volume that is of critical importance to practicing dentists.

The programs and activities of the Council on Dental Therapeutics are directed to both the membership and the public. The Council has a moderate role in the shaping of Association policies.

H. Council on Federal Dental Services: This Council's main *Bylaw* functions are to assist in improving the efficiency of the federal dental services and to encourage dental participation in disaster preparedness activities. The Council's activities have tended to go beyond its *Bylaw* functions. For example, the Council has devoted much of its effort to the resolution of serious defects in the administration of the uniformed services dependents' care program. The way in which dental care is provided to veterans and to American Indians has also received extensive study by the Council. If the Council on Federal Dental Services is expected to provide continuing consultation on the care programs covering federal beneficiaries, that responsibility should be included as a *Bylaw* function of the Council. The federal government's concern with disaster preparedness is now limited to assisting communities to prepare for natural disasters and to contend with airplane and highway disasters. The Council's activities in disaster preparedness are not significant today.

The activities of the Council on Federal Dental Services are directed mainly to the membership. The Council has a moderate to heavy role in the formation of Association policy. Efforts to improve the efficiency of the federal dental services usually require a legislative remedy and the House of Delegates is frequently called upon to urge an appropriate legislative approach to the solution of federal dental service problems.

I. Council on Hospital Dental Service: This Council's main *Bylaw* assignment is the evaluation and approval of dental services in hospitals and other patient care units, such as nursing homes. The Council's programs and activities are closely related to its *Bylaw* responsibilities.

The activities of the Council on Hospital Dental Service are directed mainly to the membership, but the public obviously is benefited by improved hospital dental services. The Council has a moderate role in the formation of Association policy.

J. Council on Insurance: The Council's principal assignments are to arrange for group insurance coverages for the membership and to assist constituent societies in developing and improving their insurance programs for their memberships. The language prescribing the Council's

Bylaw assignments does not describe the Council's role in developing insurance programs for members and in monitoring those programs.

The activities of the Council on Insurance are directed entirely to the membership. The Council has only a small role in the formation of Association policies.

K. Council on International Relations: This Council's main *Bylaw* assignments are to assist in the international exchange of dental knowledge and to foster international goodwill. The Council's activities are closely related to the accomplishment of its *Bylaw* assignments and in some major respects extend beyond those assignments. The Council's efforts in behalf of care programs, such as Project Hope and Care-Medico are not reflected in its *Bylaw* assignments.

The activities of the Council on International Relations are directed mainly to the membership, to foreign dentists and dental agencies and, in a limited way, to beneficiaries of international care programs. The Council has only a small role in the formation of Association policies.

L. Council on Journalism: This Council's *Bylaw* function is to assist in the development of dental journalism. The Council's activities are closely related to its *Bylaw* function.

The activities of the Council on Journalism are directed to the membership. The Council has only a small role in the formation of Association policy.

M. Council on Judicial Procedures, Constitution and Bylaws: This Council's *Bylaw* assignments include two separate areas of activities. The Council is responsible for interpreting the Association's *Principles of Ethics* and in assisting in the enforcement of the *Principles* through its role as the final court of appeals in disciplinary actions against dentists for ethical violations. The Council in its judicial capacity also has responsibility for deciding disputes between constituents or between a constituent and component society. The Council also has the responsibility to recommend appropriate changes in the *Bylaws* and to act as the Standing Committee on Constitution and Bylaws during each annual session of the House of Delegates. The Council's activities are closely related to its *Bylaw* responsibilities.

The activities of the Council on Judicial Procedures, Constitution and Bylaws are directed almost entirely to the membership. The Council is heavily involved in the formation of Association policies, mainly because of its responsibility for reviewing all proposed amendments to the *Principles of Ethics* and its obligation to review editorially all proposed amendments to the *Bylaws*.

N. Council on Legislation: This Council's chief *Bylaw* assignments are monitoring federal and state legislation and regulations to insure that the interests of the public and the dental profession are adequately protected and disseminating helpful information to constituents and components on legislative and regulatory matters. The Council has an additional responsibility to review legislation and regulations involving patents. This latter assignment has had a minimal application to dentistry during the past 30 years. The Council's activities are closely related to its *Bylaw* assignments. In the area of federal legislation, the Council relies heavily upon the Washington Office to carry on the day-to-day relations with Congressional personnel and executive agency personnel. State legislation and most of the regulatory matters are handled by the Council's staff in the Headquarters Building.

The activities of the Council on Legislation are mainly directed to the membership, with obvious benefit to the public from furthering legislation that improves dental health. The Council is heavily involved in the formation of Association policies and receives frequent directives from the House of Delegates on legislative approaches to obtaining Association objectives in major areas, such as care programs, manpower plans and the elimination of discriminatory taxes on dentists.

O. Council of National Board of Dental Examiners: This Council's principal *Bylaw* function is to design and administer written examinations to assist the state and regional boards of dentistry in qualifying dentists and dental hygienists for licensure. The Council's programs and activities are closely and fully related to its *Bylaw* functions.

The activities of the Council of National Board of Dental Examiners are directed to dental

and dental hygiene students, but assistance in improving the dental licensure system obviously increases protection of the public. The Council has no involvement in the formation of Association policies.

P. Council on Relief: The Council's main *Bylaw* assignments are to assist in administering the ADA Relief Fund program and to provide for appropriate increases in the Fund. The Council also acts as Trustees of the Relief Fund. The program and activities of the Council extend beyond its *Bylaw* assignments. The Council reviews applications for Relief Fund benefits and for renewal of grants from the Fund. The Council also administers the ADA Disaster Victims Emergency Loan Fund. The Council has proposed an amendment to the *Bylaws* to describe the Council's function with respect to the Disaster Victims Program.

The activities of the Council on Relief are directed entirely to the members and their families. Except for infrequent changes in the *Indenture of Trust* for the Fund, the Council is not involved in the formation of Association policy.

Q. Council on Scientific Session: This Council's principal *Bylaw* assignment is to arrange the scientific program for the Association's annual session. The Council's program and activities are closely related to its *Bylaw* assignments.

The activities of the Council on Scientific Session are directed mainly to the membership. The Council has very little involvement in the formation of Association policies.

IV. Recommendations on Councils: As a general principle, the Committee on Advance Planning agreed that councils with five members be increased to seven members in order to provide greater representation on the Association's policy recommending and implementing agencies and more frequent rotation of council membership among the 14 trustee districts.

A. Council on Dental Care Programs: The Committee on Advance Planning recommends that this Council be retained and that the number of members continue to be 14. It is the Committee's view that the *Bylaws* will need to be modified in order to more precisely reflect the full range of the Council's present activities.

B. Council on Dental Education: The Committee recommends that the Council be retained, that the number of members continue to be 12, and that its name be the same with the deletion of "Dental."

C. Council on Dental Health: The Committee recommends that this Council be changed and more carefully specified with its present duties being divided between a successor agency, the *Council on Health Planning,* and a new agency, the *Council on Practice Administration.* The Committee makes this recommendation for the following reasons:

1. The Council on Dental Health has suffered for some years from the ambiguity surrounding its duties as well as from the sharp differences in character between some of those duties. "Dental Health" is, in fact, a concern of the entire Association as well as of every agency of the Association. The achievement of good dental health for individuals and for the nation as a whole is the ultimate purpose of nearly all the work of the Association. To designate one agency with that title leads to a substantial problem of identifying precisely which subject areas are assigned to that agency. This has, in fact, happened to the present Council.

2. If there were no substantive activities carried out only by this agency, then the Committee would have simply recommended elimination. Such duties do exist, however, and are of a sufficiently fundamental nature that a Council is necessary to carry them out.

Specifically, these duties revolve about the planning and implementation of a local, state and national network giving attention to the need dentistry has at all these levels to create and maintain agencies encompassing community dental health projects including preventive dentistry, public health initiatives, future plans for growth of the community, state and national resources needed for these tasks and for the cooperative efforts between dentistry and other facets of the total health community.

3. In addition, there is a need for an agency of the Association to be supportive of dental health agencies of the local, state and federal governments in order to assist their growth into appropriate areas and to monitor developments that may be objectionable to the Association. Examples on the local and state level are obvious. On the federal level, it would include such agencies of the Department of Health, Education, and Welfare as the Bureau of Indian Health Affairs and the Office of Health Planning and Development. Relations with the former HEW agency is presently the duty of the Council on Federal Dental Services but, in the Committee's view, its substantive work relates far more sensibly to this Council's purview. Career problems of BIHA dental officers would be attended to elsewhere.

Accordingly, the Committee on Advance Planning recommends that the *Council on Health Planning* with seven members be considered the successor agency with newly drawn *Bylaws* specifying the nature of its work as reflected in the foregoing narrative.

The Committee had some discussion about the use of the word "Planning" in the title as being too reflective of federal activities to which the profession has well-reasoned objection. It is the Committee's belief that the word is precise, important and ought to be used. If there is one complaint now current of the Association that is all but pervasive, it is that it too often reacts to others rather than looking ahead and planning for its future. The objections to activities of the federal government are not rooted in the fact that the federal government plans. It does so quite properly. So should the profession, particularly with respect to this area. It is a clear signal to the membership that the Association intends to formulate and promote its own plans for the network of dental health systems and not merely react to the plans of others.

This direction for the *Council on Health Planning* leaves a void with respect to practice administration activities that have theoretically been within the purview of the present Council on Dental Health, though it has not historically been active in that area.

The Committee believes that this is an area of such major importance that it requires a separate council. Throughout the years, a flourishing industry has grown up within the dental world directed toward assisting the new dentist as well as those already in practice but experiencing difficulty on the administration and business aspects of conducting a professional health practice. Our members have looked to the Association in vain for any significant help whatever on these matters. At the same time, the leaders of the profession have been aware that not all of the advice being given to dentists from other sources is invariably what it should be or is in the best long-range interests of either dentists or their patients.

The Association today is spearheading a concerted campaign to the public about the value of private practice. Building and maintaining a private practice requires more than professional knowledge and clinical skills. It requires business acumen. In this inflationary era, and in a time of increased competition from alternate delivery modes, the ability to operate in a businesslike manner is more difficult to achieve than before. There could be no more opportune time for the Association to enter this essential area of membership service. Accordingly, the Committee is recommending creation of a *Council on Practice Administration* to be composed of seven members with *Bylaws* reflective of the duties outlined above.

D. Council on Dental Laboratory Relations: The Committee recommends that the Council be retained, that its membership be increased to seven, and that its name be the same with the deletion of "Dental."

E. Council on Dental Materials and Devices: The Committee recommends that this Council be retained, that its membership be reduced to seven and that its name remain as it is except for the deletion of "Dental."

F. Council on Dental Research: The Committee recommends that this Council be eliminated. The clear need for the Association to have a visible interest in national research policy and direction do not, in the Committee's view, require the existence of the Council.

Consideration was given to the merging of this Council with the Council on Dental Therapeutics. After examination, however, the Committee was strongly of the view that this would give rise to intractable problems tending to lessen the high degree of effectiveness of the

Council on Dental Therapeutics without serving the Association's research interests well. The qualifications needed by a member to be expert in therapeutic and prophylactic agents differ sharply from those concerning research policy and trends. In the practical order, it would place an impossible burden on trustees making nominations and the House when electing by asking for men who combined expertness in these dissimilar areas.

Nonetheless, the Committee is firm in believing that the Association's interest in research must remain active and have high visibility. Accordingly, the Committee recommends the creation of a *Bureau of Basic and Clinical Research*. Such a Bureau will meet the needs outlined above, will permit a day-to-day activity at the staff level that is required and, through nomination of consultants to the Board of Trustees for its consideration, allow ample use of expert members to guide and shape the Bureau's work. Existing staff resources are sufficient for these purposes and the Committee does not contemplate additional staffing needs in view of the elimination of the Council.

In the view of the Committee, this new Bureau should be delegated formal responsibility for examination of new and developing treatment techniques.

G. Council on Dental Therapeutics: The Committee recommends retention of the Council, reduction of its membership to seven and retention of its present name except for elimination of the word "Dental."

H. Council on Federal Dental Services: The Committee recommends that this Council be, in effect, merged with the Council on Legislation. A full discussion of the rationale for this recommendation appears under "Council on Legislation."

There was some discussion within the Committee about straightforwardly eliminating this Council rather than merging it with another agency. The general view, however, was that the large number of federal Association members and the relatively unique career needs of that group necessitate the designation of a specific agency to carry out appropriate activities.

I. Council on Hospital Dental Service: The Committee recommends that this Council be retained, that the number of members be increased to seven and that the name be changed to *Council on Institutional Health Services* to reflect more accurately the range of institutions beyond hospitals within which dental services are rendered.

J. Council on Insurance: The Committee recommends that this Council be eliminated. It does not, in the Committee's view, carry out policy recommending or implementing duties but is, instead, wholly directed toward the accurate and businesslike administration of membership insurance matters. In its place, the Committee recommends that a *Department of Membership Insurance* be administratively created to carry out necessary functions and that the Board of Trustees assume the "Trusteeship" for membership insurance programs. The Committee does not anticipate that this Department will need additional staffing beyond that presently serving the Council.

K. Council on International Relations: The Committee recommends that this Council be eliminated. It does not presently carry out any policy recommending or implementing activities that cannot be more satisfactorily and economically performed by, depending upon the matter, a topic-oriented council or by a staff member. In its place, the Committee recommends that the Bureau of Public Information be assigned necessary duties relating to international relations.

L. Council on Journalism: The Committee recommends that this Council be eliminated as it carries out no significant policy recommending or implementing functions. The Committee is of the opinion that vital activities are presently part of this agency but that those can be better assigned to the Bureau of Public Information where the Association's core expertise in journalism and public relations is now centered.

M. Council on Judicial Procedures, Constitution and Bylaws: The Committee recommends that this Council be retained, that its membership be increased to seven and that its name be shortened to *Council on Judicial Affairs* with explicit *Bylaw* responsibilities for the *Constitution and Bylaws*.

N. Council on Legislation: The Committee recommends that the Council be retained, that its membership be increased to seven, that its name be changed to *Council on Legislation and Federal Dental Services* to indicate that some duties are being transferred to it (together with some to the *Council on Health Planning*) as it is merged with the Council on Federal Dental Services, and that an Advisory Committee to the Council be appointed composed of the Chairmen of the proposed Council on Dental Care Programs, Council on Education and Council on Health Planning.

This recommendation was arrived at by the Committee after lengthy discussion and consideration of alternate positions.

O. Council of National Board of Dental Examiners: The Committee recommends that this Council be retained, that its membership remain at nine and that its name be modified to *Council on National Board Examinations* as being more precise with respect to its duties, which are directed toward the examinations being constructed rather than the examiners monitoring the examinations.

P. Council on Relief: The Committee recommends that this Council be eliminated. It does not discharge duties that require it to hold council status. However, because of the necessity for an independent group of trustees to administer the *Indenture of Trust*, a *Commission on Relief and Disaster Fund Activities* should be established. In the Committee's view, the Commission can carry out the necessary duties with equal efficiency and responsiveness to members with less expense and increased efficiency in allocation of staff time.

Q. Council on Scientific Session: The Committee considered Recommendations 20-24 of the Special Committee to Study the Annual Session, which were referred by the Board of Trustees at its August 1976 session with "the recommendation that serious thought be given to establishing a Council on Annual Session." The Committee on Advance Planning concurs with the Special Committee's recommendations and recommends that they be approved by the Board of Trustees:

> Recommendation 20: The Council on Scientific Session should be deleted from the *Bylaws* and replaced by a Council on Annual Session consisting of seven members (two of whom shall be the General Chairman and the General Chairman-elect of the Local Arrangements Committee) whose duties and responsibilities include all aspects of the annual session of the American Dental Association presently assumed by the Council on Scientific Session, the Bureau of Convention Services, and the Department of Sales and Advertising. The new Council will coordinate and utilize the expertise of other bureaus and agencies concerned with the conduct of the annual session.
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> Recommendation 21: Five members of the Council on Annual Session shall be elected for a term of three years. The General Chairman of the Committee on Local Arrangements for the current year and the General Chairman-elect for the succeeding year shall serve as *ex officio* members of the Council with the right to vote.
>
> Recommendation 22: The General Chairman of the Local Arangements Committee for the current and succeeding year, who are members of the Council on Annual Session, shall not be eligible to serve as Chairman of that Council.
>
> Recommendation 23: All members nominated for the Council on Annual Session should have proven expertise in planning and conducting dental meetings.
>
> Recommendation 24: There shall be a secretary who shall coordinate the activity of the Council on Annual Session and of all other staff members involved in the conduct of the annual session. The Special Committee strongly believes that there is sufficient expertise among the present staff members who have been involved with the annual session and that the selection of staff for the Council on Annual Session should be made from among these individuals.

V. Comparison of Bureau Activities with Bylow Responsibilities: Bureau functions in the Association's *Bylaws* are as concisely expressed as those of councils. Again this evaluation will concentrate mainly on *Bylaw* functions reflected in Bureau activities and programs that are not included in *Bylaw* functions. Materials submitted by each bureau illustrated its principal activities in relation to its *Bylaw* functions. That material also indicated the audience for each bureau's programs. Bureaus are not involved in the formation of Association policies.

A. Bureau of Audiovisual Services: This Bureau's principal *Bylaw* assignments are developing and maintaining a film library and distributing films upon request. The Bureau's activities are closely related to its *Bylaw* responsibilities.

B. Bureau of Convention Services: This Bureau has three distinct *Bylaw* assignments: the first is to make all arrangements for annual sessions; the second is arrangement of travel accommodations for persons on official Association travel assignments; and third to arrange for and supervise the use of meeting rooms in the Association's Headquarters Building. The Bureau's activities are closely and fully related to its *Bylaw* assignments.

The activities of the Bureau are directed to both the membership and to other agencies of the Association.

C. Bureau of Data Processing Services and Membership Records: This Bureau's main *Bylaw* functions are: (1) to provide data processing services to all other Association agencies needing such services and to related and other outside agencies on a contract basis, (2) to maintain ADA membership records, and (3) to publish the annual *American Dental Directory*.

The activities of the Bureau are directed mainly to the membership and to other Association agencies.

D. Bureau of Dental Health Education: The Bureau's *Bylaw* functions are to develop and maintain national programs of dental health education and to assist constituent societies and other agencies in developing and maintaining effective dental health education programs. The Bureau's activities are fully consistent with its *Bylaw* responsibilities.

The Bureau's programs are designed principally for members of the public, but the Bureau also relates to constituent dental associations and to other private and public agencies, such as schools and public health departments.

E. Bureau of Dental Society Services: This Bureau's principal *Bylaw* functions are to provide or to arrange for the provision of information and available services to the constituent and component societies and to other dentally related organizations. The Bureau's activities extend beyond its *Bylaw* assignments. The management of numerous conferences at Association Headquarters and the ADA sponsored Regional Conferences are not covered in the Bureau's *Bylaw* assignments. These and other assignments should have *Bylaw* identification, at least in general, categorical language.

The activities of the Bureau are directed to the membership, to dental and dentally related organizations and to other agencies of the Association.

F. Bureau of Economic Research and Statistics: This Bureau's main *Bylaw* assignment is the collection and dissemination of data and statistics concerning the dental profession. The Bureau's activities are closely and fully related to its *Bylaw* assignment. Consideration might be given to describing in categorical language the research functions conducted by the Bureau and its survey and analyses in the area of behavioral science. As the Bureau expands its efforts in the development and analysis of economic data, this category of activity should have *Bylaw* identification.

G. Bureau of Library Services: This Bureau's principal *Bylaw* responsibilities are maintaining the Association's library and its services to members, maintaining the Association archives, publishing an index to dental literature and developing uniform standards of dental nomenclature. The Bureau's activities are closely related to its *Bylaw* functions.

The activities of the Bureau are directed to the membership and other Association agencies.

H. Bureau of Public Information: This Bureau's principal *Bylaw* assignment is the maintenance of the Association's public relations program and the dissemination of information and publicity concerning activities of the Association. The Bureau's activities extend beyond its *Bylaw* assignments.

VI. Recommendations on Bureaus:

A. It is the recommendation of the Committee on Advance Planning that the following Bureaus should be retained essentially as they are, that their titles should be modified as indicated and that, in a number of instances, the *Bylaws* need careful examination to assure pertinence with present activities:

1. Bureau of Data Processing Services and Membership Records becomes *Bureau of Data Processing and Membership Records.*
2. Bureau of Dental Health Education becomes *Bureau of Health Education and Audiovisual Services.*
3. Bureau of Economic Research and Statistics becomes *Bureau of Economic and Behavioral Research.*
4. Bureau of Library Services
5. Bureau of Public Information
6. Bureau of Society Services

B. The Committee recommends establishment of a *Bureau of Basic and Clinical Research.* The reasons for the recommendation are given under "Recommendations on Councils," under the subsection, "Council on Dental Research."

C. The Committee recommends that, as indicated above, the present Bureau of Audiovisual Services be eliminated from the *Bylaws* and its activities merged into the newly named *Bureau of Health Education and Audiovisual Services.* These two Bureaus now have a major amount of overlapping duties requiring *ad hoc* agency-to-agency coordination that, in the Committee's view, would be far more effectively and efficiently coordinated within a single agency structure.

D. The Committee recommends that the Bureau of Convention Services be changed to a *Department of Conference Services.*

VII. Commission Activities with Bylaw Responsibilities: The Association has three commissions. One of these, the Board of Trustees' Special Study Commission on the Care of Fully and/or Partially Edentulous Patients, will go out of existence this year. The second commission, the Commission on Licensure, was established by the House of Delegates and is scheduled to complete its assignments this year. The duties assumed by the Commission on denture care will devolve upon the Council on Dental Laboratory Relations and the duties assigned to the Commission on Licensure will go to the Council on Dental Education if the Committee's recommendations are approved by the Board of Trustees and the House of Delegates.

The third commission, the Commission on Accreditation, is established as a *Bylaw* agency. Its principal *Bylaw* function is to set educational requirements for and to accredit dental educational and dental auxiliary educational programs. It formulates the guidelines for its accreditation functions.

The activities of the Commission on Accreditation are directed to dental educational institutions but eventually to the public by maintaining high standards of education leading to the provision of high quality care to patients. The Commission has an indirect and moderate impact on formation of Association policies. Its main function is implementing Association policies.

VIII. Recommendations on Commissions:

A. The Committee recommends that the Commission on Accreditation be retained, that the number of members continue to be 20, and that its duties be examined to assure pertinence.

B. The Committee recommends that a new *Commission on Relief and Disaster Fund Activities* be created for reasons given in "Recommendations on Councils" under the subsection, "Council on Relief."

IX. Comparison of ADA Health Foundation Activities with Bylaw Responsibilities: The ADA Health Foundation has two operating units identified in the Association's *Bylaws*. The ADA Research Institute and the ADA Research Unit at the National Bureau of Standards have as their principal *Bylaw* functions the conduct of basic and applied research relating to oral health and the sponsorship of related research training. The ADA Health Foundation activities are directed to the membership and the public. The Foundation has no involvement in the formation of Association policies.

X. Functions of the Washington Office: The Washington Office performs a unique service in the implementation of Association policies. It is not specifically identified in the Association's *Bylaws*. The *Constitution* provides for the establishment of ADA branch offices; the Washington Office is the only branch office officially created and recognized under this *Constitutional* authority.

The Washington Office works closely with the Council on Legislation and its Chicago-based staff. The activities of the Washington Office include staff liaison and communications with members of Congress and the executive agencies on a day-to-day basis. In essence, the Washington Office is responsible for determining what federal activities are related to or impinge upon Association policies and principles and for assisting the Council on Legislation in developing approaches and responses to federal initiatives. The Washington Office relies upon staff of other Association agencies in the preparation of testimony before Congressional committees.

The activities of the Washington Office are directed mainly to members of Congress and officials of federal agencies. The membership and the public are, of course, beneficiaries of the Washington Office's endeavors. The Washington Office is heavily involved in both the formation and implementation of Association policies.

XI. Functions of Departments and Other ADA Staff Agencies: The functions of departments and other staff agencies identified in the organizational chart are not established in the *Bylaws*.

XII. Recommendations on Agencies and Activities Not Established Through the Bylaws:

A. The Committee on Advance Planning recommends retention of the following agencies, administratively created, essentially as they now exist and with the services gathered within these as shown on the new organizational chart:

1. Department of Advertising Review: Because of the number of divergent agencies involved in the question of advertising acceptability, the Committee believes this should be an independent agency within the Division of Scientific Affairs and not administratively attached to any other. Its independent status does not indicate the necessity for staffing levels beyond those normally contemplated.

2. Department of Business Affairs

3. Department of Central Services

4. Department of Congressional and Federal Agency Affairs

5. Department of Legal Affairs

6. Department of Membership Insurance

7. Department of Sales and Advertising

B. The Committee recommends creation of a *Department of Grants Assistance*. This Department would have a two-fold role: first, to identify sources of external funding for projects that Association agencies wish to carry out and, second, to assist the agency to structure its proposal in a form required by the particular private or public agency to which the application is to be made.

It is already apparent that there are a number of activities that various agencies need to

perform but where lack of available funds hinders initiation of the work. There is now a lack of coordination in the search for available sources of such funding and expert counsel on how the particular foundation or public agency can best be approached. The existence of this Department—in close liaison with the American Fund for Dental Health—could greatly increase the efficiency of these endeavors and, over a period of time, enable the Association to locate additional sources beyond those presently known. The nucleus of such an activity now exists and can be expanded as the need develops.

C. The Committee recommends that a professional news editor be employed to serve as *Editor of the ADA News*.

XIII. Recommendations on Senior Staff: The senior staff of the Association is presently composed of an Executive Director and an Editor, who are officers of the Association, and seven Assistant Executive Directors.

The Committee on Advance Planning recommends the following modifications in this existing management:

A. Creation of the Position, Administratively, of Chief Counsel: This position will not be primarily concerned with administrative operations. Its occupant will, instead, have full responsibility for advising the House of Delegates, Board of Trustees, Executive Director and Association agencies on the legal implications of actions they are contemplating and on questions that arise, in a new climate, about actions already taken in a previous, more legally permissive time. The amount of time that the Board of Trustees and such Association agencies as the Council on Dental Care Programs, Council on Dental Education, Council on Dental Materials and Devices and the Bureau of Economic Research and Statistics have been spending in recent years on matters related to actions by state attorneys general, the Justice Department, Federal Trade Commission, Federal Food and Drug Administration and other such groups is ample demonstration of the extraordinary growth of such matters. No competent observer of the health law expects this to diminish: it will continue to grow.

If the Association is going to have the fullest and most current knowledge of the legal climate, the significance of court orders and consent decrees involving similar associations, and the most careful advice on how to proceed with essential functions with the least possible legal exposure, the *Chief Counsel* must be freed now from other work and permitted to concentrate fully on these duties.

Further, while not all statements to a House Counsel or *Chief Counsel* made by agencies of the Association will be protected from discovery by the attorney-client privilege, such privilege, when applicable, could be asserted and claimed with more confidence if the agency understood at the time it sought such legal guidance that the advisor was acting solely as an attorney who had no other management responsibilities that might color his counsel.

In order to accomplish this, the Committee on Advance Planning further recommends that a *Division of Business Affairs* be administratively created in order to accommodate the massive amount of business activity now borne by the House Counsel. In effect, then, the Committee recommends two new or differently structured positions: *Chief Counsel* and *Assistant Executive Director for Business Affairs*. While not wishing to anticipate the actions of the Executive Director, it is the Committee's judgment that these recommendations, if followed, will not require massive additions to staff nor give rise to significant additional expense. The nucleus for these evolutionary steps is already well established.

XIV. Summary of Recommendations:

A. The Committee on Advance Planning recommends that examination of Association structure, its relevance and rationale, be recognized as a necessary, continuing function rather than an ad hoc task. It recommends that the Executive Director provide for such continuing examination.

B. The Committee recommends that a new senior staff position be created administratively by the Executive Director: *Chief Counsel*.

C. The Committee recommends that the Executive Director transfer all House Counsel functions to the *Chief Counsel's Office* and that the administrative division that now includes House Counsel functions be redesignated the *Division of Business Affairs*.

D. The Committee recommends the following disposition and redesignation of agencies of the Association (the number of council members, present and recommended, is in parentheses):

Present	Recommended
Council on Dental Care Programs (14)	Council on Dental Care Programs (14)
Council on Dental Education (12)	Council on Education (12)
Council on Dental Health (5)	Council on Health Planning (7)
	Council on Practice Administration (7)
Council on Dental Laboratory Relations (5)	Council on Laboratory Relations (7)
Council on Dental Materials and Devices (9)	Council on Materials and Devices (7)
Council on Dental Research (5)	Bureau of Basic and Clinical Research
Council on Dental Therapeutics (9)	Council on Therapeutics (7)
Council on Federal Dental Services (5)	Merged into Council on Legislation
Council on Hospital Dental Services (5)	Council on Institutional Health Services (7)
Council on Insurance (5)	Department of Membership Insurance
Council on International Relations (5)	Eliminate; duties transferred to Bureau of Public Information
Council on Journalism (5)	Eliminate; duties transferred to Bureau of Public Information
Council on Judicial Procedures, Constitution and Bylaws (5)	Council on Judicial Affairs (7)
Council on Legislation (5)	Council on Legislation and Federal Dental Services (7)
Council of National Board of Dental Examiners (9)	Council on National Board Examinations (9)
Council on Relief (5)	Commission on Relief and Disaster Fund Activities (5)
Council on Scientific Session (5)	Council on Annual Session (7)
Commission on Accreditation	No change
. . .	Commission on Relief and Disaster Fund Activities (5)
Bureau of Audiovisual Services	Merged into Bureau of Health Education
Bureau of Convention Services	Department of Conference Services
Bureau of Data Processing Services and Membership Records	Bureau of Data Processing and Membership Records
Bureau of Dental Health Education	Bureau of Health Education
Bureau of Economic Research and Statistics	Bureau of Economic and Behavioral Research
Bureau of Library Services	No change
Bureau of Public Information	No change
Bureau of Dental Society Services	Bureau of Society Services
. . .	Bureau of Basic and Clinical Research
Department of Advertising Review	No change
Department of Business Affairs	No change
Department of Central Services	No change
Department of Congressional and Federal Agency Affairs	No change
Department of Legal Affairs	No change
Department of Membership Insurance	Formed from Council on Insurance
Department of Sales and Advertising	No change
. . .	Department of Grants Assistance

COMPARISON OF COSTS BETWEEN EXISTING AND PROPOSED COUNCILS

Based on Proposed 1977 Budget

PROPOSED COUNCILS

Council	Council Members	× Meeting Days	= Per Diem Days	Meetings	Travel*	Per Diem	Total
Dental Care Programs	14	11	154	4	$11,200	11,550	22,750
Education	12	4	48	2	4,800	3,600	8,400
Health Planning	7	4	28	2	2,800	2,100	4,900
Materials & Devices	7	5	35	2	2,800	2,625	5,425
Therapeutics	7	4	28	2	2,800	2,100	4,900
Labaratory Relations	7	4	28	2	2,800	2,100	4,900
Institutional Health Services	7	4	28	2	2,800	2,100	4,900
Judicial Affairs	7	4	28	2	2,800	2,100	4,900
Legislation & Federal Dental Services (1)	7	6	42	3	4,200	3,150	7,350
National Board Examinations	9	3	19**	1	1,800	1,425	3,225
Annual Session	7	15	105	3	4,200	7,875	12,075
Practice Administration	7	4	28	2	2,800	2,100	4,900
Total Councils (12 Councils)	98	68	571	27	$45,800	42,825	88,625

COMPARISON OF COSTS BETWEEN EXISTING AND PROPOSED COUNCILS

Based on Proposed 1977 Budget

EXISTING COUNCILS

Council	Council Members	× Meeting Days	= Per Diem Days	Meetings	Travel*	Per Diem	Total
Dental Care Programs	14	12	168	4	$11,200	12,600	23,800
Dental Education	12	4	48	2	4,800	3,600	8,400
Dental Health	5	4	20	2	2,000	1,500	3,500
Dental Materials & Devices	9	5	45	2	3,600	3,375	6,975
Dental Research	5	4	20	2	2,000	1,500	3,500
Dental Therapeutics	9	4	36	2	3,600	2,700	6,300
Dental Laboratory Relations	5	4	20	2	2,000	1,500	3,500
Federal Dental Services (1)	5	3	15	1	1,000	1,125	2,125
Hospital Dental Services	5	4	20	2	2,000	1,500	3,500
Insurance	5	2	10	1	1,000	750	1,750
International Relations	5	2	10	1	1,000	750	1,750
Journalism	5	2	10	1	1,000	750	1,750
Judicial Procedures, Constitution and Bylaws	5	4	20	2	2,000	1,500	3,500
Legislation (1)	5	6	30	3	3,000	2,250	5,250
National Board of Dental Examiners	9	3	19**	1	1,800	1,425	3,225
Scientific Session	5	16	76	3	3,000	5,700	8,700
Total (16 Councils)	108	79	567	31	$45,000	42,525	87,525

*Travel cost estimated at $200 per trip. This amount determined as follows:

Chgo/Los Angeles	$ 300
Chgo/New York	156
Chgo/Dallas	166
Chgo/Atlanta	138
Chgo/Wash., D.C.	138
Chgo/Kansas City	106
	$1,004 ÷ 6 = $167
Estimated Travel Costs Per Trip	$200
Surface Transportation	33

**8 members 2 days; Chairman 3 days.

COMPARISON OF COSTS BETWEEN EXISTING AND PROPOSED COUNCILS

Based on Proposed 1977 Budget

Existing Council	Cost	Proposed Council	Cost	Increase (Decrease)	Percentage Increase (Decrease)	Reason For Change in Cost
Dental Care Programs	$23,800	Dental Care Programs	$22,750	$(1,050)	(5%)	Reduction in meeting days from 12 to 11
Dental Education	8,400	Education	8,400	. . .	. . .	No change
Dental Health	3,500	Health Planning	4,900	1,400	40%	Increase in number of council members from 5 to 7
Dental Materials & Devices	6,975	Materials & Devices	5,425	(1,550)	(22%)	Reduction in number of council members from 9 to 7
Dental Research	3,500					Council for Dental Research to become a Bureau
Dental Therapeutics	6,300	Therapeutics	4,900	(4,900)	(50%)	Reduction in number of council members from 9 to 7
Dental Laboratory Relations	3,500	Laboratory Relations	4,900	1,400	40%	Increase in number of council members from 5 to 7
Federal Dental Services (1)	2,125					
Hospital Dental Service	3,500	Institutional Health Services	4,900	1,400	40%	Increase in number of council members from 5 to 7
Insurance	1,750			(1,750)	(100%)	
International Relations	1,750			(1,750)	(100%)	
Journalism	1,750			(1,750)	(100%)	
Judicial Procedures, Constitution & Bylaws	3,500	Judicial Affairs	4,900	1,400	40%	Increase in number of council members from 5 to 7
Legislation (1)	5,250	Legislation & Federal Dental Services (1)	7,350	(25)	. . .	Merger of Federal Dental Services & Legislation into one council results in a small reduction in cost
National Board of Dental Examiners	3,225	National Board Examinations	3,225	. . .	. . .	No change
Scientific Session	8,700	Annual Session	12,075	3,375	38%	Increase in number of council members from 5 to 7
		Practice Administration	4,900	4,900	100%	New council established
	$87,525		$88,625	$ 1,100		

Reasons for Cost Differences Between Existing and Proposed Councils

1. It would be misleading to compare the travel costs by using totals of all council members and all meetings. Although the proposed number of council members and total number of council meetings decreased, the number of trips to council meetings remained approximately the same. Therefore, the council costs have to be reviewed individually. A short example of the *wrong* conclusion that can be arrived at is as follows:

EXISTING			PROPOSED		
Council Members	Meetings	Travel Cost	Council Members	Meetings	Travel Cost
9	1	1,800	9	2	3,600
5	2	2,000	5	1	1,000
14	3	3,800	14	3	4,600

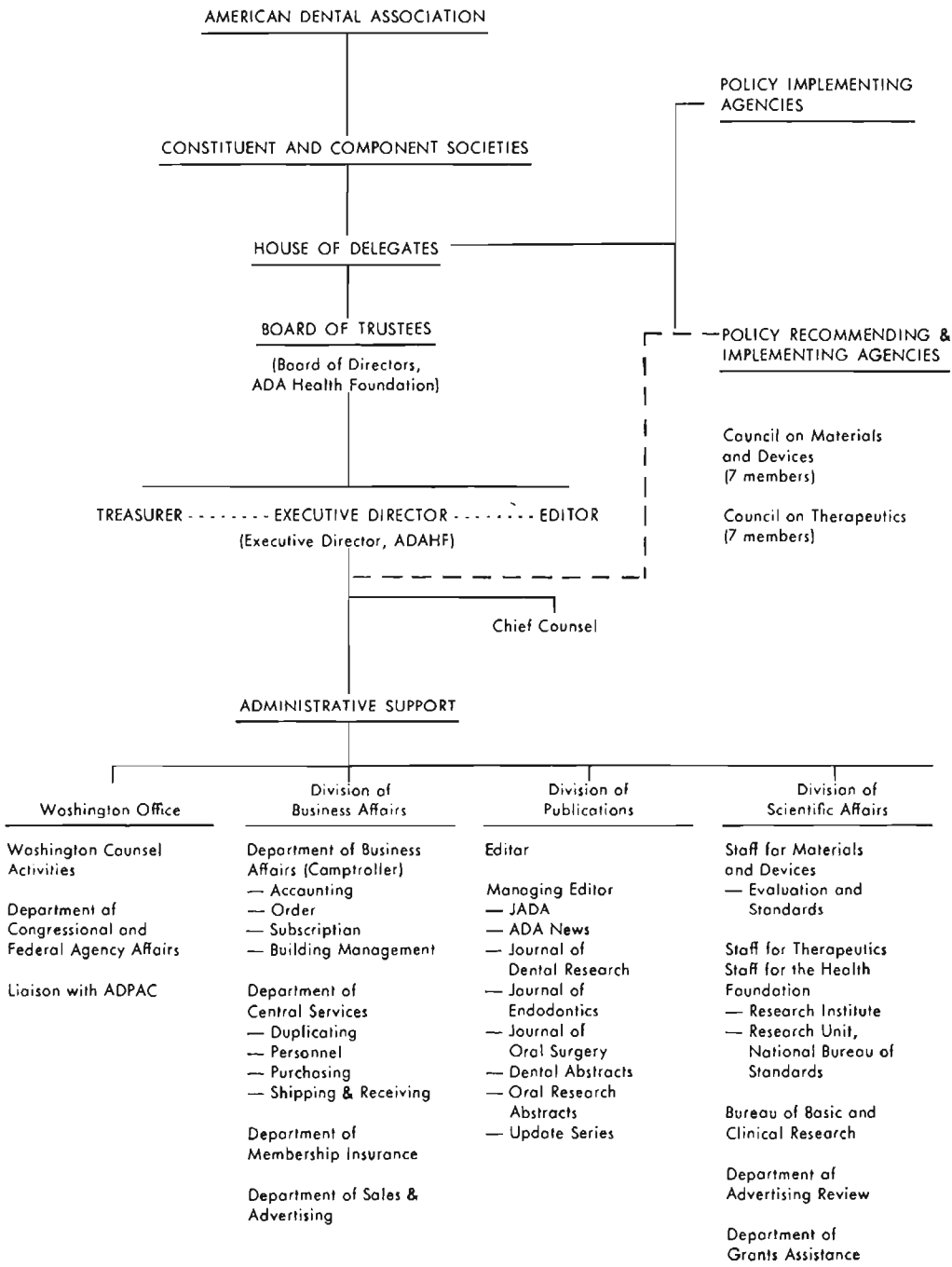
As can be seen above, although the total number of council members and meetings remained the same, the costs differ because the larger number of council members went to a greater number of meetings making the total cost higher.

2. Per diem costs for the proposed councils are higher because the council member meeting days increased from 567 to 571, an increase of $300.

3. Total costs increased by $1,100 because of the following:

Increased in Costs		Reason
Health Planning	$ 1,400	Increase in number of council members from 5 to 7
Laboratory Relations	1,400	Increase in number of council members from 5 to 7
Institutional Health Services	1,400	Increase in number of council members from 5 to 7
Judicial Affairs	1,400	Increase in number of council members from 5 to 7
Annual Session	3,375	Increase in number of council members from 5 to 7
Practice Administration	4,900	New council established
Total Increases	$13,875	

Decreased in Costs		Reason
Dental Care Programs	$ 1,050	Reduction of meeting days from 12 to 11
Materials & Devices	1,550	Reduction in number of council members from 9 to 7
Therapeutics	4,900	Reduction in number of council members from 9 to 7
Insurance	1,750	Eliminated
International Relations	1,750	Eliminated
Journalism	1,750	Eliminated
Legislation & Federal Dental Services	25	Merger of two councils
Total Decreases	$12,775	
Net Increase	$ 1,100	


AMERICAN DENTAL ASSOCIATION
CONSTITUENT AND COMPONENT SOCIETIES
HOUSE OF DELEGATES
BOARD OF TRUSTEES
(Board of Directors, ADA Health Foundation)
TREASURER
EXECUTIVE DIRECTOR
(Executive Director, ADAHF)
EDITOR
Chief Counsel
ADMINISTRATIVE SUPPORT
POLICY IMPLEMENTING AGENCIES
POLICY RECOMMENDING & IMPLEMENTING AGENCIES
Council on Materials and Devices (7 members)
Council on Therapeutics (7 members)
Washington Office
Washington Counsel Activities
Department of Congressional and Federal Agency Affairs
Liaison with ADPAC
Division of Business Affairs
Department of Business Affairs (Camptroller)
— Accounting
— Order
— Subscriptian
— Building Management
Department of Central Services
— Duplicating
— Personnel
— Purchasing
— Shipping & Receiving
Department of Membership Insurance
Department of Sales & Advertising
Division of Publications
Editar
Managing Editor
— JADA
— ADA News
— Journal of Dental Research
— Journal of Endodontics
— Journal of Oral Surgery
— Dental Abstracts
— Oral Research Abstracts
— Update Series
Division of Scientific Affairs
Staff for Materials and Devices
— Evaluation and Standards
Staff for Therapeutics
Staff for the Health Foundation
— Research Institute
— Research Unit, National Bureau of Standards
Bureau of Basic and Clinical Research
Department of Advertising Review
Department of Grants Assistance

Commission on Accreditation (20 Members)

Commission on Relief & Disaster Fund Activities (5 members)

Council on Education (12 members)

Council on Institutional Health Services (7 members)

Council on National Board Examinations (9 members)

Council on Judicial Affairs (7 members)

Council on Legislation and Federal Dental Services (7 members)

Council on Laboratory Relations (7 members)

Council on Dental Care Programs (14 members)

Council on Health Planning (7 members)

Council on Practice Administration (7 members)

Council on Annual Session (7 members)

Division of Education & Hospitals

Staff for Education
— Accreditation
— Continuing Education
— Educational Measurements
— Licensure

Staff for Institutional Health Services

Staff for National Board Examinations

Division of Legislation & Legal Affairs

Staff for Relief & Disaster Fund Activities

Staff for Judicial Affairs

Staff for Legislation & Federal Dental Services

Staff for Laboratory Relations

Bureau of Data Processing & Membership Records

Department of Legal Affairs
— Clearinghouse on Antitrust & Related Matters
— Federal & State Regulations
— Professional Liability
— Taxation

Division of Health Affairs

Staff for Dental Care Programs

Staff for Health Planning

Staff for Practice Administration

Bureau of Economic & Behavioral Research

Bureau of Health Education
— Audiovisual Services
— Health Education Activities

Division of Communications

Staff for Annual Session

Bureau of Library Services

Bureau of Public Information
— Journalism Services
— International Relations
— Leadership Bulletin

Bureau of Society Services

Department of Conference Services

Public Education Program

Preliminary Amendments to "Bylaws"

Existing

CHAPTER IX · COUNCILS

Section 10. NAME: The councils of this Association shall be:

Council on Dental Care Programs
Council on Dental Education
Council on Dental Health
Council on Dental Laboratory Relations
Council on Dental Materials and Devices
Council on Dental Research
Council on Dental Therapeutics
Council on Federal Dental Services
Council on Hospital Dental Service
Council on Insurance
Council on International Relations
Council on Journalism
Council on Judicial Procedures, Constitution and Bylaws
Council on Legislation
Council of National Board of Dental Examiners
Council on Relief
Council on Scientific Session

Section 20. MEMBERS, NOMINATIONS AND ELECTIONS:

A. All councils, except as otherwise provided for in these *Bylaws,* shall be composed of five (5) members. Nominations for all councils shall be made by the Board of Trustees. Additional nominations may be made by the House of Delegates unless otherwise provided for in these *Bylaws.* Members of councils shall be elected by the House of Delegates in accordance with Chapter V, Section 140.

New

B. NOMINATIONS AND ELECTIONS FOR THE COUNCIL ON DENTAL EDUCATION. The Council on Dental Education shall be composed of twelve (12) members nominated and elected as follows:

Proposed

Resolved, that Chapter IX, Councils, of the *Bylaws* be amended by substitution to read as follows:

CHAPTER IX · COUNCILS

Section 10. NAME: The councils of this Association shall be:

Council on Annual Session
Council on Dental Care Programs
Council on Education
Council on Health Planning
Council on Institutional Health Services
Council on Judicial Affairs
Council on Laboratory Relations
Council on Legislation and Federal Dental Services
Council on Materials and Devices
Council on National Board Examinations
Council on Practice Administration
Council on Therapeutics

Section 20. MEMBERS, NOMINATIONS AND ELECTIONS:

A. All councils, except as otherwise provided for in these *Bylaws,* shall be composed of seven (7) members. Nominations for all councils shall be made by the Board of Trustees. Additional nominations may be made by the House of Delegates unless otherwise provided for in these *Bylaws.* Members of councils shall be elected by the House of Delegates in accordance with Chapter V, Section 140.

B. NOMINATIONS AND ELECTIONS FOR THE COUNCIL ON ANNUAL SESSION. The Council on Annual Session shall be composed of seven (7) members nominated and elected as follows:

a. NOMINATION.

(1) Five (5) members shall be nominated in accordance with Section 20A of this Chapter.

(2) Two (2) members shall be the General Chairmen of the Local Arrangements Committee for the two years following the current year's Annual Session and shall serve as *ex officio* members of the Council with the right to vote. The Chairman of the Local Arrangements Committee for the Annual Session to be held two years after the current year's Annual Session shall be nominated for a two year term.

b. ELECTION. All members shall be elected by the House of Delegates from nominees in accordance with this section.

C. NOMINATIONS AND ELECTIONS FOR THE COUNCIL ON EDUCATION. The Council on Education shall be composed of twelve (12) members nominated and elected as follows:

Existing

a. NOMINATION.

(1) Four (4) members shall be nominated by the Board of Trustees from the active, life or retired members of this Association, no one of whom shall be a member of a faculty of a school of dentistry or a member of a state board of dental examiners.

(2) Four (4) members shall be nominated by the American Association of Dental Examiners from the active membership of that body, no one of whom shall be a member of a faculty of a school of dentistry.

(3) Four (4) members shall be nominated by the American Association of Dental Schools from its active membership. These members shall hold positions of professorial rank in dental schools accredited by this Association and shall not be members of any state board of dental examiners.

b. ELECTION. All members of the Council on Dental Education shall be elected by the House of Delegates from nominees selected in accordance with this section.

C. NOMINATIONS AND ELECTIONS FOR THE COUNCIL OF NATIONAL BOARD OF DENTAL EXAMINERS. The Council of National Board of Dental Examiners shall be composed of nine (9) members nominated and elected as follows:

a. NOMINATION.

(1) Three (3) members shall be nominated by the Board of Trustees from the active or life members of this Association, no one of whom shall be a member of a faculty of a school of dentistry or a member of a state board of dental examiners.

(2) Three (3) members shall be nominated by the American Association of Dental Examiners from the active membership of that body, no one of whom shall be a member of a faculty of a school of dentistry.

(3) Three (3) members shall be nominated by the American Association of Dental Schools from its active membership. These members shall hold positions of professorial rank in dental schools accredited by this Association and shall not be members of any state board of dental examiners.

b. ELECTION. All members of the Council of National Board of Dental Examiners shall be elected by the House of Delegates from nominees selected in accordance with this section.

D. NOMINATIONS AND ELECTIONS FOR THE COUNCIL ON LEGISLATION. The Council on Legislation shall be composed of six (6) members nominated and elected as follows:

a. NOMINATION.

(1) Five (5) members shall be nominated in accordance with Section 20A of this Chapter.

(2) One (1) member, who is a physician, shall be nominated annually by the American Medical Association.

b. ELECTION. All members shall be elected by the House of Delegates from nominees in accordance with this section.

Proposed

a. NOMINATION.
(1) Four (4) members shall be nominated by the Board of Trustees from the active, life or retired members of this Association, no one of whom shall be a member of a faculty of a school of dentistry or a member of a state board of dental examiners.

(2) Four (4) members shall be nominated by the American Association of Dental Examiners from the active membership of that body, no one of whom shall be a member of a faculty of a school of dentistry.

(3) Four (4) members shall be nominated by the American Association of Dental Schools from its active membership. These members shall hold positions of professorial rank in dental schools accredited by this Association and shall not be members of any state board of dental examiners.

b. ELECTION. All members of the Council on Education shall be elected by the House of Delegates from nominees selected in accordance with this section.

D. NOMINATIONS AND ELECTIONS FOR THE COUNCIL ON NATIONAL BOARD EXAMINATIONS. The Council on National Board Examinations shall be composed of nine (9) members nominated and elected as follows:

a. NOMINATION.
(1) Three (3) members shall be nominated by the Board of Trustees from the active or life members of this Association, no one of whom shall be a member of a faculty of a school of dentistry or a member of a state board of dental examiners.

(2) Three (3) members shall be nominated by the American Association of Dental Examiners from the active membership of that body, no one of whom shall be a member of a faculty of a school of dentistry.

(3) Three (3) members shall be nominated by the American Association of Dental Schools from its active membership. These members shall hold positions of professorial rank in dental schools accredited by this Association and shall not be members of any state board of dental examiners.

b. ELECTION. All members of the Council on National Board Examinations shall be elected by the House of Delegates from nominees selected in accordance with this section.

E. NOMINATIONS AND ELECTIONS FOR THE COUNCIL ON LEGISLATION AND FEDERAL DENTAL SERVICES. The Council on Legislation and Federal Dental Services shall be composed of eight (8) members nominated and elected as follows:
a. NOMINATION.
(1) Seven (7) members shall be nominated in accordance with Section 20A of this Chapter.

(2) One (1) member, who is a physician, shall be nominated annually by the American Medical Association.
b. ELECTION. All members shall be elected by the House of Delegates from nominees in accordance with this section.

Existing

E. REMOVAL FOR CAUSE. The Board of Trustees may remove a council member for cause in accordance with procedures established by the Board of Trustees.

Section 30. ELIGIBILITY:
A. All members of councils must be active, life or retired members in good standing of this Association except as otherwise provided in these *Bylaws*.
B. A member of the Council on Dental Education or of the Council of National Board of Dental Examiners, who was nominated by the American Association of Dental Examiners and who is no longer an active member of the American Association of Dental Examiners, may continue as a member of the council for the balance of his elected term.
C. When a member of the Council on Dental Education or the Council of National Board of Dental Examiners, who was nominated by the American Association of Dental Schools, shall cease to be a member of the faculty of a member school of that Association, his membership on either council shall terminate, and the President of the Association shall declare the position vacant.

Section 40. CHAIRMEN: One member of each council shall be appointed annually by the Board of Trustees to serve as chairman. The chairman of the Council on Dental Education and of the Council of National Board of Dental Examiners shall be appointed from nominations submitted by their respective councils.

Section 50. CONSULTANTS, ADVISERS AND SECRETARIES:
A. CONSULTANTS AND ADVISERS. Each council shall have the authority to nominate consultants and advisers in conformity with rules and regulations established by the Board of Trustees.

B. SECRETARIES. Secretaries of councils, in the event they are employees, shall be employed by the Executive Director of the Association subject to the approval of the Board of Trustees.

Section 60. TERM OF OFFICE: The term of office of members of councils shall be three (3) years except that the physician nominated by the American Medical Association for membership on the Council on Legislation shall be elected for a one (1) year term. The consecutive tenure of a member of a council shall be limited to two (2) terms of three (3) years each except that the physician nominated by the American Medical Association for membership on the Council on Legislation shall not be limited as to the number of consecutive one (1) year terms that he may serve.

Proposed

F. REMOVAL FOR CAUSE. The Board of Trustees may remove a council member for cause in accordance with procedures established by the Board of Trustees.

Section 30. ELIGIBILITY
A. All members of councils must be active, life or retired members in good standing of this Association except as otherwise provided in these *Bylaws.*

B. A member of the Council on Education or of the Council on National Board Examinations who was nominated by the American Association of Dental Examiners and who is no longer an active member of the American Association of Dental Examiners, may continue as a member of the Council for the balance of his elected term.

C. When a member of the Council on Education or the Council on National Board Examinations, who was nominated by the American Association of Dental Schools, shall cease to be a member of the faculty of a member school of that Association, his membership on either council shall terminate, and the President of the Association shall declare the position vacant.

Section 40. CHAIRMEN: One member of each council shall be appointed annually by the Board of Trustees to serve as chairman. The chairman of the Council on Education and of the Council on National Board Examinations shall be appointed from nominations submitted by their respective councils. The *ex officio* members of the Council on Annual Session shall not be eligible to serve as chairman of that Council.

Section 50. CONSULTANTS, ADVISERS AND SECRETARIES:
A. CONSULTANTS AND ADVISERS. Each council shall have the authority to nominate consultants and advisers in conformity with rules and regulations established by the Board of Trustees.
B. ADVISORY COMMITTEE TO THE COUNCIL ON LEGISLATION AND FEDERAL DENTAL SERVICES. The Chairmen of the Councils on Dental Care Programs, Education, and Health Planning shall constitute the Advisory Committee to and shall be *ex officio* members without the right to vote of the Council on Legislation and Federal Dental Services.
C. SECRETARIES. Secretaries of councils, in the event they are employees, shall be employed by the Executive Director of the Association subject to the approval of the Board of Trustees.

Section 60. TERM OF OFFICE. The term of office of members of councils shall be three (3) years except that the physician nominated by the American Medical Association for membership on the Council on Legislation and Federal Dental Services shall be elected for a one (1) year term, and except that the *ex officio* members of the Council on Annual Session shall be elected for two (2) year terms. The consecutive tenure of a member of a council shall be limited to two (2) terms of three (3) years each except that the physician nominated by the American Medical Association for membership on the Council on Legislation and Federal Dental Services shall not be limited as to the number of consecutive one (1) year terms that he may serve.

Existing

Section 70. VACANCY: In the event of a vacancy in the membership of any council, the President shall appoint a member of the Association possessing the same qualifications as established by these *Bylaws* for the previous member, to fill such vacancy until a successor is elected by the next House of Delegates for the remainder of the unexpired term. In the event such vacancy involves the chairman of the council, the President shall have the power to appoint an *ad interim* chairman.

Section 80. QUORUM: A majority of the members of any council shall constitute a quorum.

Section 90. PRIVILEGE OF THE FLOOR: Chairmen and members of councils who are not members of the House of Delegates shall have the right to participate in the debate on their respective reports but shall not have the right to vote.

Section 100. ANNUAL REPORT AND BUDGET:
A. ANNUAL REPORT. Each council shall submit, through the Executive Director, an annual report to the House of Delegates and a copy thereof to the Board of Trustees.
B. PROPOSED BUDGET. Each council shall submit to the Board of Trustees, through the Executive Director, a proposed itemized budget for the ensuing fiscal year.

Section 110. DUTIES:

COUNCIL ON SCIENTIFIC SESSION

A. COUNCIL ON DENTAL CARE PROGRAMS. The Council shall be composed of fourteen (14) members, one (1) member from each trustee district,* and its duties shall be:

a. To formulate and recommend policies relating to the planning, administration and financing of dental care programs.

b. To study, evaluate and disseminate information on the planning, administration and financing of dental care programs.

c. To assist the constituent societies and other agencies in developing programs for the planning, administration and financing of dental care programs.

*Since the seven members currently serving on the Council are from the Second, Fifth, Seventh, Ninth, Eleventh, Twelfth and Thirteenth Trustee Districts, the seven new members authorized by action of the 1975 House of Delegates shall be from the other seven trustee districts and shall serve terms, commencing when appointed in 1975 by the President and subject to confirmation or replacement through election by the 1976 House of Delegates, for the following periods. Members from the First, Third and

Proposed

No Change

Section 110. DUTIES:

A. COUNCIL ON ANNUAL SESSION. The duties of the Council shall be:

a. To serve as the program and coordinating committee for the annual session.

b. To establish rules and regulations governing section officers in the performance of their duties, subject to approval by the Board of Trustees.

B. COUNCIL ON DENTAL CARE PROGRAMS. The Council shall be composed of fourteen (14) members, one (1) member from each trustee district,* and its duties shall be:

a. To formulate and recommend policies relating to the planning, administration and financing of dental care programs.

b. To study, evaluate and disseminate information on the planning, administration and financing of dental care programs.

c. To maintain liaison with and disseminate information concerning programs of insurance companies and other sponsors of third party dental plans including governmental agencies.

d. To assist the constituent societies and other agencies in developing programs for the planning, administration and financing of dental care programs.

Fourth Trustee Districts for an initial one year term expiring with the annual session in 1976, and members from the Sixth, Eighth, Tenth and Fourteenth Trustee Districts for a two year term expiring with the annual session in 1977. Those appointed for a one year term and those appointed and later confirmed by election for a two year term shall be eligible for re-election to two additional three year terms. The effect of this footnote lapses with the 1977 annual session of the House of Delegates.

Existing

B. Council on Dental Education. The duties of the Council shall be:

a. To act as the agency of the Association in matters related to the evaluation and accreditation of all dental educational, dental auxiliary educational and associated subjects and as liaison to provide the staff assistance for the Commission on Accreditation of Dental and Dental Auxiliary Educational Programs.

b. To study and make recommendations including the formulation and recommendation of policy on

(1) Dental education and dental auxiliary education.

(2) The recognition of special areas of dental practice.

(3) The recognition of categories of dental auxiliaries.

(4) The approval or disapproval of national certifying boards for special areas of dental practice and for dental auxiliaries.

(5) The educational and administrative standards of the certifying boards for special areas of dental practice and for dental auxiliaries.

(6) Associated subjects that affect all dental, dental auxiliary and related education.

c. To act on behalf of this Association in maintaining effective liaison with certifying boards and related agencies for special areas of dental practice and for dental auxiliaries.

C. Council on Dental Health. The duties of the Council shall be:

a. To formulate and recommend policies relating to dental practice, preventive dentistry and dental public health.

b. To study, evaluate and disseminate information on dental practice, preventive dentistry and dental public health.

c. To assist the constituent societies and other agencies in the development and promotion of programs to improve dental practice, preventive dentistry and dental public health.

Council on Hospital Dental Service

Proposed

C. Council on Education. The duties of the Council shall be:

a. To act as the liaison agency of the Association in matters related to the evaluation and accreditation of all dental educational, dental auxiliary educational and associated subjects with and to provide the staff assistance for the Commission on Accreditation of Dental and Dental Auxiliary Educational Programs.

b. To study and make recommendations including the formulation and recommendation of policy on:

(1) Dental education and dental auxiliary education.
(2) The recognition of special areas of dental practice.
(3) The recognition of categories of dental auxiliaries.
(4) The approval or disapproval of national certifying boards for special areas of dental practice and for dental auxiliaries.

(5) The educational and administrative standards of the certifying boards for special areas of dental practice and for dental auxiliaries.

(6) Associated subjects that affect all dental, dental auxiliary and related education.

c. To act on behalf of this Association in maintaining effective liaison with certifying boards and related agencies for special areas of dental practice and for dental auxiliaries.

D. Council on Health Planning. The duties of the Council shall be:

a. To formulate plans and recommend policies concerning activities of public health agencies and programs respecting dental health and preventive dentistry, including consideration of adequate organization, community projects, and public health initiatives as well as formulating future plans and maintaining an inventory of existing and projected resources.
b. To maintain liaison with public health agencies and to study, evaluate and disseminate information concerning dental programs, including preventive dentistry, and the organization of existing public health agencies at the local, state and national level.
c. To support existing dental public health agencies and programs, identify deficiencies and plan for and promote improvement of these programs and agencies.
d. To assist constituent and component societies, dental public health and other agencies in dental public health affairs in planning resources and facilities for preventive dentistry and community health programs.

E. Council on Institutional Health Services. The duties of the Council shall be:

a. To examine dental services in hospitals and patient care units other than hospitals and to issue, in the name of the American Dental Association, certificates of approval to those institutions having dental services which meet the basic standards or requirements established by the House of Delegates.

b. To act on behalf of the Association in the inspection and improvement of dental services in hospitals and patient care units other than hospitals.

c. To study and make recommendations on the effective involvement of hospital dental services in community, state, regional and federal health care programs.

Existing

D. Council on Dental Laboratory Relations. The duties of the Council shall be:

a. To conduct studies and make recommendations on programs which will maintain for the dental profession the complete legal, as well as professional, responsibility for providing prosthetic dental services to members of the public.

b. To encourage and develop satisfactory relations with the various organizations representing the dental laboratory industry and craft.

c. To formulate programs for establishing and maintaining the greatest efficiency of the dental laboratory industry and craft in their relation to the dental profession.

E. Council on Dental Materials and Devices. The Council shall be composed of nine (9) members and its duties shall be:

a. To determine the safety and effectiveness of, and disseminate information on, materials and devices which are offered to the public or to the profession.

b. To encourage the development and improvement of materials and devices for use in dental practice or to improve the oral health of the public.

Council on Judicial Procedures, Constitution and By-Laws

Council on Dental Laboratory Relations

Proposed

COUNCIL ON LABORATORY RELATIONS

COUNCIL ON MATERIALS AND DEVICES

F. COUNCIL ON JUDICIAL AFFAIRS. The duties of the Council shall be:

a. To consider proposals for amending the *Principles of Ethics.*

b. To provide advisory opinions regarding the interpretation of the *Principles of Ethics.*

c. To consider appeals from members of the Association or from component societies subject to the requirements of Chapter XI, Section 20 of these *Bylaws.*

d. To hold hearings and render decisions in disputes arising between constituent societies or between constituent and component societies.

e. To review the articles of the *Constitution and Bylaws* in order to keep them consistent with the Association's program.

f. To recommend editorial corrections in the *Bylaws.*

g. To act as the Standing Committee on *Constitution and Bylaws* during the annual session of the House of Delegates.

Decisions of the Council shall be subject to appeal to the House of Delegates except in the event of appeals which are covered by the provisions of Chapter XI, *Principles of Ethics* and Judicial Procedure, Section 20, Discipline of Members.

G. COUNCIL ON LABORATORY RELATIONS. The duties of the Council shall be:

a. To conduct studies and make recommendations on programs which will maintain for the dental profession the complete legal, as well as professional, responsibility for providing prosthetic dental services to members of the public.

b. To encourage and develop satisfactory relations with the various organizations representing the dental trade and the dental laboratory industry and craft.

c. To formulate programs for establishing and maintaining the greatest efficiency of the dental trade and the dental laboratory industry and craft in their relation to the dental profession.

Existing

F. COUNCIL ON DENTAL RESEARCH. The duties of the Council shall be:

a. To guide and assist and act as liaison to the American Dental Association Health Foundation and its agencies.

b. To encourage efforts demonstrating the relationship of oral health research to the practice of dentistry.

c. To formulate and recommend policies identifying and promoting needed research in oral health.

d. To evaluate and promulgate its opinion regarding the scientific efficacy of concepts, procedures and techniques for use in the treatment of patients.

G. COUNCIL ON DENTAL THERAPEUTICS. The Council shall be composed of nine (9) members and its duties shall be:

a. To study, evaluate and disseminate information with regard to dental therapeutic agents, their adjuncts and dental cosmetic agents which are offered to the public or to the profession.

b. To formulate plans for encouraging, establishing and supporting programs of research in the field of dental therapeutics.

H. COUNCIL ON FEDERAL DENTAL SERVICES. The duties of the Council shall be:

a. To review and study the professional problems of the federal dental services and formulate programs to increase the efficiency of such services.

b. To formulate programs for the participation of dentists in disaster preparedness activities.

Members of the Council shall not be in the full-time employ of the federal government, and at least three (3) members shall be service veterans.

I. COUNCIL ON HOSPITAL DENTAL SERVICE. The duties of the Council shall be:

a. To examine dental services in hospitals and patient care units other than hospitals and to issue, in the name of the American Dental Association, certificates of approval to those institutions having dental services which meet the basic standards or requirements established by the House of Delegates.

b. To act on behalf of the Association in the inspection and improvement of dental services in hospitals and patient care units other than hospitals.

c. To study and make recommendations on the effective involvement of hospital dental services in community, state, regional and federal health care programs.

J. COUNCIL ON INSURANCE. The duties of the Council shall be:

a. To study programs for insuring members of this Association and to make recommendations regarding such programs.

b. To assist the constituent societies and other agencies in matters relating to such programs.

Proposed

BUREAU OF BASIC AND CLINICAL RESEARCH

COUNCIL ON THERAPEUTICS

Merged into COUNCIL ON LEGISLATION

COUNCIL ON INSTITUTIONAL HEALTH SERVICES

DEPARTMENT OF MEMBERSHIP INSURANCE

K. Council on International Relations. The duties of the Council shall be to cooperate with dentists and dental and other organizations in the United States and abroad for the purpose of supporting an international exchange of dental knowledge and information and fostering international good will.

L. Council on Journalism. The duty of the Council shall be to develop methods and programs for the advancement of dental journalism. The Editor of the Association shall be a member *ex officio*.

M. Council on Judicial Procedures, Constitution and Bylaws. The duties of the Council shall be:

a. To consider proposals for amending the *Principles of Ethics*.

b. To provide advisory opinions regarding the interpretation of the *Principles of Ethics*.

c. To consider appeals from members of the Association, or from component societies subject to the requirements of Chapter XI, Section 20 of these *Bylaws*.

d. To hold hearings and render decisions in disputes arising between constituent societies or between constituent and component societies.

e. To review the articles of the *Constitution and Bylaws* in order to keep them consistent with the Association's program.

f. To recommend editorial corrections in the *Bylaws*.

g. To act as the Standing Committee on *Constitution and Bylaws* during the annual session of the House of Delegates.

Decisions of the Council shall be subject to appeal to the House of Delegates except in the event of appeals which are covered by the provisions of Chapter XI, *Principles of Ethics* and Judicial Procedure, Section 20, Discipline of Members.

N. Council on Legislation. The duties of the Council shall be:

a. To protect and further the interests of the public and the dental profession in matters of legislation, patents and regulations by appropriate activities.

b. To disseminate information which will assist the constituent and component societies in their problems involving legislation and affecting the dental health of the public or the practice of dentistry.

and

Council on Federal Dental Services

Council on Dental Materials and Devices

Eliminate; duties transferred to Bureau of Public Information

Eliminate; duties transferred to Bureau of Public Information

Council on Judicial Affairs

H. Council on Legislation and Federal Dental Services. The duties of the Council shall be:

a. To protect and further the interests of the public and the dental profession in matters of legislation, patents and regulations by appropriate activities.

b. To disseminate information which will assist the constituent and component societies in their problems involving legislation and affecting the dental health of the public or the practice of dentistry.

c. To review and study the professional problems of the federal dental services and formulate programs to increase the efficiency of such services.

I. Council on Materials and Devices. The Council shall be composed of seven (7) members and its duties shall be:

a. To determine the safety and effectiveness of, and disseminate information on, materials and devices which are offered to the public or to the profession.

b. To encourage the development and improvement of materials and devices for use in dental practice or to improve the oral health of the public.

Existing

O. Council of National Board of Dental Examiners. The duties of the Council shall be:

a. To provide and conduct written examinations, exclusive of clinical demonstrations, for the purpose of determining qualifications of dentists who seek license to practice in any state, district or dependency of the United States. Dental licensure is subject to the laws of the state, district or dependency and the conduct of all clinical examinations for licensure is reserved to the individual board of dental examiners.

b. To provide and conduct written examinations, exclusive of clinical demonstrations, for the purpose of determining qualifications of dental hygienists who seek license to practice in any state, district or dependency of the United States. Dental hygiene licensure is subject to the laws of the state, district or dependency and the conduct of all clinical examinations for licensure is reserved to the individual board of dental examiners.

c. To make rules and regulations for the conduct of examinations and the certification of successful candidates.

New

P. Council on Relief. The duties of the Council shall be:

a. To formulate programs for increasing the principal of the American Dental Association Relief Fund.

b. To recommend to the Board of Trustees rules and regulations for the granting of financial aid to dentists, their dependents and survivors.

The members of the Council shall be the trustees of the American Dental Association Relief Fund.

Q. Council on Scientific Session. The duties of the Council shall be:

a. To serve as the program committee for the scientific session.

b. To establish rules and regulations governing section officers in the performance of their duties, subject to approval by the Board of Trustees.

Council on Dental Therapeutics

Proposed

J. Council on National Board Examinations. The duties of the Council shall be:

a. To provide and conduct written examinations, exclusive of clinical demonstrations, for the purpose of determining qualifications of dentists who seek license to practice in any state, district or dependency of the United States. Dental licensure is subject to the laws of the state, district or dependency and the conduct of all clinical examinations for licensure is reserved to the individual board of dental examiners.

b. To provide and conduct written examinations, exclusive of clinical demonstrations, for the purpose of determining qualifications of dental hygienists who seek license to practice in any state, district or dependency of the United States. Dental hygiene licensure is subject to the laws of the state, district or dependency and the conduct of all clinical examinations for licensure is reserved to the individual board of dental examiners.

c. To make rules and regulations for the conduct of examinations and the certification of successful candidates.

K. Council on Practice Administration. The duties of the Council shall be:

a. To study, evaluate and disseminate information concerning various forms of business organization of a dental practice, economic factors related to dental practice, practice management techniques and related current developments.

b. To develop and provide educational and other programs to assist dentists in improved practice management.

c. To assist constituent and component societies and other dental organizations in the development of programs designed to improve practice management techniques.

Commission on Relief and Disaster Fund Activities

Council on Annual Session

L. Council on Therapeutics. The Council shall be composed of seven (7) members and its duties shall be:

a. To study, evaluate and disseminate information with regard to dental therapeutic agents, their adjuncts and dental cosmetic agents which are offered to the public or to the profession.

b. To formulate plans for encouraging, establishing and supporting programs of research in the field of dental therapeutics.

Existing

CHAPTER XII • BUREAUS

Section 10. NAME: The bureaus of this Association shall be
A. Bureau of Audiovisual Service
B. Bureau of Convention Services
C. Bureau of Data Processing Services and Membership Records
D. Bureau of Dental Health Education
E. Bureau of Dental Society Services
F. Bureau of Economic Research and Statistics
G. Bureau of Library Services
H. Bureau of Public Information

Section 20. PERSONNEL: The personnel of all bureaus shall be employees of the Association.

Section 30. DUTIES: The duties of each bureau shall be assigned by the Board of Trustees through the Executive Director of the Association under whose jurisdiction each shall operate. The general duties of each bureau shall be:

A. BUREAU OF AUDIOVISUAL SERVICE.
a. To develop and maintain a film library and a program of audiovisual service for the Association.
b. To foster the use and production of audiovisual materials of interest to the dental profession.

COUNCIL ON DENTAL RESEARCH

B. BUREAU OF CONVENTION SERVICES

a. To prepare and submit recommendations concerning, and arrange and coordinate details respecting, the annual session of the Association.
b. To arrange the travel accommodations of those persons on official assignment on behalf of the Association.
c. To coordinate the use of meeting rooms in the Headquarters Building of the Association.

Proposed

and be it further,
Resolved, that Chapter XII, Bureaus, of the *Bylaws* be amended by substitution to read as follows:

CHAPTER XII • BUREAUS

Section 10. NAME: The bureaus of this Association shall be:
A. Bureau of Basic and Clinical Research
B. Bureau of Data Processing and Membership Records
C. Bureau of Economic and Behavioral Research
D. Bureau of Health Education and Audiovisual Services
E. Bureau of Library Services
F. Bureau of Public Information
G. Bureau of Society Services

No Change

No Change

Merged into BUREAU OF HEALTH EDUCATION

A. BUREAU OF BASIC AND CLINICAL RESEARCH.

a. To guide and assist and act as liaison to the American Dental Association Health Foundation and its agencies.

b. To encourage efforts demonstrating the relationshp of oral health research to the practice of dentistry.

c. To formulate and recommend policies identifying and promoting needed research in oral health.

d. To examine new and developing treatment techniques.

e. To evaluate and promulgate its opinion regarding the scientific efficacy of concepts, procedures and techniques for use in the treatment of patients.

DEPARTMENT OF CONFERENCE SERVICES

Existing

C. Bureau of Data Processing Services and Membership Records.

a. To establish, maintain and operate data processing services for the Association.

b. To maintain the membership records of the Association.

c. To prepare and cause to be published the *American Dental Directory*.

Bureau of Economic Research and Statistics

Bureau of Audiovisual Services and

D. Bureau of Dental Health Education. To develop and maintain a program of dental health education for this Association and to assist the constituent societies and other agencies in the development of effective programs of dental health education.

E. Bureau of Dental Society Services.

a. To develop, maintain and disseminate informational services related to the administrative and program activities of constituent, component and other dental societies and organizations composed of members of dental auxiliaries.

b. To coordinate and respond to requests for information and services presented by constituent, component and other dental societies and organizations composed of members of dental auxiliaries.

F. Bureau of Economic Research and Statistics. To collect, compile, develop, analyze and disseminate data and statistics that concern the dental profession.

G. Bureau of Library Services.

a. To maintain and develop the library services of the Association.

b. To prepare and cause to be published an index to dental literature.

c. To develop uniform standards of nomenclature in the field of dental science.

d. To maintain the archives of the Association.

e. To collect published and original documentary material of historical interest to the dental profession.

H. Bureau of Public Information. To develop and maintain a public relations program for this Association, including the dissemination of information and publicity concerning activities of this Association.

Proposed

B. Bureau of Data Processing and Membership Records.

a. To establish, maintain and operate data processing services for the Association.

b. To maintain the membership records of the Association.
c. To prepare and cause to be published the *American Dental Directory*.

C. Bureau of Economic and Behavioral Research.

a. To develop, collect, and compile data and statistics from surveys of the profession, the public and other sources.

b. To analyze and publish data and statistics that are of concern to the dental profession.

c. To assist Association agencies, constituent societies and others to develop, collect, compile, analyze and publish such data and statistics.

d. To maintain liaison for the Association with private and public agencies as are engaged in the development, use or publication of such data and statistics.

D. Bureau of Health Education and Audiovisual Services. To develop and maintain a program of dental health education for this Association and to assist the constituent societies and other agencies in the development of effective programs of dental health education. To develop and maintain a film library and a program of audiovisual service for the Association, and to foster the use and production of audiovisual materials of interest to the dental profession.

Bureau of Society Services

Bureau of Economic and Behavioral Research

E. Bureau of Library Services.

a. To maintain and develop the library services of the Association.

b. To prepare and cause to be published an index to dental literature.

c. To develop uniform standards of nomenclature in the field of dental science.

d. To maintain the archives of the Association.

e. To collect published and original documentary material of historical interest to the dental profession.

F. Bureau of Public Information. To develop and maintain a public relations program for this Association, including the dissemination of information and publicity concerning activities of this Association.

Existing

BUREAU OF DENTAL SOCIETY SERVICES

COUNCIL ON RELIEF

Proposed

G. BUREAU OF SOCIETY SERVICES.

a. To develop, maintain and disseminate informational services related to the administrative and program activities of constituent, component and other dental societies and organizations composed of members of dental auxiliaries.

b. To coordinate and respond to requests for information and services presented by constituent, component and other dental societies and organizations composed of members of dental auxiliaries.

c. To conduct and manage Association sponsored conferences and seminars for constituent and component societies and dentally related organizations.

and be it further,

Resolved, that the *Bylaws* be amended by redesignating Chapters XV through XX as Chapters XVI through XXI and by adding a new Chapter XV, to be entitled "Commission on Relief and Disaster Fund Activities", to read as follows:

CHAPTER XV. COMMISSION ON RELIEF AND DISASTER FUND ACTIVITIES.

Section 10. ESTABLISHMENT: This Association shall create a Commission on Relief and Disaster Fund Activities as successor to the Council on Relief. References to the "Council on Relief" in these *Bylaws* or elsewhere shall be construed as referring to this Commission.

Section 20. COUNCIL PROVISIONS, GOVERN: Except as otherwise provided in this Chapter, Chapter IX, Sections 20 through 100 shall govern the conduct of the Commission. The Commission shall be composed of five (5) members.

Section 30. DUTIES: The duties of the Commission shall be:

a. To formulate programs for increasing the principal of the American Dental Association Relief Fund, and the American Dental Association Disaster Victims Emergency Loan Fund.

b. To recommend to the Board of Trustees rules and regulations for the granting of financial aid to dentists, their dependents and survivors, and for the granting of emergency assistance loans to dentists who are victims of natural disasters.

c. To review applications for Relief Fund benefits, renewal of Relief Fund grants, and Disaster loans.

d. To plan and conduct the annual campaign for contributions to the Relief and Disaster Funds.

The members of the Commission shall be the trustees of the American Dental Association Relief Fund and the American Dental Association Disaster Victims Emergency Loan Fund.

(Note: the above language incorporates the amendatory language contained in the first resolving clause of Resolution 22 (p. 181).)

and be it further,

Resolved, that the *Bylaws* be amended with appropriate editorial and punctuational corrections consistent with this resolution.

REPORT 8 OF THE BOARD OF TRUSTEES TO HOUSE OF DELEGATES: THE PUBLIC EDUCATION PROGRAM

In reporting on the Association's Public Education Program, the Board of Trustees first wishes to express its support of the accomplishments of this program in the past two years and to reiterate its belief that a major Public Education Program is necessary. The Board especially wishes to commend the PEP Advisory Committee which has performed such outstanding service in these past two years.

The Board of Trustees firmly believes that a major Public Education Program is necessary. The Board has given thorough consideration to the recommendations of the Advisory Committee to the Public Education Program and remains cognizant that cutbacks in proposed programs have temporarily inhibited program growth. However, the Board cannot justify establishing a 1977 budget deficit of $1 million.

In the Committee's August report to the Board of Trustees, it stated:

> If PEP is to have real impact in urgently communicating the story of private practice, fee-for-service, if PEP is to compete for the attention and the support of the public, of legislators, of business and union leaders, then sufficient funds must be provided. The need to communicate our story is too urgent to delay.

The Board strongly sympathized with this comment (p. 512) but was then forced to face the very difficult problem of presenting a balanced budget to this House of Delegates. A Public Education Program of $1,796,000, as requested by the PEP Advisory Committee, simply could not be accommodated within the 1977 budget without throwing it into deficit by more than $1 million.

Following is the Board's Report on PEP activities to date and on the proposed 1977 program.

Background: The second year of PEP continued the major effort to tell target audiences and the general public the story of private practice, fee-for-service. Continued were spokesmen training seminars for dental leaders, assistance to state societies with critical problems in third and fourth party areas, a press support program to reach the public through mass media and a nationwide radio, TV and newspaper tour by PEP's broadcast interview specialist.

1976 Major Statement: PEP is primarily a public relations program, that is, it uses the news and features columns of mass media and the public service programs of the electronic media. However, each year there has been a purchase of space in national publications to deliver a controlled message directly to the public—controlled in content, in format and in placement. It is neither financially feasible nor, in all probability, would it be wise to utilize all PEP funds in this manner; however, limited use of advertising does provide very real benefits. In 1976, advertising has been placed in *Time* and *Newsweek* magazines for three public messages concerning the cost, quality and accessibility of dental care. The purpose of the advertisements has been to reinforce public awareness that the private practice dental system is working and that it is working in their best interest. Total audience is estimated at 30 million. Desk display copies of these three messages were sent to every Association member.

Community Action Programs

Duluth: It is anticipated that the steel companies and union in the Iron Range region of northeast Minnesota soon will be offering its employees/members a dual choice between their present dental prepayment plan and an HMO plan for dental care. When this happens, the HMO will be competing for patients currently seeking care in private offices. The purpose of the community action program is to mobilize a communications campaign by members of the Duluth District Dental Society to inform union members about the advantages of private practice. Members of the society are working to obtain a voice for private practice in local media as well as engaging in one-to-one communications with insured patients.

The 93 dentists trained at a communications session are contacting print and broadcast media throughout the Iron Range and Duluth. News articles and radio interview shows are being prepared for the local media stressing the benefits of private practice dentistry. Selected spokesmen are also carrying the message to community organizations, company management and labor. The Action Plan, consisting of office literature, press materials, speakers bureau and union-carrier strike force, is designed to motivate workers to choose private pactice, fee-for-service dentistry by electing to continue their present dental prepayment plan. Official announcement of the dual choice has not yet been made.

Southern New Jersey: In recent years, southern New Jersey has been the site of an influx of alternative dental delivery systems which are competing for private practice patients. Closed panel clinics claim to serve 80,000 patients. PEP is helping members of the Southern District Dental Society to mobilize a communications campaign to inform union officials, management and the public about the advantages of the dental plans involving private practice. Members of the society are working to obtain a voice for private practice in the local media. Fifty dentists have been trained to communicate the positive message of private practice in the New Jersey action plan which includes a speakers bureau, press materials, press tours and media contacts.

Tenth District Dental Society: The Tenth District (Long Island) Dental Society of New York received PEP support for a special project to build a better understanding of dental health issues in the Long Island community. The project was a two-day conference series titled "Dental Health Care on Long Island: How Accessible Is It?". Speakers included representatives of labor, management, community health agencies, health professions and insurance companies. Invitations were sent to local leadership in labor, industry, business, politics, consumer groups, health agencies, religious groups and dentistry. The first seminar was held on September 22 and the second was scheduled for October 13.

These three community action activities are funded on a cost-sharing basis and are serving as national testing grounds for the effectiveness of campaigns organized by local dentists to win support for private practice.

Press Support: The dental profession has a strong story to tell about holding the line on fees. In July, President Robert B. Shira appeared before the President's Council on Wage and Price Stability and, as a supplement to his testimony, presented the Council with an ADA staff-written report documenting the fact that the profession has held its fees in line with the cost of living index. This document is now being offered through PEP to syndicated columnists, the op-ed pages of major newspapers, feature writers, etc.

In another effort, a feature article on the dentists' record on fees was distributed by Newspaper Enterprise Association and featured by 87 daily newspapers.

"How to Design the Best Dental Prepayment Plan," incorporating Association policy and thinking on prepayment, is being developed. The article will be submitted to leading insurance, personnel and industrial relations journals.

Leroy Pope, business columnist for United Press International, wrote a column on dentistry's fees published in 75 newspapers with circulation totaling 3 million.

A discussion of dental fees was also written by Don Oakley, Newspaper Enterprise Association, published in over 90 newspapers.

In the broadcast phase of press support, the ABC Weekend News reported on dental insurance in its close-up segment featuring an interview with Dr. Robert B. Shira. In addition, Dr. Shira was interviewed by WLS-TV Chicago on national health insurance, dental prepayment and access to care. Similar topics were discussed by news personnel at WGBQ-TV Memphis.

Four interviews were arranged for ADA President-elect Frank F. Shuler in Washington, D.C., with UPI wire service, Associated Press Radio, Mutual Broadcasting and WMAL-Radio.

Spokesmen Training: Five regional spokesmen training seminars have been held in 1976 resulting in 158 additional dentists being prepared to provide strong and uniform advocacy of the profession's positions as additions to the cadre of well-informed and articulate spokesmen at the national, state and local levels.

Seminars were held in:

Atlanta, for 36 participants from 11 states
Philadelphia, for 35 participants from 12 states
San Francisco, for 24 participants from 4 states
Denver, for 33 participants from 9 states
Minneapolis, for 30 participants from 8 states

The Public Education Program this year initiated special programs for selected graduates of the 1975 and 1976 regional seminars. Eighteen dentists participated in the first graduate seminar in April and 16 participated in the second graduate seminar in October. The purpose of the training is to advance and refine the communications skills of outstanding spokesmen graduates.

Spokesmen Utilization: A national program to utilize trained spokesmen has been underway to maximize the results of the training seminars. To date, 74 spokesmen training graduates have been contacted to arrange placements: 147 interviews have taken place or been scheduled, 102 appearances and 44 firm commitments and an additional 22 interviews are in the process of being confirmed. Additionally, state and local societies are being encouraged to use these spokesmen.

Broadcast Interview Specialist: PEP's broadcast interview specialist, Dr. Nancy Reynolds, continued her tour of television, radio and newspaper interviews. Her appearances are an excellent vehicle for reaching large public audiences. Her 1976 tour included Atlanta, Akron/Canton, Cleveland, Milwaukee, Philadelphia, San Antonio, San Francisco, Dallas/Ft. Worth, Denver, Detroit, Pittsburgh, St. Louis, Champaign/Decatur/Springfield, San Diego/Sacramento/Modesto, Columbus, Kansas City, Minneapolis, Portland/Eugene, Chicago, New York, Syracuse and Washington, D.C. Projected total audience is 10 million people.

Informing the Patient: A booklet, *Do You Believe in Private Practice?,* was designed to help the practicing dentist become an effective spokesman by winning support for private practice through chairside conversation. The booklet contains more than 50 statements of hard facts in a discussion of the U.S. private practice system. A copy of the booklet has been mailed to every ADA member.

Legislative Action Program: The legislative information packet, which is in preparation, is part of PEP's efforts to communicate with lawmakers and their staffs about key issues such as national health insurance and dental health care for the indigent. Purpose of the packet is to identify key legislative issues relating to dental care, outline the profession's position on each and recommend legislative action on the issues that Congressmen should consider.

Measuring Program Effectiveness: The effectiveness of the *Time* and *Newsweek* ads will be measured in a study to be conducted by Social Research, Inc., and the Bureau of Economic Research and Statistics. The results will be used to provide guidance for PEP activities and priorities for future major statements.

Reporting to the Profession: Articles and photographs on the progress of the Public Education Program continue to appear in nearly every issue of the *ADA News* and the *Journal.* Regular and special PEP progress reports have been carried as inserts in every second issue of the *ADA Leadership Bulletin.* Each report informs the leadership of the developments in all areas of the program since the previous report, outlines upcoming activities and discusses the latest PEP "tools." As noted, every Association member received desk display copies of the *Time* and *Newsweek* advertisements. Presentations on PEP have been given by the Advisory Committee and ADA staff at the Association's Regional Conferences, Third Conference of National Dental Organizations, Tenth National Conference on Dental Public Relations, the Conference of State Society Officers and the Conference on the Preservation of Private *Practice.* Special presentations on PEP have also been given at various component and constituent society meetings.

1977 PEP PROPOSAL

1977 Budget: The Public Education Program in 1977 will build on the accomplishments of 1975 and 1976. It will be redirected so as to provide more help to state and local societies while at the same time moving forcefully to tell the private practice story at the national level.

Following are specific comments on some of the programs which PEP will be carrying out in 1977.

Operation Grassroots: PEP Cooperation with Constituent and Component Societies: Major emphasis will be given in 1977 to bringing the Public Education Program to the state and local levels. If PEP is to have any immediate or long-range impact on the general public, on thought leaders, on current or potential dental patients, then it must become fully activated at the "grass roots."

Community Action: The Community Action facet of PEP is designed to assist dental societies which have major, immediate problems such as third and fourth party programs.

Board Minutes

March 11-13, 1976

HEADQUARTERS BUILDING, CHICAGO
MARCH 11-13, 1976

Call to Order: The third regular session of the Board of Trustees of the American Dental Association was called to order at 9:00 a.m., Thursday, March 11, 1976, in the Board Room of the Headquarters Building, Chicago, by President Robert B. Shira.

Roll Call: The following officers were present: Robert B. Shira, president, Frank F. Shuler, president-elect; Irving E. Gruber, first vice-president, George E. Kearns, second vice-president; Frank P. Bowyer, speaker of the House of Delegates; C. Gordon Watson, executive director; James W. Etherington, treasurer; Herbert C. Butts, editor.

The following members of the Board of Trustees were present: George P. Boucek, Weston D. Brown, Joseph P. Cappuccio, Charles D. Carter, Floyd E. Dewhirst, Robert B. Dixon, John M. Faust, Coleman Gertler, Robert H. Griffiths, John J. Houlihan, I. Lawrence Kerr, Jack H. Pfister, Lloyd J. Phillips, and Eugene A. Savoie.

The following members of staff were present: Eric M. Bishop, assistant executive director, dental health; Hal M. Christensen, assistant executive director, Washington Office; John M. Coady, assistant executive director, education and hospitals; Bernard J. Conway, assistant executive director, legislation and legal affairs; Peter C. Goulding, assistant executive director, communications; John P. Noone, assistant executive director, business affairs and house counsel; Richard W. Tiecke, assistant executive director, scientific affairs; Walter E. Wisniewski, associate house counsel; Leo Kleck, comptroller; Susan W. Brock, administrative assistant; John Goetz, managing editor; Howard I. Wells, director, Bureau of Dental Society Services.

Approval of Minutes of Previous Sessions: A resolution was adopted approving the minutes of the August 18-23, October 22-24, and October 30, 1975 sessions of the Board of Trustees as amended by Dr. Pfister.

Recording of Mail Ballot: A resolution was adopted placing in the record the following mail ballot which was taken by the Board of Trustees during the period December 18, 1975 through March 9, 1976:

> Grant to Maine Dental Association: Mail Ballot No. 1 was circulated on January 30, 1976. The following resolution was adopted by a vote of 18 affirmative ballots, no negative ballots and no missing ballots.
>
> > Resolved, that $8,500 be appropriated from the 1976 Contingent Fund and allocated to the Grants line item in the budget *Grants and Loans to Related Health Groups* for the Maine Dental Association to assist that Association in its efforts to combat the passage of a "denturism bill" in the legislature of the State of Maine.

A motion was adopted instructing the Committee on Rules and Order to decide whether the President votes or does not vote on a mail ballot, except in the case of a tie vote, and to report to the August session of the Board of Trustees.

REPORT OF COMMITTEE ON RULES AND ORDER

The Executive Director read the Report of the Committee on Rules and Order. The other members of the Committee were Dr. Shira, chairman, Drs. Faust, Griffiths and Savoie, and Dr. Shuler, observer.

Approval of Agenda: A resolution was adopted approving the agenda on Pages 1-3 of the *Board Manual* as the official order of business for the current session.

Special Orders of Business: A resolution was adopted establishing the following special orders of business:

> Executive Meeting at the call of the Chair
>
> Meeting of Board of Directors, American Dental Association Health Foundation at the call of the Chair
>
> Appearance of Dr. James P. Kerrigan, chairman, Special Committee to Study the ADA Annual Session, and Dr. Lyle A. Brecht, chairman, Council on Scientific Session, Thursday, March 11, 10:30 a.m.
>
> Appearance of Dr. Harvey C. Janke, Ohio, and Dr. Jack Weinrich, president of The John Harris Dental Museum Foundation, Thursday, March 11, 11:45 a.m.

1976 Schedule of Board of Trustees: The Committee noted that the Board of Trustees had selected the following dates for the remaining 1976 sessions of the Board of Trustees:

> Summer Session: August 16-21, with the Committee on Finance and Investments meeting on July 21-24 and the Committee on Rules and Order and Salary and Tenure meeting on August 15.

Annual Session: November 9-12, with the Committee on Finance and Investments and the Committee on Rules and Order meeting on November 8.

New Board Session: November 18, following the adjournment of the House of Delegates.

1976-1977 Schedule of Board of Trustees: The Committee recommended that consideration be given at this session to the establishment of the 1977 schedule of the Board of Trustees in order to assist the officers and trustees in preparing their schedules and in order to reserve hotel rooms in advance. The Committee also recommended that when possible meetings of the Board's Special Committee on Inter-Agency Affairs be scheduled to permit an orderly planning of such Committee meetings. If such meetings are not required, they may be cancelled.

The following resolution presented by the Committee was adopted:

1-1976-B. Resolved, that the 1976-77 Winter Session of the Board of Trustees be held on January 6-7, 1977 with the Committee on Rules and Order, the Committee on Finance and Investments, and the Special Committee on Inter-Agency Affairs meeting on January 5, and be it further

Resolved, that the 1977 Spring Session of the Board of Trustees be held on March 24-26 with the Committee on Rules and Order, the Committee on Finance and Investments, and the Special Committee on Inter-Agency Affairs meeting on March 23, and be it further

Resolved, that the 1977 Summer Session of the Board of Trustees be held on August 15-20 with the Committee on Rules and Order and the Special Committee on Inter-Agency Affairs meeting on August 14 and the Committee on Finance and Investments meeting on July 20-23, and be it further

Resolved, that the 1977 Annual Session of the Board of Trustees be held on October 4-7 with the Committee on Rules and Order, the Committee on Finance and Investments and the Special Committee on Inter-Agency Affairs meeting on October 3, and be it further

Resolved, that the 1977 Session of the New Board of Trustees be held on October 13, and be it further

Resolved, that the 1977 Winter Session of the Board of Trustees be held on December 13-14 with the Committee on Rules and Order, the Committee on Finance and Investments and the Special Committee on Inter-Agency Affairs meeting on December 12.

Nominations to Councils: The Committee reported that, in accordance with the *Rules of the Board of Trustees,* the Executive Director had provided the following schedule for the 1976 nominations to councils:

April 16	Nominations are requested from voting members of the Board of Trustees.
May 17	Nominations must be in the hands of the Executive Director.
June 16	The list of nominations will be circulated by the Executive Director and additional nominations will be requested.
July 16	The complete list of nominations will be circulated by the Executive Director.

August 16- 12	The Board of Trustees will formally vote on the list of nominees previously circulated. Additional nominees may not be presented without a majority vote of the Board of Trustees.
November 14-18	The House of Delegates will consider and elect the list of nominees submitted by the Board of Trustees.

The Committee reported that the expiration of terms of council members had been projected for the current year and the list was appended to the report.

UNFINISHED BUSINESS

Student Aid Program: The Board of Trustees considered the following report:

During the December 1975 session of the Board of Trustees a report was presented in behalf of the Board of Directors of the American Fund for Dental Health indicating that it would no longer be possible for the Equitable Life Assurance Company of the United States to continue a graduate and professional student tuition loan program through student life funding which is jointly run with the United Student Aid Funds. On the basis of this decision, the American Fund for Dental Health's program would be discontinued unless an alternate source of funding was derived.

The Board of Trustees recommended that a staff committee be appointed to review this matter and provide an interim report to the March 1976 session of the Board of Trustees. In trying to provide an adequate background and understanding of potential problems associated with student aid, this matter was discussed with representatives of the American Association of Dental Schools to determine what effect, ultimately, the discontinuation of the AFDH program might have on dental students.

No clear consensus can be obtained but from all indication it appears that middle income students may become hard pressed in finding alternative solutions for student aid. The discontinuation of the AFDH program, in and of itself, will have little affect; but with the potential drying up of governmental sources through the health professions act and the general lack of availability of funds will undoubtedly cause some problems in the long term. As capitation funds for educational programs have shrunk, tuition increases have risen significantly and this spiral of additional costs will have its affect on the applicant's ability to pay for the dental education program.

In considering this entire issue, the Board of Trustees will have to decide certain basic issues prior to pursuing the development of a student aid program by the American Dental Association on a national basis.

1. Is there sufficient need for the development of a national dental student loan program?
2. Should the program be initiated through the American Dental Association if one should be established?
3. Should a program be capitalized through the American Fund for Dental Health with the support of the American Dental Association?
4. What role, if any, should the American Dental Association play in the inauguration or establishment of such a program?
5. What are the alternatives for capitalizing such a program since it is assumed that approximately five million dollars would be necessary to underwrite the initiation of a successful program?

In reviewing this matter, the staff committee contacted the American Medical Association to determine mechanisms used by the AMA in the development of its medical student loan program. The AMA guaranteed student loan program is conducted under the auspices of the AMA Educational Research Foundation and utilizes a guaranteed student loan program technique decentralized nationally with particular emphasis on the utilization of local banks that currently handle the medical school and the university accounts. The AMA spokesman was emphatic in his belief that local bank decentralization of a guaranteed student loan program can be effective since the local university and dental school would have a great deal of leverage in dealing with the bank. The AMA program has now been in operation for a good number of years, and has apparently been fairly successful. In pursuing this matter with the AMA, the delinquency rate and obligations of the American Medical Association related to both delinquency and administration of the loan program were of special interest and will be reported to the Board for its information.

It is the belief of the staff committee that before investigating further the development of any national student aid program within the auspices of the American Dental Association, the Board of Trustees should consider the issues associated with such a program and make its recommendation regarding this matter.

After discussion the following resolution was adopted by the Board of Trustees:

2-1976-B. **Resolved**, that the American Dental Association support the philosophy that a program be developed to assist dental students in the acquisition of student loans, and be it further

Resolved, that the American Fund for Dental Health be encouraged to continue to investigate possible programs for loan mechanisms utilizing the expertise of the American Dental Association in such development, and be it further

Resolved, that the American Fund for Dental Health be encouraged to investigate the student loan program for the implementation on the local level, and be it further

Resolved, that the representatives of the American Fund for Dental Health and American Dental Association be requested to submit a joint report to the August session of the Board of Trustees with the results of its investigation as to the feasibility and any possible recommendations for implementation.

SPECIAL ORDERS OF BUSINESS

Appearance of Dr. James P. Kerrigan, Chairman, Special Committee to Study the ADA Annual Session, and Dr. Lyle A. Brecht, Chairman, Council on Scientific Session: Dr. James P. Kerrigan, chairman of the Special Committee to Study the ADA Annual Session, and Dr. Lyle A. Brecht, chairman of the Council on Scientific Session, appeared before the Board of Trustees as a special order of business. Drs. Kerrigan and Brecht each addressed the Board of Trustees. After a question and answer session, President Shira stated that the recommendations presented by the Special Committee to Study the ADA Annual Session and the Council on Scientific Session would be considered by the Board of Trustees.

Appearance of Dr. Thomas E. Marr and Dr. Jack Weinrich for Presentation on Behalf of The John Harris Dental Museum Foundation: Dr. Thomas E. Marr, director, and Dr. Jack Weinrich, president, of The John Harris Dental Museum Foundation, appeared before the Board of Trustees as a special order of business. Dr. Weinrich

addressed the Board of Trustees and presented the American Dental Association with a sesquicentennial plate in recognition of support.

After the presentation the Board of Trustees adopted the following resolution for transmission to The John Harris Dental Museum Foundation:

> 3-1976-B. Resolved, that the Board of Trustees of the American Dental Association expresses its appreciation for the presentation of a commemorative plate honoring the sesquicentennial founding of The John Harris Dental Museum Foundation as presented to the Association on March 11, 1976 by Dr. Jack Weinrich, president, and Dr. Thomas E. Marr, director of the museum.

Recess: The Board of Trustees recessed at 12:00 a.m. and reconvened at 1:00 p.m. in Executive Session.

EXECUTIVE SESSION

Call to Order: An Executive Meeting of the Board of Trustees was convened at 1:00 p.m. with President Robert B. Shira presiding.

Roll Call: Those present were the President, President-Elect, First and Second Vice-Presidents, Executive Director, Treasurer, Editor, Speaker of the House of Delegates, all members of the Board of Trustees, and the official reporter.

Report of Special Committee to Study ADA Annual Session: The Board of Trustees considered the Report of the Special Committee to Study the ADA Annual Session in which the following recommendations were submitted:

Manual on Annual Sessions

> Recommendation 1: The ladies activities should be subsidized up to $2,500 to hold down the price of the tickets and encourage greater attendance at their functions.
>
> Recommendation 2: The honorarium for clergymen should be increased to $75.00.

Manual on Scientific Session

> Recommendation 3: The Council on Scientific Session should be authorized to provide expense reimbursement as necessary for nondentist speakers and for instructors in the Extended Lecture Program of the scientific session.
>
> Recommendation 4: The Council on Scientific Session should be authorized to charge tuition for Extended Lecture Programs.

House of Delegates Procedures and Manual of House of Delegates

> Recommendation 5: Presentation of the following awards should be made at the Opening Ceremony to conserve the time of the House of Delegates: Brookdale Award, Distinguished Service Award, Science Writers Awards, Science Fair Awards, Preven-

tive Dentistry Awards, and all other such awards. Honorary Memberships and Student Clinician Awards should be presented in the House of Delegates.

Recommendation 6: The President of the American Dental Association should give a brief welcoming address at the Board of Trustees Luncheon following the Opening Ceremony.

Recommendation 7: Nominations for officers should be scheduled for the first meeting of the House of Delegates on Sunday. Further nominations would still be in order on Wednesday. (Amendment to *Manual of House of Delegates*)

Recommendation 8: If officer nominations take place on Sunday, candidates need not receive lengthy introductions at the caucuses but should simply be presented, thereby saving considerable caucus time.

Recommendation 9: The "Report of the Committee on Rules and Order" of the House of Delegates should be published in the *Supplement to Annual Reports and Resolutions* and the reading of the "Report" in the House should be discontinued, except for the resolutions and changes in the *Rules of the House of Delegates.*

Recommendation 10: Reference Committee reports should be streamlined to include only that information essential to understanding by the delegates. If the reference committee supports the resolution it is considering, the resolution should be presented in its report with its recommendation for House action, but without further comment. If the committee submits a revised or new resolution, its reasons should be stated as briefly as possible in the report.

Recommendation 11: Chairman of caucuses should be encouraged to help curb excessive debate by members of their delegations on the floor of the House of Delegates.

Recommendation 12: An attempt should be made to limit the number of speakers and the length of speeches on matters not directly related to the immediate business of the House of Delegates.

Recommendation 13: An investigation should be made of the use of two voting cards of different colors, one for "yes" and one for "no." Each card should have printed on it the word "yes" or "no." In this way, it would be possible on doubtful votes for all persons voting—whether voting yes or no—to raise their cards simultaneously. The Speaker and the Secretary of the House would then be able to make a more accurate judgment and reduce the need for division of the House.

Scientific Session

Recommendation 14: The General Chairman for the current annual session and the General Chairman-designee for the following year's session should be consultants to the Council on Scientific Session. Each individual would then serve two years as a consultant.

Recommendation 15: The theme for the annual session, which is to be suggested each year by the Council on Scientific Session for approval of the Board of Trustees, should be carried through in the preliminary and official programs, the exhibitor's prospectus and other promotional materials.

Survey of the Annual Session

Recommendation 16: Further study of the valuable data contained in the survey should

be made by the Advance Planning Committee, the Council on Scientific Session and all agencies concerned with the conduct of the annual session.

Recommendation 17: Based on the survey results, the annual session should continue to combine the business sessions of the Board of Trustees and House of Delegates and the scientific session.

Recommendation 18: Future surveys of dentists' opinions should contain some questions on the annual session; however, the annual session survey itself should be continued, each year if possible, with modifications as needed.

Recommendation 19: Future surveys of the annual session should include a question on whether the dentist comes from a state that has a compulsory continuing education requirement.

Council on Annual Session

Recommendation 20: The Council on Scientific Session should be deleted from the *Bylaws* and replaced by a Council on Annual Session consisting of seven members (two of whom shall be the General Chairman and the General Chairman-Elect of the Local Arrangements Committee) whose duties and responsibilities include all aspects of the annual session of the American Dental Association presently assumed by the Council on Scientific Session, the Bureau of Convention Services, and the Department of Sales and Advertising. The new Council will coordinate and utilize the expertise of other bureaus and agencies concerned with the conduct of the annual session.

(Note: The Committee believes that the Bureau of Convention Services and the Department of Sales and Advertising should remain intact, but that their duties pertaining to the annual session should come under the jurisdiction of the Council on Annual Session.)

Recommendation 21: Five members of the Council on Annual Session shall be elected for a term of three years. The General Chairman of the Committee on Local Arrangements for the current year and the General Chairman-Elect for the succeeding year shall serve as *ex officio* members of the Council with the right to vote.

Recommendation 22: The General Chairman of the Local Arrangements Committee for the current and succeeding year, who are members of the Council on Annual Session, shall not be eligible to serve as Chairman of that Council.

Recommendation 23: All members nominated for the Council on Annual Session should have proven expertise in planning and conducting dental meetings.

Recommendation 24: There shall be a secretary who shall coordinate the activities of the Council on Annual Session and of all other staff members involved in the conduct of the annual session. The Special Committee strongly believes that there is sufficient expertise among the present staff members who have been involved with the annual session and that the selection of staff for the Council on Annual Session should be made from among these individuals.

Miscellaneous

Recommendation 25: The officers and trustees of the American Dental Association should promote the annual session in their talks before the membership.

Recommendation 26: An interdenominational service should be held, where feasible, at the annual session.

Recommendation 27: The President should continue to appoint experienced personnel to reference committees.

After discussion on the report of the Special Committee, the Board of Trustees referred the report and the following resolutions, which were presented by the Special Committee, to Reference Committee A of the Board of Trustees for study and report to the August 1976 session of the Board.

Resolved, that the revised *Manual on Annual Sessions* be approved.

Resolved, that the revised *Manual on Scientific Session* be approved.

Council on Scientific Session Comment on Recommendations of Special Committee to Study ADA Annual Session: The Board of Trustees considered the following report submitted by the Council on Scientific Session regarding the recommendations of the Special Committee to Study the ADA Annual Session:

At its January meeting the Council on Scientific Session considered the recommendations on the scientific session made by the Special Committee to Study the ADA Annual Session during its final meeting earlier in the month. The following comments are offered by the Council:

I. Revision of *Manual on Scientific Session*

1. *Honoraria*—Page 7

Proposed revision: Add paragraph, "Expense reimbursement may be established as necessary by the Council on Scientific Session for nondentists and extended course concept instructors."

Comment: In obtaining outstanding speakers, or instructors, to present extended course concept programs for the past two years and for the current year's scientific session, it has not been found necessary to offer expense reimbursement. The Council feels strongly that this would create a precedent and destroy the long-standing policy of not paying honoraria or expenses to members of the profession participating in the annual session scientific program as currently stated in the *Manual*.

2. *Section Officers*—Page 10

Proposed revision: Paragraph 4, line 7, add, "and the General Chairman of the Committee on Local Arrangements for the following year" after the word "vice-chairman."

Comment: It is the Council's opinion that this should not be compulsory on the part of the General Chairman. The Council would welcome the presence of the General Chairman at the individual conferences with the vice-chairman if he has a sincere interest in the development of the scientific session. The General Chairman and the Chairman of Clinics and Motion Pictures for the following year are invited to observe the activities of the Council during the annual session as their time permits.

3. *Following Limited Attendance Seminars*—Page 14

Proposed revision: Add, "EXTENDED LECTURE PROGRAM: Extended lecture program will consist of half-day and two-day programs. These programs are designed by the Council on Scientific Session to provide for maximum continuing education in specific areas of dentistry or other related topics. The Council on Scientific Session shall establish appropriate tuition for these courses."

Comment: Extended lecture programs are scheduled each year when outstanding speakers are available at the time of the annual session and a meeting room of sufficient size is a part of the convention hall facilities. The Council considers this program a special feature or "highlight" of the scientific session to be included as often as possible but not listed in the *Manual* as a regularly scheduled event. It has also been stated previously that the Council opposes all payment of honoraria and/or expenses for member dentists participating in the scientific session.

4. *Following Table Clinic Program*—Page 17

Proposed revision: Add, "LUNCH AND LEARN" definition and participation in the program.

Comment: Lunch and learn sessions are included each year as a part of the scientific session where convention hall facilities, including catering service, are available. The costs of the luncheon charged to each participant varies from city to city. It is the Council's opinion that this program should not be listed in the manual as an annual event in the scientific session. In the paragraph under *Council on Scientific Session*, Page 6, it is stated: "In its presentation of the program, the Council is guided by convention hall facilities and budgetary appropriations determined by the Board of Trustees and the House of Delegates."

II. Final Comment

The Council on Scientific Session believes that the Committee's basic recommendation for a new Council on Annual Session is both unworkable and unnecessary. The Council believes, for example, that the General Chairman-Elect and the General Chairman can become consultants to the Council on Scientific Session without adding *Bylaws* and administrative complications of making them Council members for two years, changing the Council name and giving it responsibilities for the work of other departments such as the Bureau of Convention Services, Sales and Advertising, et cetera. The Council firmly opposes the concept of a Council on Annual Session.

During Dr. Brecht's appearance as a special order of business, he stated that there would be no problem with the Council on Scientific Session accepting the recommended changes to the *Manual on Scientific Session*.

After discussion on the report of the Council on Scientific Session, the Board of Trustees adopted the following resolutions:

4-1976-B. Resolved, that the Council on Scientific Session should schedule the usual scientific session on Wednesday afternoon during the 1976 annual session in Las Vegas.

5-1976-B. Resolved, that the Board of Trustees accepts the Council on Scien-

tific Session's decision to close the technical exhibits on Wednesday afternoon during the 1976 annual session in Las Vegas.

6-1976-B. Resolved, that the Board of Trustees expresses its concern to the Council on Scientific Session over its decision regarding shortening the scientific program at the 1976 annual session without consulting the Board of Trustees.

Assignment to Committee on Rules and Order: A motion was accepted by the Board of Trustees requesting the Committee on Rules and Order to consider a mechanism whereby the members of the Board can be assured of receiving Board reports at least a week in advance of the session. The committee was requested to report to the August session of the Board of Trustees.

Adjournment: The Executive Meeting adjourned at 2:30 p.m.

UNFINISHED BUSINESS

Call to Order: The meeting of the Board of Trustees was called to order at 2:30 p.m. by President Shira.

Roll Call: The officers, members of the Board of Trustees, and members of staff were present as previously recorded.

Final Report of Manpower Project Advisory Committee: The Board of Trustees reviewed the final report of the Manpower Project Advisory Committee which follows:

The final meeting of the Manpower Project Advisory Committee was held on February 2-3, 1976.

The purpose of the meeting was the final oral report on the dental planning information system presented by Leonard Davis Institute (LDI) staff. The contract with the LDI ends on January 31, 1976, but an extension until February 29, 1976 with no additional funds was given to LDI.

The final written reports of the project are to be provided to the ADA by the end of February. These final written documents include the following:

1. The questionnaire as edited at the February 2-3, 1976 Advisory Committee meeting.
2. The computer software delivered, set up on a local university computer (IBM) and demonstrated by an LDI staff member to appropriate American Dental Association staff before the end of February. This includes data tapes on the Health Information Survey information and utilization rates, population tapes, and production model and the demand model.
3. The data in card and/or tape form from Massachusetts, North Carolina, Louisiana, Indiana, and Pennsylvania.
4. A comprehensive, written computer program operations manual.
5. A comprehensive, written technical description of the modeling for both the production and demand functions.
6. A list of the states requesting participation in the program.

7. A written operations manual for states wishing to participate in the project outlining all activities to ensure a successful project.

8. The complete results from the pretests in Massachusetts, North Carolina, Louisiana, Indiana, and Pennsylvania including marginals run on the questionnaires, the productivity and demand functions produced from the analysis, and a report and analysis on response rates. This report will include both tabular and descriptive results.

9. Six copies of the final draft of the questionnaire should be provided to the manpower committee members so that this final version can be pretested on a small group of dentists.

The current allocation of funds for 1976 which is a combination of monies in the Bureau's budget and a grant from the ADAHF is approximately $130,000. Without further financial assistance, it is anticipated that the project will continue and that funds will be distributed during 1976.

Recommendations: The Manpower Project Advisory Committee makes the following recommendations to the Board of Trustees:

1. Efforts to seek outside funding for various portions of the project should be continued. A proposal has been forwarded to the Division of Dentistry, US Department of HEW.

2. No immediate contract should be established with the Leonard Davis Institute or other outside firms until the capabilities of the ADA staff are determined and until the potential of outside funding is established. The time frame for this self-analysis is August 1976.

3. It is recommended that the spring months of 1976 be spent by the Bureau of Economic Research and Statistics learning how to operate the system, training staff, and making decisions regarding the future plans.

4. Since the operating success of this project is completely dependent upon sophisticated computer facilities, the ADA's present facilities are inadequate and since it is inefficient to have staff out of the office at other computer facilities, the Committee recommends the upgrading of ADA facilities or the placement of remote terminal in the Bureau of Economic Research and Statistics for this as well as other analysis activities of the Bureau.

5. A presentation illustrating the functional aspects of the system should be given by Dr. Helen Gift to both the 26th National Dental Health Conference on April 5-6 and the 27th Annual Management Conference on June 7-9, 1976.

Announcement of the completion of the first phase of the project should be made in the *ADA News* and *Leadership Bulletin*. This announcement should include a discussion of future activities. A general outline of the steps involved in the project are:

a. The ADA provides the state a uniform questionnaire directed toward assessing productivity.

b. The ADA assists the states in selecting a sample.

c. The states distribute the questionnaires, receive them, do follow-up on nonrespondents to ensure a high response rate (70% to 80%) using guidelines provided in a handbook from the ADA. The cost to the states is dependent on the mailing and follow-up costs. Range of costs are $250 to $2,000, if efficiently performed.

d. The states provide the ADA the completed questionnaires.

e. The ADA processes the questionnaires.

f. ADA staff work with state staff and a selected committee to work out the appropriate use of the data and the decisions that can be made from it.

6. By July 1976, six to ten states indicating an interest in the manpower study will be selected to participate. The selection will depend on:

a. The dentist population characteristics in the state.

b. The regional location of the state for its impact with national statistics.

c. Assurance that those states can be fully and accurately surveyed.

d. Current budget allocations.

An effort will be made to determine if, by using appropriate state selection, the Association can avoid complete surveys in each state by establishing baseline statistics in certain states and projecting to the others.

7. Use of outside individual consultants should be considered as an alternative until supplemental funding is found. Because of their present knowledge, the consultants used by the Division of Dentistry to review the project should be given particular consideration.

8. The Committee foresees no immediate need for a continuing manpower advisory committee during the next operational months. The staff for the project should report through the Bureau Director to Board Reference Committee B with informational reports to the Council on Dental Education and the Council on Dental Health as requested by those agencies. At a later point, a more formalized advisory committee may prove useful and, if so, can be created.

Mr. Eric M. Bishop, assistant executive director for dental health, and Dr. Helen C. Gift, director of the Bureau of Economic Research and Statistics, commented on several of the recommendations. The Board of Trustees accepted the informational report.

Fee Information Distribution: The Board of Trustees considered the following report on fee information distribution:

For the past several years, the Bureau of Economic Research and Statistics has been operating under the following resolution with respect to the distribution of fees and overhead costs:

> **Resolved,** that reports of surveys on fees and office overhead costs be published as monograph reports, rather than published in *The Journal* and that distribution of these reports be limited to members through constituent societies and to others when in the best interest of the Association.

The operational interpretation of this resolution has been as follows:

Implementation of Policy

The *1971 Survey of Dental Practice* is out of print and is not being recopied since the information is outdated. Persons requesting this publication are so informed. Members requesting this information are referred to their constituent society with the suggestions that they be provided the 1973 information.

The *1973 Survey of Dental Practice*, which includes fee and overhead cost data among other information, will continue to be distributed to members through constituent societies. This process involves notifying the dentist that his request is being forwarded to the constituent society, and notifying the constituent society of his request for the information. Requests for fee or overhead cost information by the public will be referred without comment to the component society in that person's area. Requests for fee information related to the state level will always be referred to the appropriate constituent society.

Publication and Distribution of 1975 Survey Statistics

Survey of Dental Practice: Because of the restrictions of the policy, the format for the publication of the monograph will be reconsidered. The information, other than overhead costs and

fee information, will be compiled into a publication (either monograph or journal article) as a descriptive document on dental practice. Deleting the overhead and fee information will assure that data on practice characteristics will be available to interested persons without transgressing the policy.

Dentists' Overhead Expenses and Fee Survey Tables: These data will be reported in tabular form as well as used for extensive analysis for the project on determining the costs of running a dental practice. The amount of information compiled for presentation will determine whether the publication will be a monograph or a paper. In either case, the publication can be copyrighted and the following statement added: "All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, recording or otherwise, without the prior written permission of the publisher (BERS, ADA)."

Since one of the major objections to the publication of these data is the public abuse of the information, the use of "rights reserved" will provide those interested in these data to study the information, but will not allow them to publish or otherwise distribute without the consent of the Association. If reproduction of these data does occur without Association consent, legal action will be a potential answer.

Members will be able to receive this information through their constituent societies. Members who are referred to the appropriate constituent society, who later return to us with the complaint that they were unable to obtain the information, or any dentist who has complaints regarding the distribution policy, will be referred to the President of the appropriate constituent society and the Trustee will be notified.

Prior to the availability of this information (March 1976), the Director of the Bureau of Economic Research and Statistics will outline the distribution policy for the elected officials and appropriate staff of each constituent and component society. Under this policy, members of the Association who are in Federal Service can receive the information directly from the Bureau of Economic Research and Statistics.

The staff of the Bureau of Economic Research and Statistics will remain available to constituent and component societies, as well as related dental organizations, to assist them in their own research activities. The Bureau is prepared to assist such organizations in implementation of surveys or analysis and reporting of data.

Requests for this information by the public will be referred to the appropriate constituent or component society.

"In the Best Interest of The Association" Category: A significant number of requests for fee information come from management, unions, and prepayment companies who are attempting to plan or adjust a dental benefit plan. In staff's opinion, many of these requests could be honored under the clause of the resolution, "to others in the best interest of the Association." In consideration of the various alternatives of judging how to respond to these requests, the following procedure is recommended as having logical merit.

Requests for this information by industries and persons interested in dental manpower (i.e., dental prepayment plans, consultants to dentists setting up a practice, etc.) will be initially considered by staff. If the request for information is relevant to only one state or a region, the request will be forwarded to the appropriate state(s) for its disposition. However, if the request for information is national in scope, and is preliminarily deemed by the Assistant Executive Director: Dental Health and the Director of the Bureau of Economic Research and Statistics to be "in the best interest of the Association," the request will be routed to the Council on Dental Care Programs or a committee of such body, and, barring a majority objection within 15 days, the information will be provided to the person(s). The necessary precaution will be given at the time the request is honored.

This will allow the Association staff to use dentists holding elective, national offices to assess these requests for information that does fit within the category of "in the best interest of the Association." By making Association staff available to consult with persons making these requests, the Association may have more effectiveness in working with these organizations whose decisions are affecting the dental profession.

The Council on Dental Care Programs considered a request at its last meeting, in a trial fashion, and believes that consideration of such requests can be construed to fall within its

purview. Preliminarily, the Council approved the request. However, the Council does not wish to pursue the activity permanently without agreement from the Board of Trustees as to the appropriateness of this procedure.

In addition to a decision on this process, staff also requests an interpretation of the resolution from the Board of Trustees with respect to the staff's posture on discussing fee data with persons who have obtained the information through some other source and who would have been denied the information if they had requested it from the Association.

After discussion on the report, the following resolution was adopted by the Board of Trustees:

7-1976-B. Resolved, that the Board of Trustees considers that in the best interest of the Association the Association's 1975 fee survey data not be published or distributed until such time as such fee survey data no longer present a substantial, potential legal risk or until the 1976 House of Delegates, fully aware of the potential legal risk, formulates clear and concise direction as to its distribution.

The Board of Trustees also adopted a motion directing that a letter be sent, over the President's signature, to the constituent societies advising them of the action of the Board of Trustees.

Request for Hypertension Guidelines from American Heart Association: The Board considered the following request for hypertension guidelines from the American Heart Association:

Background: The House of Delegates in 1975 rejected and turned back to the Council on Dental Health the guidelines on hypertension detection in the dental office that the Council had been directed to develop by the previous House of Delegates (*Trans.* 1974:644). The Seventh Trustee District resolution directing the Council to redraft the guidelines was very clear in describing their problem areas and also called for the development of new guidelines consisting of "only a few, brief, broad generalities or considerations."

In reconsidering the guidelines at its December meeting, the Council agreed that they had become too explicit and technical as information had been added by the American Heart Association in the process of gaining AHA's endorsement.

However, as the Council is restricted from sending out the guidelines, requests continue from dentists seeking such technical details as were contributed by the AHA and which cannot be included in the Council's revised or new guidelines. The AHA and its local chapters and the National High Blood Pressure Education Program are also getting inquiries from dentists for this explicit information.

Requested Action: In order to make necessary technical information available to dentists, the AHA has requested the permission to take over the rejected Council guidelines and to disseminate them under the AHA's aegis. The AHA has requested a prompt response in order to fill the information gap for dentists.

In considering this request, the Council recognizes that obviously certain directives to dentists contained in the guidelines would not be appropriate for dissemination by an organization other than ADA, but also recognizes that some of those very technical aspects that made the initial guidelines objectionable would be appropriate from the AHA as an organization more intimately involved with high blood pressure control. Also, information for dentists coming from a nondental agency would not have the objectionable implications for establishing norms or standards of care which were chief among the concerns underlying the rejection of the initial guidelines.

The Council therefore proposes that selected parts of its guidelines be submitted to the AHA with an appropriate statement indicating the cooperation of the ADA, and requests the approval of the Board of Trustees for this action. The Council would then completely revise

the guidelines along the lines suggested by the Seventh Trustee District resolution, but the necessary technical information would be available under the aegis of AHA.

After discussion, the following resolution presented to the Board of Trustees was postponed indefinitely:

> Resolved, that stipulated sections of the Council on Dental Health's *Guidelines for Hypertension Detection in the Dental Office* be transmitted to the American Heart Association for its dissemination, with an appropriate indication of cooperation from the American Dental Association.

Revision of 1971 "Guidelines for Dentistry's Position in a National Health Program": The Board noted that the Councils on Dental Care Programs, Dental Education, Dental Health, Hospital Dental Service and Legislation have undertaken a review of the 1971 *Guidelines for Dentistry's Position in a National Health Program* and that the Council on Dental Care Programs will serve as the coordinating agency. The Council reported that a formal report of review and recommended revisions from all concerned agencies will not be available until late spring, at which time it will be submitted to the Board of Trustees.

The Board of Trustees adopted a motion presented by Dr. Kerr which requested the President of the Association to write to the President of the American Society of Oral Surgeons, thanking him for his position of willingness to work within the structure of dentistry and with the American Dental Association on many issues.

Council on Dental Health Comments on Nebraska Statement on Fluoridation: The Board of Trustees considered the following informational report from the Council on Dental Health:

> In developing a response to the 1974 resolution submitted by the Nebraska Dental Association calling for a "qualified person" to "be available to constituent societies to train personnel in the conduct of successful fluoridation campaigns" (*Trans.* 1974:650), the Council on Dental Health reviewed the status of fluoridation and found it essentially as pessimistic as expressed in the statement sent to President Shira in November 1975, by Dr. Philip J. Maschka, Nebraska. Since that time, fluoridation has lost further ground because of movements and events not noted in Dr. Maschka's letter. Sympathetic to Dr. Maschka's concerns, the Council is further worried about fluoridation's future for the following reasons:
>
> > State Laws: As so sadly exemplified by Nebraska's experience, the enactment of state laws, once thought to be the answer to extending fluoridation more rapidly, has in at least two states put fluoridation into an even more highly political posture than before. In Nebraska and Ohio, the "mandatory" fluoridation laws included an option for communities to hold referendums to vote on whether or not to comply. In both states, the referendums were a long series of losses for fluoridation. In Nebraska, out of an estimated 300 referendums, fluoridation won only 30. In view of this, Dr. Maschka's frustration is understandable, but it must be recognized that it would not have been possible to organize effective political campaigns when more than one hundred referendums were scheduled for one voting day.
> >
> > PHS: The Public Health Service fluoridation program has finally, after many delays, been transferred from the Division of Dentistry in Bethesda to the Center for Disease Control in Atlanta. The early rationale and reports of the move included a one million dollar budget and 12 positions to concentrate on fluoridation in the broader setting of preventive dentistry. The present facts, however, are that two persons have been transferred and the promised funding and other positions have not yet been approved. Thus, the new CDC "preventive dentistry unit" will consist for an unknown period of

time of Dr. William B. Bock, chief, and Mrs. Cora Leukhart, who is well known as a fluoridation resource person. It cannot be estimated how long it will take for this new unit to become a viable force in fluoridation. Moreover, depending upon how the mission of the unit is outlined, the new possibility has arisen that fluoridation might be only a secondary interest. The unit will also be operating under several disadvantages, including that of being the only dental unit in CDC and also from being removed from the NIH environment with all its resources and quick contacts.

National Health Federation: This most prominent of the antifluoridation groups has become more active and politically successful with the employment of a travelling "science director" John Yiamouyiannis, Ph.D. Dr. Yiamouyiannis takes the credit for the loss of fluoridation in Los Angeles and is currently concentrating on stimulating a statewide fluoridation referendum in Washington. NHF is now billing itself as "America's largest noncommercial health consumer organiaztion."

New Cancer Controversy: Amidst national publicity, longterm fluoridation has been linked with increased incidence of cancer through Dr. Yiamouyiannis' imaginative and repeated misuse of vital statistics and epidemiological data. His public claims are supposedly confirmed by a new recruit to the NHF antifluoridation cause, Dean Burk, Ph.D., retired chemist of the National Cancer Institute who was reportedly active in the promotion of the Laetrile "cancer cure". The cancer claims by these NHF spokesmen have stimulated the request by Congressman James J. Delaney for a full-scale Congressional hearing on fluoridation with the intent of stopping it as a carcinogen under the Delaney amendment under which cyclamate was removed from the market. The NHF cancer claims were to have been answered by a report of the Cancer Institute which has not been officially released and is not considered to be a totally satisfactory response.

Research Needs: In the face of the foregoing opposition, there is a paucity of ongoing research on the technical aspects of fluoridation and no younger generation of research scientists with knowledge on fluoridation. This absence of young "experts" on the technical scientific aspects is increasingly felt as litigation or legislative efforts require this type of testimony. There is now some hope that NIDR, under its new leadership, will become involved in community water fluoridation.

As a result of all the foregoing, there has been little forward movement in fluoridation in the last five years as the opponents become more litigious and as the proponents have come down to the difficult hold-out-areas. Many dentists and dental societies feel the job is done as well as it could be in their states or are discouraged by the continued pressing needs of promoting the measure or have been embittered by political losses. The result is little action. Thus, the status of fluoridation nationally is more serious than can be resolved by the Nebraska resolution. This resolution, moreover, calls for political assistance that cannot be provided by an outsider on short-term consultation. What is needed is a new national initiative on fluoridation—both to advance the measure and to protect its advances. This should come from the American Dental Association, the American Medical Association, and the newly forming fluoridation unit at CDC. Some components of such a program could be:

—press releases, spot focused on areas where fluoridation is a political subject as well as general in areas where fluoridation has been successfully in operation for a long time.

—wide distribution of the public service advertisements funded by $12,500 approved by the Board of Trustees, in both fluoridated areas and communities considering fluoridation.

—redissemination of existing community action materials (as noted in the 1975 resolution prompted by the Council on Dental Health). In particular, the Association's fluoridation campaign manual, if followed, would have prevented some recent fluoridation defeats.

—using all means by ADA and AMA of assuring an effective fluoridation effort at CDC.

—reawakening state dental societies to the importance of promoting and protecting fluoridation.

—provision of a review of fluoridation law cases, in process by the legal staff.

—encouragement of research to underline fluoridation's merits and confirm its safety.

—stimulation of research and information on the cost/effectiveness of fluoridation, particularly in terms of publicly funded care programs for children.

—advice to states to hold off on fluoridation bills unless they can be assured of passage without option for referendums.

—promotion of articles on fluoridation in consumer magazines.

—enlistment of new national organizations, possibly consumer-oriented, to work for fluoridation.

Some of these projects are already under way by the Council on Dental Health, but others will require the actions of other Association agencies and the continuing support and interest of the Board of Trustees.

Recess: The Board of Trustees recessed at 5:20 p.m.

FRIDAY, MARCH 12, 1976

Call to Order: The meeting of the Board of Trustees was called to order at 9:10 a.m. by President Shira.

Roll Call: The officers, members of the Board of Trustees and members of staff were present as previously recorded.

UNFINISHED BUSINESS

Report on Maine "Denturism" Bill: The Board of Trustees reviewed the following informational report with respect to the Maine "denturism" bill:

The following report to the ADA Board of Trustees from the Maine Dental Association was transmitted by Dr. Earle W. Pulsifer, MDA president-elect, on February 19, 1976:

The hearing on the "denturism" bill in Maine was scheduled for 1:30 p.m., February 26, before the Health and Institutional Services Committee. As of this writing the outcome of the hearing is not yet known. There have been several attempts at having the bill withdrawn, but it still exists.

The proposed act would establish a seven-member denturist licensing board composed of four denturists, two dentists and a consumer which would regulate full *and* partial denture services to the public. Denturist advertising, except for price advertising, would be legal. Those engaged in denturist-type activity for one year prior to the act would be granted temporary licenses for one additional year during which time they must successfully pass a denturist licensure examination.

The denturists and their sympathizers have organized and have purchased the services of two lobbyists, one of them among the very best in the state. The denturists also have $15,000 remaining in their treasury. The Maine Dental Association has its own lobbyist on retainer; now with the assistance of a drawing account of $8,500 voted by the ADA Board of Trustees, the MDA has been able to obtain the services of a second lobbyist of very high caliber.

The MDA intends to pack the hearing, notices of all sorts having been sent to every dentist in the state society. These same dentists have been instructed to bring their individual legislators, if possible, in accordance with listings of senators and representatives sent them along with a Legislative Manual prepared by our legislative chairman and our original lobbyist.

Representatives from the National Association of Dental Laboratories (NADL) are expected to present a statement opposing the bill at the hearing. Signed statements from most of our ethical laboratories here in Maine will be introduced by the laboratory association at the hearing, saying that they do not endorse the bill.

Should the bill go before the House, Mr. William Garsoe, representative from Comberland and a Dental Health Council member, will lead the floor fight against it. Mr. Garsoe is of interest for two reasons:

1. He was one of the original sponsors of the Office of Dental Health bill which the MDA fought last year and which created the Dental Health Council.

2. The day after our last Council meeting, February 11, he tried to kill the bill on the floor.

Our principal effort will be in the Senate which has but 34 members including the Senate President and which is neither as excitable nor young and liberal as the House. Our new lobbyist Mr. Charles Cragin, III of Verrill, Dana, Philbrick, Putnam, & Williamson feels that we at this point can count on 22 sure votes there. Our feeling generally tends in the same direction. We believe it will die here.

Efforts have been made to have each dentist personally talk with his legislator over these past weekends, and it seems to be paying off in the House as well. The current nose count for favorable votes looks better than we had hoped.

Financially, the Maine Dental Association is running on a deficit budget, according to our treasurer. Last year's legislative lobbying plus the creation, equipping and staffing of our new Central Office left us in a borderline posture. Then this sudden denturism bill with our own lobbyist plus the massive phone, printing and mailing expenses has put us into the red.

Since this denturism matter has national implications, we will see that the ADA is kept fully informed of our activities. If any Board member has questions or needs additional information, please ask him not to hesitate in calling Dr. Henry Pollard, MDA president, at 207/772-2652, or me at 207/563-5222.

Report on Budget of "Fédération Dentaire Internationale" and Proposed Relocation of the Office of the US Treasurer: The Board of Trustees reviewed the 1975-1976 budget of the *Fédération Dentaire Internationale* and the system used to determine the dues assessment for each country which holds membership in the FDI.

The Board also considered the following report recommending relocation of the Office of the US Treasurer:

The Board of Trustees at its meeting following the 1975 annual session selected Dr. L. M. Kennedy as the new US Treasurer to the *Fédération Dentaire Internationale* replacing Dr. Maynard K. Hine who was elected as President of the FDI.

For several years the operating office of the US Treasurer has been in Watertown, Wisconsin. Miss Eugenia Uttech has served as the secretary for this activity and is desirous of being relieved of this responsibility. During the Chicago Dental Society's Midwinter Meeting in February, Dr. Hine and Dr. Kennedy, along with Miss Uttech, Miss Driscoll, and the Executive Director, met to explore the possibilities of transferring the activities of the Office of the US Treasurer to the Headquarters Building of the ADA.

After review of this matter it was apparent that the transfer could be made and that such a transfer would have several advantages, the principal one being a closer identification with the American Dental Association which could encourage more dentists to become supporting members of the FDI. The staff of the Council on International Relations could be used to handle the business of the Office of the US Treasurer under the direction of Dr. Kennedy.

The annual income of the U.S.A. Section is $12,000 based on 2,400 supporting members with a retention of $5 dues per member. The annual budget is approximately $11,000 with a savings account of $19,000.

It is recommended that the operating Office of the US Treasurer be relocated to the Headquarters Building of the ADA within the office space of the Council on International Relations. If this relocation is approved, a salary amount of $5,000 for a part-time secretary and $1,500 for clerical help will be budgeted from resources of the U.S.A. Section as well as all other additional expenses such as postage, etc.

After discussion, the Board of Trustees adopted the following resolution:

8-1976-B. Resolved, that the proposed relocation of the Office of the US Treasurer of the *Fédération Dentaire Internationale* from Watertown, Wisconsin, to the Headquarters Building of the American Dental Association be approved, and be it further

Resolved, that the U.S.A. Section of the FDI be responsible to this Association for all costs incurred by the concerned activity.

Resolution of Appreciation to Miss Eugenia Uttech: The following resolution was adopted by the Board of Trustees:

9-1976-B. Resolved, that the Board of Trustees of the American Dental Association recognize and express its highest appreciation for the productive and laudatory contribution to international dentistry of Miss Eugenia Uttech during two decades of dedicated service as Secretary of the U.S.A. Section of the *Fédération Dentaire Internationale*.

Report of Committee D on House of Delegates Resolution 112: The Board of Trustees considered the following report from Committee D with respect to Resolution 112 which was adopted by the 1975 House of Delegates (*Trans.* 1975:736):

Background: Resolution 112 reflects a recommendation presented by Dr. L. M. Kennedy in his President's report to the House of Delegates. Dr. Kennedy proposed that the Association consider sponsoring a bill before Congress to authorize a national dental care program for indigent persons. The resolution in effect asks the Board of Trustees to study Dr. Kennedy's recommendation, determine if it is feasible, and if feasible present an outline of a legislative draft to the 1976 House of Delegates.

Comments of Council on Legislation: Although the Council on Legislation was not identified in House Resolution 112, the Chairman of Committee D agreed that the Council's comments on the pros and cons of a specific legislative proposal could help the Committee. The Council stressed some significant disadvantages which the Committee will refer to later in this report. At this point the Committee sets out an outline of advantages and disadvantages of ADA sponsorship of a national dental care bill prepared by the Secretary of the Council on Legislation.

I. Advantages and disadvantages of an ADA sponsored national health insurance bill

A. Advantages

1. Emphasizes positive action
2. Clarifies ADA's position on major aspects of national health insurance

—for ADA members
—for members of Congress
—for media representatives
—for other health, civic and consumer groups
—for the public-at-large

3. Facilitates inclusion of ADA recommendations as legislation proceeds through Congressional processes

B. Disadvantages

1. Dental care is only one segment of comprehensive health care
2. Dental care for children, ADA's priority, is less than comprehensive dental care
3. Technical difficulties

—Drafting less than a full care plan
—Selecting a financing method compatible with ADA policies
—Accommodating dental care specifications in a final comprehensive care plan

C. Relating advantages and disadvantages to the kind of ADA bill contemplated by Dr. Kennedy

1. For indigents only—*therefore*

a. No priority problems
b. No financing problems

2. Positive action but not certain to please major private and government agencies
3. Confusing some members while eliciting undue acclaim from others

II. Some reasons for supporting existing *Guidelines* approach to national health insurance

A. Guidelines are readily applicable to all legislative proposals for national health insurance
B. Guidelines make for a readily adaptable scheme to accommodate dental care within provisions for other major health services
C. Guidelines provide a more acceptable approach to the majority of ADA members —willingness to tolerate some kind of plan, but not wanting ADA to look like an advocate for national health insurance.

ADA Sponsorship of National Dental Care Bill: The Committee believes that the disadvantages of ADA sponsoring a national dental care bill for indigent persons outweigh the advantages, particularly at this time. The Ford Administration proposal to eliminate adult dental care benefits under Medicaid illustrates the trend toward reducing rather than expanding federal support for Medicaid. President Ford also recommends that block grants to states substitute for federal formula grants that are tied to federal standards and requirements. The likelihood of Congressional acceptance of either Administration proposal is slim at best. But any expectation that Congress and the Administration will approve a significant expansion of Medicaid is equally tenuous. The Committee appreciates and commends Dr. Kennedy's emphasis upon projecting a positive image before Congress and the public. The Committee believes, however, that at this time the Association will improve dentistry's position with all

elements of the public more effectively by helping constituent dental societies strengthen their state Medicaid dental programs.

Medicaid and Medicare Guidelines: At the federal level some changes in the Medicaid enabling law might be considered, for example a national minimum dental benefit package for all categories of Medicaid recipients. Additionally, some concern for a national minimum needs test is warranted, at least a study of its feasibility and desirability. In the Committee's consideration of dental needs of indigent persons, some thought was given to those over 65 who are not eligible for Medicaid but who must rely upon limited retirement benefits. Medicare offers these individuals little in the way of dental services. At least a review of the Medicare dental situation is indicated. Such a review certainly must include concern for the possible exploitation of low income elderly persons by the illegal practitioners of dentistry. Unquestionably the move to obtain legislative approval of illegal denture services is enhanced by any evidence that a significant portion of the elderly population is unable to afford denture care from dentists.

Recommendations: The Committee recommends that the Association defer action on sponsorship of national legislation to provide dental care for indigent persons. The interested Association agencies should, however, review the feasibility of such sponsorship at a later date. The Council on Legislation and the Washington Office have prepared bill drafts that indicate the approaches that are available to establish the dental care plan reflected in Dr. Kennedy's proposal. The Committee recommends that the Council on Legislation continue its study of appropriate statutory designs for improving both Medicaid and Medicare. Finally, the Committee recommends that the Councils on Dental Care Programs and Dental Health review the Association's *Guidelines* for Medicaid and its policies applicable to Medicare. Priority should attach to consideration of a national minimum dental benefit package for all categories of indigent persons. Perhaps of greatest priority is the need to help constituent dental societies strengthen their state Medicaid dental programs. In fact for some it is a matter of preserving meager dental benefits. The urgency for this endeavor may call for special communication efforts. The Committee recommends that the concerned Councils consider requesting publication of a special information bulletin on strengthening state Medicaid dental programs.

The Committee offers the following resolutions for the approval of the Board of Trustees at this time or for the Board's review and action at the August Board session.

After discussion, the Board of Trustees adopted the following resolutions:

10-1976-B. **Resolved,** that Immediate Past President L. M. Kennedy is commended for alerting the Association to the necessity for positive action on dental care for indigent persons, and be it further

Resolved, that Dr. Kennedy's recommendation for consideration of an ADA sponsored bill to establish a national dental care program for indigent persons be deferred in favor of a high priority ADA program to help constituent dental societies strengthen their state Medicaid plans.

11-1976-B. **Resolved,** that the Councils on Dental Care Programs and Dental Health review the ADA *Guidelines for Dental Programs Under Title XIX* (Medicaid) (*Trans.* 1968:56, 308) and give special attention to national minimum dental benefits for all categories of indigent persons and national minimum means tests.

12-1976-B. **Resolved,** that the Councils on Dental Care Programs and Dental Health review ADA policies on Medicare dental benefits with special attention to the dental needs of low income retired persons.

NEW BUSINESS

Report of President: President Shira briefly reported on his activities during his term of office. He noted in particular the meetings of the Board of Trustees' Special Committee on Inter-Agency Affairs with the American Dental Assistants Association, American Dental Hygienists' Association, American Association of Dental Examiners, and American Association of Dental Schools, and the meeting of the Board of Trustees' Committee on Advance Planning with the American Dental Trade Association.

Report of President-Elect: President-elect Shuler briefly reported on his activities since assuming office. He commented in particular on the Presidents-Elect Day, indicating that it had been a good meeting and that the presidents-elect in attendance found merit in having the meeting separate from the Management Conference and felt that the meeting should be longer.

Report of Executive Director: The Report of the Executive Director included comment on membership statistics, staff appointments, terminations and promotions, participation in meetings and general activities. The Executive Director advised the Board of Trustees that the position descriptions of the Executive Director and the Editor requested by the Committee on Advance Planning had been referred by the Committee on Advance Planning to the Committee on Salary and Tenure for review. The Executive Director also informed the Board of Trustees of the discontinuation of the Brookdale Award in Dentistry which had been funded by Mr. and Mrs. Arnold Schwartz.

The Board of Trustees was informed that Mrs. Grace Parkin, secretary of the Council of National Board of Dental Examiners, would retire on April 1, 1976 after completing 20 years of service with the American Dental Association. The Board adopted the following resolution:

> 13-1976-B. Resolved, that the Board of Trustees of the American Dental Association expresses its deepest appreciation to Mrs. Grace Parkin for her 20 years of dedicated service and for her significant contributions to the Association's Councils on Dental Education and National Board of Dental Examiners.

Commemorative Certificates—Executive Director: The following resolutions were adopted:

> 14-1976-B. Resolved, that a commemorative certificate for the following be authorized:
>
> > 25th anniversary of the American Board of Dental Public Health, Las Vegas, Nevada, November 12, 1976.
>
> 15-1976-B. Resolved, that a framed commemorative certificate be presented to the Vermont State Dental Society to commemorate the Society's 100th anniversary at its annual session in September, 1976.
>
> 16-1976-B. Resolved, that the Board of Trustees of the American Dental Association authorize a suitable certification or citation of recognition conveying its

high regard and sincere congratulations to Dr. J. Ben Robinson on the occasion of his recognition by the West Virginia alumni of the University of Maryland on April 9, 1976.

The Board of Trustees also adopted a motion directing the Executive Director to report to the August session of the Board of Trustees with recommendations for a standard procedure for handling commemorative certificates.

Reports on Contracts—Executive Director: Appended to the Report of the Executive Director was a list of contracts entered into since the last session of the Board of Trustees which were reported in accordance with the *Rules of the Board of Trustees.*

Report of Assistant Executive Director (Business Affairs-House Counsel): Mr. Noone reported on the current status of various lawsuits: the Arizona membership suit; actions between the Association and the United States Dental Institute; a libel suit by two purported advertising dentists; a suit for diplomate status as an endodontist; a suit against Northern Virginia Dental Society arising from a disciplinary proceeding; a suit by two dental school faculty members; antitrust action by the Arizona Attorney General; Dr. Block's suit against the Tri-County Dental Society, California; eleven dentists' class action suit against the California Dental Service; the suit of the late Dr. Garvin; the dismissal of the bootleg dentistry suit; litigation in New Jersey involving North American Dental Plans, Inc.; Oklahoma Dental Association versus the Internal Revenue Service.

Mr. Noone also reported that an article entitled "Guidelines for Avoiding Antitrust Problems" by Arthur L. Herold would be distributed to constituent society executive directors and secretaries.

Mr. Noone also presented the following information regarding the Association's federal income tax status:

> The Association filed Exempt Organization Business Income Tax Returns (Form 990-T) as well as a Return of Organization Exempt from Income Tax (Form 990) for the years ended December 31, 1968-74 inclusive, indicating no liability for federal income tax on business activities, including advertising and subscription revenues because expenses of the Association's publications exceeded advertising and subscription income. The Association anticipates that returns to be filed for the year ended December 31, 1975 also will reflect an excess of publication expenses over publication income. However, it should be noted that the Internal Revenue Service currently is actively reviewing the Association's tax returns for the period 1970-4 for the purpose of determining whether, under the provisions of the rules and regulations issued by the Internal Revenue Service on December 18, 1975, the Association is to be assessed substantial taxes on the income that it realized from advertising and subscriptions during said period.
>
> On August 16, 1974, the Internal Revenue Service found that the Association realized unrelated taxable net income from advertising in the amounts of $213,470.27 in 1968 and $334,761.26 in 1969 and assessed the Association for income taxes of $102,647.16 in 1968 and $169,075.95 in 1969. The Association has protested the assessment. The Association's contention that the Treasury Regulations, upon which the IRS places its reliance, are invalid has been supported in two cases. The first case was decided in 1975 in favor of the Massachusetts Medical Society by the United States District Court in Massachusetts and the second was decided on February 18, 1976 in favor of the American College of Physicians by the United States Court of Claims. In brief, each court found that the advertising and editorial activities of said two professional societies' journals should be treated as inseparable parts of single integrated enterprises, all income from which should be wholly exempt from federal income tax.

Late in 1975 the IRS issued five revenue rulings relating to the treatment of income received by a tax-exempt organization from the rental of display space to exhibitors. In each of the rulings the ultimate determination of whether the income produced by the sale of display space is taxable unrelated business income turns on the existence or nonexistence of selling on the floor of the show. These rulings do not really change what always has been known to be the law, but they do have the beneficial effect of warning tax-exempt organizations that IRS is now embarking on a program of enforcement. At this writing, no one knows what offsetting costs can be allocated against trade show income, but IRS is expected to provide the answers with new rulings. Until this is done, no meaningful advice on how to plan a commercial exhibit show that could serve as a guide can be given. However, one bright feature in the rulings is that any organization that had binding contracts in existence with exhibit halls as of December 1, 1975, will not be assessed for taxes on rental income by IRS even though exhibitors might be engaged in making sales at such organization's trade show. The American Dental Association has binding agreements for exhibit halls through 1979.

After discussion on the report, the following resolution was unanimously adopted by the Board of Trustees:

17-1976-B. **Resolved**, that the American Dental Association assist the Arizona State Dental Association to the maximum extent possible, including, if feasible or necessary, the total assumption of the defense and costs of defending any litigation growing out of the Arizona Attorney General's letter of February 11, 1976, concerning alleged anticompetitive practices.

Report of Assistant Executive Director (Communications): Mr. Goulding reported on media contacts and stated that the first NBC network showings of ADA spots have now been scheduled. ABC and CBS began using ADA dental health messages in 1973.

Mr. Goulding requested from the Board of Trustees approval for the Council on International Relations to apply to the Department of Commerce for STAR (Special Traveler Arrangements Recognition) for the 1977 annual session in Miami Beach. If the application is approved by the Department of Commerce, the Department would promote attendance from other countries through its overseas offices. There would be no cost to the Association for this designation. The Council on International Relations is exploring the possibility of obtaining a grant without involvement of Association funds to assist in bringing selected speakers from other countries to participate in the 1977 annual session program and to provide for simultaneous interpretation in English, Portuguese, and Spanish.

Mr. Goulding also reported that information on dental needs resulting from the earthquake in Guatemala was relayed to the Council on International Relations via the U.S. Department of State during the Midwinter Meeting of the Chicago Dental Society. In cooperation with the Christian Dental Society, who agreed to receive and administer funds, the Council on International Relations is supervising the collection and shipment of equipment and supplies.

After discussion on the report, the following resolution was adopted by the Board of Trustees:

18-1976-B. **Resolved**, that the Council on International Relations be authorized to apply for STAR designation for the 1977 annual session in Miami Beach.

Recess: The Board of Trustees recessed at 12:00 a.m. and reconvened at 1:30 p.m.

Report of Assistant Executive Director (Dental Health): Mr. Bishop reported on the activities of the Council on Dental Care Programs and on the Bureau of Economic Research and Statistics' postcard survey forms as part of its 1976 updating of *Distribution of Dentists*. Mr. Bishop also reported on the Council on Dental Health's activities concerning the new National Health Planning legislation and on the Bureau of Audiovisual Services' feasibility study of a videotape continuing education program.

Report of Assistant Executive Director (Education and Hospitals): Dr. Coady reported on the activities of the Commission on Accreditation of Dental and Dental Auxiliary Educational Programs, the Council on Dental Education, the Division of Educational Measurements, the Council on Hospital Dental Service, the Council of National Board of Dental Examiners, and the Commission on Licensure.

The activities of the Commission on Accreditation of Dental and Dental Auxiliary Educational Programs include a comprehensive study of dental curriculums of all accredited dental schools in the United States with an eleven-member Coordinating Committee to provide advice and counsel to the project staff on general policy, planning, operations, and reporting. An Advisory Committee on the Study of Dental Auxiliary Expanded Functions, with Dr. L. M. Kennedy as chairman, has been appointed to develop a position statement on functions which should be delegated to auxiliaries. Also, in accordance with a 1975 House of Delegates directive, a workshop conference on expanded functions has been scheduled for March 31, April 1, and April 2, 1976. It was reported that two weeks prior to the workshop conference on expanded functions of dental auxiliaries the preregistrants for the conference from the practicing dental community represented only 45 percent of the total group. The resolution adopted by the House of Delegates directed that the majority of the participants at the workshop conference be practicing dentists. The Board of Trustees adopted a motion to continue with the workshop conference regardless of whether the majority of participants are practicing dentists. In addition, the Board agreed to assist in obtaining additional constituent society participants. A Continuing Education Evaluation Study Committee has been appointed to respond to the 1975 Washington State Dental Association resolution which was referred to the Council on Dental Education for a feasibility study and report to the 1976 House of Delegates. The resolution proposed that the Association establish and operate a national program to evaluate continuing education programs and courses for the purpose of determining whether they are in conformity with the ADA *Guidelines for Continuing Dental Education*. The Washington resolution also details what programs should be evaluated, to whom the results of such evaluations should be furnished, and how the program is to be financed.

Report of Assistant Executive Director (Legislation and Legal Affairs): Mr. Conway reported on matters of interest in the areas of legal affairs, legislation, dental laboratory relations, and judicial procedures. The report was informational in nature.

Report of Assistant Executive Director (Scientific Matters): Dr. Tiecke reported on the activities of the American Dental Association Health Foundation, the Council on Dental Materials and Devices, the Council on Dental Therapeutics, the Office of Advertising Review, and the Council on Dental Research. Dr. Tiecke also reported on the study of N2 (RC 2B—Sargenti Technique) and stated that a meeting was held on February 15 to identify the problem areas and explore approaches to resolve

them. The meeting was attended by representatives of the American Association of Endodontists, the American Endodontic Society, and the American Dental Association. Dr. Shira commented that a letter had been received from the Academy of General Dentistry urging the ADA to expedite its study of the efficacy and safety of N_2 (RC 2B) and transmit its findings to the Food and Drug Administration with appropriate recommendations.

Report of Assistant Executive Director (Washington Office): Mr. Christensen reported on the matters of current importance on the federal health legislative scene including national health insurance, the major budget changes proposed by the President, health manpower, health planning, HMOs, health education and disease control, dentists' services under Medicare, Veterans Omnibus Health Care Act, Indian Health Care Improvement Act, and the National Health Service Corps.

After discussion on the report, the Board of Trustees adopted a resolution directing ADA counsel to report to the August 1976 session of the Board of Trustees on what is being done to monitor and respond to allegations pertaining to dentistry contained in the Federal Trade Commission report on regional office task force goals and achievements.

Report of Editor: Dr. Butts commented briefly on the following publications: *The Journal of the American Dental Association, ADA News, Dental Abstracts, Journal of Endodontics, Journal of Dental Research, Oral Research Abstracts, Journal of Oral Surgery.*

After discussion, a motion was adopted that the Board of Trustees support the continued publication for 1977 of the *Journal of Dental Research.* The Board also adopted a motion that the Association continue to publish *Oral Research Abstracts* through 1977 and also directed the Editor to recommend ways to improve financing and quality of production at the end of 1977.

Recess: The Board of Trustees recessed at 5:00 p.m.

SATURDAY, MARCH 13, 1976

Call to Order: The meeting of the Board of Trustees was called to order at 9:10 a.m. by President Shira.

Roll Call: The officers, members of the Board of Trustees and members of staff were present as previously recorded.

REPORT OF COMMITTEE ON FINANCE AND INVESTMENTS

The Report of the Committee on Finance and Investments was read by Dr. Carter, chairman. The other members of the Committee were Drs. Boucek, Kerr, Shira, Shuler, and Etherington, and Dr. Watson, Mr. Noone, Mr. Kleck, Mr. Wisniewski and Mr. Starkey, *ex officio.*

Report of Audit: A resolution presented by the Committee was adopted placing on file the *Report of Audit* of the American Dental Association for the year ended December 31, 1975.

Review of Financial Operations for 1975: The Committee reported that in 1975 the Association's income was $15,075,721 and its operating expenses and nonoperating disbursements were $14,418,258, resulting in an excess of $657,463. This surplus was $632,813 greater than the budget surplus of $24,650.

Disposition of 1975 Budget Surplus: The Committee recommended that the 1975 budget surplus of $657,463 be transferred to the Reserve Division of the General Fund to be invested by Wright Investors' Service, Inc. in accordance with the *Organization and Rules of the Board of Trustees*. The following resolution presented by the Committee was adopted:

> 19-1976-B. Resolved, that the Excess of Income over Expense and Nonoperating Disbursements for the year 1975, amounting to $657,463, be transferred from the Operating Division to the Reserve Division of the General Fund.

Report of Headquarters Building Operations for 1975: The Committee noted that in 1975 the Headquarters Building produced income of $1,135,659 and incurred expenses, excluding depreciation, in the amount of $1,707,223. However, if the square footage which the Association occupies were valued at an annual rate of $7.50 per gross square foot and then added to building income, building income would exceed expenses, excluding depreciation by $467,186. The Committee noted further that based on an original investment of $13,913,000 for the Headquarters Building and an income in 1975 of $2,174,409 the Association realized a 15.6 percent rate of return on its investment which is an excellent rate of return for real estate investments.

Report of Treasurer: The Committee stated that the Treasurer made a detailed report on the current status of the Reserve Division of the General Fund and the Relief Fund investments.

Status of Contingent Fund and Supplemental Appropriation Requests: The Committee reported as follows:

> A Contingent Fund of $400,000 was authorized in the approved 1976 Budget. The Board of Trustees appropriated from the Contingent Fund $4,800 at its session on October 30, 1975, $166,950 at its December 1975 session and $8,500 by mail ballot, leaving a balance of $219,750 in the Contingent Fund.
>
> In addition to consideration of Resolution 306 which was postponed indefinitely by the Board of Trustees at its December 1975 session for decision at its March 1976 session, additional supplemental appropriation requests in the amount of $197,680 will be considered at this session. If granted, a balance of $14,120 will remain in the Contingent Fund.
>
> The Committee would point out to the Board of Trustees that as a result of tight expense budgeting for agencies in 1976 recoveries from agency-budgeted line items will, most likely, be insubstantial in 1976. Therefore, the Committee would call to the Board's attention the fact that some monies may have to be appropriated from the $1,200,000 held by Wright Investors in cash equivalents of the Reserve Division of the General Fund.
>
> Further, the Committee would recommend that the Board consider increasing the Contingent Fund for 1977 from its present $400,000 which represents 2.67 percent of the total expenditure budget to $450,300 which represents 3 percent of the total 1976 expenditure budget.

The following resolutions presented by the Committee were adopted:

20-1976-B. Resolved, that the following appropriations be made from the Contingent Fund and allocated to the line items in the budgets in accordance with the terms of the supplemental appropriation requests:

Expense Section

Annual Session		$ 2,500
Special Committee to Study the Association's Annual Session	$ 2,500	
Board of Trustees		$ 35,000
Study of the Association's Structure and Function	$35,000	
Dental Laboratory Relations, Council on		$ 67,000
Public Relations Plan on Denture Care	$67,000	
Dental Therapeutics, Council on		$ 13,500
Committee Meetings (Ad Hoc Committee on Trace Anesthetic Gases)	$13,500	

Nonoperating Disbursements Section
Grants

American Association of Dental Schools		$ 20,000
(To be paid through the American Fund for Dental Health)		
American Fund for Dental Health		$ 15,000
Hillenbrand Fellowship	$15,000	
14th International Conference on Health Education		$ 1,000
Latin American Association of Dental Schools		$ 1,000
Massachusetts Dental Society		$ 6,680
Special Commission to Evaluate the Forsyth Project	$ 6,680	
National Association of Advisors for the Health Professions		$ 2,000
Total		$163,680

21-1976-B. Resolved, that a $7,950 appropriation be made from the Contingent Fund and allocated to the Membership budget for payment to the *Fédération Dentaire Internationale,* and be it further

Resolved, that the American Dental Association Board of Trustees expresses its grave concern relative to future participation in the *Fédération Dentaire Internationale* if the present dues structure is allowed to continue.

It was agreed that the Executive Director would transmit the balance of the dues to the *Fédération Dentaire Internationale* and express the concerns of the Board of Trustees with respect to the dues structure.

22-1976-B. **Resolved,** that a $10,000 request from the National Center for Health Education be postponed definitely until August 1976, and be it further **Resolved,** that the Council on Dental Health further study the request of the National Center for Health Education and report to the August 1976 session of the Board of Trustees.

Cost Study and Objectives of Agency Publications and Mass Mailings: The Committee reported that in August of 1975 the Board of Trustees adopted a resolution calling for an in-house study of the costs and objectives relative to the individual publications and mass mailings of each Association agency with a report to the March 1976 session of the Board of Trustees. The Committee is of the opinion that the cost study needs further analysis with recommendations by the Committee on Advance Planning particularly as it relates to the structure and function of the Association.

On the recommendation of the Committee, the cost study and objectives of agency publications and mass mailings were referred to the Committee on Advance Planning for analysis and recommendation.

Criteria for Awarding Assistance Grants: The Committee reported that at its meeting on August 17, 1975 it requested that criteria be developed and presented to assist the Board of Trustees in determining whether requests for financial assistance of projects of component, constituent, and other dentally related societies, including legal actions, warrant the support of the American Dental Association. The Committee reported that it had reviewed the criteria for awarding assistance grants as well as the guidelines for assistance funds supporting litigation and is of the opinion that further study and consideration should be given to the guidelines. However, since the Association may be called upon for financial assistance in the areas outlined in the near future, the Committee recommended that interim policy be adopted until the August 1976 session of the Board of Trustees.

The following resolutions presented by the Committee were adopted:

23-1976-B. **Resolved,** that the following interim criteria to be used for grant assistance by the American Dental Association to health-related organizations:

1. The health-related organization must be making significant contributions to the art and science of dentistry or to the policies and aims of the American Dental Association.

2. The financial aid requested is commensurate with the national benefit to the dental profession reasonably expected to result.

3. The health-related organization has made every effort to obtain the funds needed from not only its own resources but other organizations as well, if feasible.

4. The need for additional funds is necessary and immediate.

5. Failure to obtain the requested funds from the American Dental Association would impair seriously the purpose for which the funds are needed.

6. Any request for grant assistance to support a project emanating from a component dental society is to be submitted through the component's constituent dental society, which, in turn, is to indicate the extent to which it is supporting the component's need for financial assistance.

24-1976-B. Resolved, that the following interim guidelines are to be used in determining financial assistance to dental societies by the American Dental Association in support of litigation:

1. The dental society has notified the Association of the litigation at a time which permits the agencies of the Association to be of maximum assistance in offering suggestions on the enforcement program or the litigation.

2. The dental society has made every reasonable effort to obtain the funds needed to sustain the litigation from its own resources.

3. The need for additional funds is immediate.

4. Failure to obtain additional funds would seriously impair the dental society efforts to pursue the litigation to a successful conclusion.

5. The disposition of the issue or issues under litigation would have a direct and substantial impact upon the dental profession nationally.

6. The financial aid requested is commensurate with the benefit reasonably expected to result, on a nationwide basis, from a favorable result of the litigation.

7. Any request for funds to support litigation emanating from a component dental society is to be submitted through the component's constituent dental society which, in turn, is to indicate the extent to which it is supporting the component's need for financial assistance.

REPORTS OF SPECIAL COMMITTEES

Report of Committee on Advance Planning: The Committee reported on the progress of the study of the structure, function, management, and operation of the Association utilizing both an in-house evaluation as well as outside expertise which is in response to a resolution adopted at the August 1975 session of the Board of Trustees. The Committee requested authorization to select an outside management firm, if needed, at a cost not to exceed $35,000 and the following resolution was adopted by the Board of Trustees:

25-1976-B. Resolved, that the Committee on Advance Planning of the Board of Trustees be authorized to select an outside management firm, if needed, to assist in its study of the structure, management, operation and function of the American Dental Association at a cost not to exceed thirty-five thousand dollars ($35,000)..

The Committee also reported on a productive meeting with representatives of the American Dental Trade Association.

Interim Report of the Special Study Commission on the Care of Fully and/or Partially Edentulous Patients: The Board of Trustees considered the interim report of the Special Study Commission on the Care of Fully and/or Partially Edentulous Patients and adopted the following resolutions:

26-1976-B. Resolved, that within its June 1, 1976 report on assignments related to denture care, the Council on Dental Education present an evaluation of current predoctoral denture care training programs and an assessment of their adequacy in preparing dentists to provide comprehensive oral health care.

27-1976-B. Resolved, that the Council on Dental Laboatory Relations and the Bureau of Public Information proceed with the proposed pilot public relations program in denture care in Oregon, and be it further
Resolved, that the pilot public relations program be continued for the coming 12 months through March 1977, as long as it continues to have the endorsement of the Oregon Dental Association and be it further
Resolved, that $67,000 be allocated to the pilot public relations project with the understanding that the Oregon Dental Association intends to contribute additional funding to the pilot program, and be it further
Resolved, that a detailed progress report of the implementation of this project be presented to the Board of Trustees at its August session.

28-1976-B. Resolved, that the Council on Dental Research proceed with its plans for an interagency committee with outside consultants to consider Assignments 14 and 15 on denture care delivery systems, and be it further
Resolved, that the plans be included in the Council's June 1, 1976 report on the implementation of its assignments related to denture care.

Report of Special Committee on Inter-Agency Affairs: The Special Committee reported on its meeting with the American Association of Dental Examiners related to National Board examinations. After discussion the Board of Trustees adopted the following resolution:

29-1976-B. Resolved, that the "Memorandum of Agreement" (March 1976 *Board Manual:*753-754) between the American Dental Association and the American Association of Dental Examiners be approved for execution.

The Special Committee also reported on meetings held with representatives of the following organizations: American Dental Assistants Association, American Dental Hygienists' Association, American Association of Dental Schools.

NEW BUSINESS

Approval of Applicants for Associate Membership—Bureau of Data Processing Services and Membership Records: The following resolution presented by the Bureau was adopted:

30-1976-B. Resolved, that the following applicants for associate membership be approved in accordance with Chapter VI, Section 90N, of the *Bylaws:*

Harvey L. Anderson	Patricia A. Gempel
Naresh K. Agrawal	Ross G. Kaplan
Jun Young Cho	David A. Keith
Gloria Cohen	Stig Osterberg
Jeanne Freeland	

Nominations to Committee on Local Arrangements for 1976 Annual Session: The following resolution was adopted by the Board of Trustees:

31-1976-B. Resolved, that the list of nominations submitted by Dr. Louis J. Hendrickson for membership on the Committee on Local Arrangements for the 1976 annual session be approved.

Nomination to Board of Directors of Delta Dental Plans Association: The following resolution was unanimously adopted by the Board of Trustees:

32-1976-B. Resolved, that Dr. Wendle E. Fitts be nominated as a representative of the American Dental Association on the Board of Directors of the Delta Dental Plans Association for the term ending in 1979.

Criteria for Selection of Annual Session Sites: The following resolution was adopted by the Board of Trustees:

33-1976-B. Resolved, that the revised Criteria for Selection of Annual Session Sites (March 1976 *Board Manual:*588) be approved.

Numbering System for Resolutions Before House of Delegates: In order to comply with a resolution adopted by the 1975 House of Delegates (*Trans.* 1975:747), the Board of Trustees considered a new numbering system for resolutions before the House of Delegates. It was agreed that a new numbering system would be implemented for the 1976 House of Delegates and the following resolution was adopted:

34-1976-B. Resolved, that a new numbering system be approved and implemented for the 1976 House of Delegates.

Personal Comments from Chairman of Public Education Program Advisory Committee: Dr. Houlihan, chairman of the Public Education Program Advisory Committee, reported on the activities of PEP.

Resolution on Smoking: The Board of Trustees reviewed a request from the Michigan Dental Association to prohibit the use of smoking tobacco during all council, bureau, committee or other official meetings of the American Dental Association. After discussion, the following resolution was postponed indefinitely:

Resolved, that the Board of Trustees prohibits the use of smoking tobacco during all council, bureau, committee or other official meetings of the American Dental Association.

Challenge to the Confidentiality of Council Minutes: The Executive Director read a report indicating that Dr. Oscar Malmin of Akron, Ohio, had submitted a letter contending that, as a member of the Association, he had a right to inspect the minutes of any council of the Association.

The Board of Trustees at its December 1975 session adopted the following resolution:

> **Resolved,** that the *Standing Rules for Councils*, page 8, be amended by the addition of the following sentence at the end of the section entitled "Minutes":
>
> > When minutes or portions of minutes are identified as confidential such minutes will be available only to members of councils, secretaries of councils, assistant executive directors having administrative responsibility for such councils, and officers and trustees of the Association.

After discussion, the Board of Trustees adopted the following resolution:

> **35-1976-B. Resolved,** that Dr. Oscar Malmin be advised of the Board of Trustees' action at its December 1975 session amending the *Standing Rules of Councils* preserving and supporting a council's right to restrict access to its minutes.

Telegram from Executive Director of New Jersey Dental Association: The Board of Trustees noted that a telegram had been received from Mr. Dennis Young, executive director of the New Jersey Dental Association, regarding distribution of the 1975 fee survey data. It was agreed that Mr. Young would be advised of the action taken by the Board of Trustees at this session concerning this matter (see p. 616).

Adjournment: The Board of Trustees adjourned at 1:53 p.m.

HEADQUARTERS BUILDING, CHICAGO
AUGUST 16-21, 1976

Call to Order: The fourth regular session of the Board of Trustees of the American Dental Association was called to order at 9:00 AM, Monday, August 16, 1976, in the Board Room of the Headquarters Building, Chicago, by President Robert B. Shira.

Roll Call: The following officers were present: Robert B. Shira, president; Frank F. Shuler, president-elect; I. E. Gruber, first vice-president; George E. Kearns, second vice-president; Frank P. Bowyer, speaker of the House of Delegates; C. Gordon Watson, executive director; James W. Etherington, treasurer; Herbert C. Butts, editor.

The following members of the Board of Trustees were present: George P. Boucek, Weston D. Brown, Joseph P. Cappuccio, Charles D. Carter, Floyd E. Dewhirst, Robert B. Dixon, John M. Faust, Coleman Gertler, Robert H. Griffiths, John J. Houlihan, I. Lawrence Kerr, Jack H. Pfister, Lloyd J. Phillips and Eugene A. Savoie.

Staff members present were: Eric M. Bishop, assistant executive director, dental

health; Hal M. Christensen, assistant executive director, Washington office; John M. Coady, assistant executive director, education and hospitals; Bernard J. Conway, assistant executive director, legislation and legal affairs; Peter C. Goulding, assistant executive director, communications; John P. Noone, assistant executive director, business affairs and house counsel; Richard W. Tiecke, assistant executive director, scientific affairs; Walter E. Wisniewski, associate house counsel; Leo Kleck, comptroller; John B. Goetz, managing editor; Howard I. Wells, assistant to the Executive Director; Susan W. Brock, administrative assistant.

Approval of Minutes of Previous Session: Dr. I. E. Gruber, first vice-president, recommended the following amendments to the minutes of the March 11-13, 1976 session of the Board of Trustees:

1. Following "II. Final Comment" on page 248 of the *Annual Reports and Resolutions, 1976,* insert the following statement:

> During Dr. Brecht's appearance as a special order of business he stated that there would be no problem with the Council on Scientific Session accepting the recommended changes to the *Manual on Scientific Session.*

2. Preceding "*Adjournment*" on page 249 of the *Annual Reports and Resolutions, 1976,* insert the following paragraph:

> **Assignment to Committee on Rules and Order:** A motion was adopted by the Board of Trustees requesting the Committee on Rules and Order to consider a mechanism whereby the members of the Board can be assured of receiving Board reports at least a week in advance of the session. The Committee was requested to report to the August session of the Board of Trustees.

3. Amend the paragraph following "Recommendation 27" on page 247 of the *Annual Reports and Resolutions, 1976* to read as follows:

> After discussion on the report of the Special Committee, the Board of Trustees referred the report and the following resolutions, which were presented by the Special Committee, to Reference Committee A of the Board of Trustees for study and report to the August 1976 session of the Board:

A resolution was adopted approving the minutes of the March 11-13, 1976 session of the Board of Trustees as amended.

Recording of Mail Ballots: A resolution was adopted placing in the record the following mail ballots which were taken by the Board of Trustees during the period March 14, 1976 through August 15, 1976:

Grant to Alaska Dental Society: Mail Ballot No. 2 was circulated on March 19, 1976. The following resolution was adopted by a vote of 17 affirmative ballots, no negative ballots and no missing ballots.

> **Resolved,** that $15,000 be appropriated from the 1976 Contingent Fund and allocated to the Grants line item in the budget Grants and Loans to Related Health Group for the Alaska Dental Society to assist that Society in resolving legislative and other difficulties confronting the Society.

President's Dinner-Dance: Mail Ballot No. 3 was circulated on July 28, 1976. The following resolution was adopted by a vote of 17 affirmative ballots, no negative ballots and no missing ballots.

> Resolved, that the price of tickets for the President's Dinner-Dance on Tuesday, November 16, 1976, be increased from $15.00 per person to $17.50 per person.

REPORT OF COMMITTEE ON RULES AND ORDER

The Executive Director read the Report of the Committee on Rules and Order. The other members of the Committee were Dr. Shira, chairman, Drs. Faust, Griffiths, Savoie, and Dr. Shuler, observer.

Approval of Agenda for Current Session: A motion was adopted amending the agenda on Pages 1-7 of the *Board Manual* by the addition of one item under "New Business." A resolution was then adopted approving the agenda, as amended, as the official order of business for the current session.

Special Orders of Business: A motion was adopted amending the special orders of business by the addition of two items under "Executive Meeting" and a resolution was adopted establishing the following special orders of business:

Executive Meeting, Tuesday, August 17, 9:00 AM and at the call of the Chair

> Election of Treasurer for one year
> Report of Committee on Salary and Tenure

Meeting of Board of Directors, American Dental Association Health Foundation, at the call of the Chair

Appearance of Dr. Michael D. Spektor, Editor, American Student Dental Association, Tuesday, August 17, 11:45 AM.

Amendment of "Organization and Rules of the Board of Trustees"—Special Orders of Business: The following resolution presented by the Committee on Rules and Order was adopted:

> 36-1976-B. Resolved, that the *Rules of the Board of Trustees* be amended by the addition of the following paragraph to precede "Quorum" under the "Rules of Procedure" on page 8:
>
> > Special Orders of Business: All requests to appear before the Board of Trustees as a special order of business shall be submitted to the Committee on Rules and Order for approval, either at a meeting of the Committee or by mail ballot.

Amendment of "Organization and Rules of the Board of Trustees"—Mail Ballots: The following resolution presented by the Committee on Rules and Order was amended by the addition of the words "at the call of the President and Executive Director or by five members of the Board of Trustees" in the second resolving clause and then adopted:

37-1976-B. Resolved, that the *Rules of the Board of Trustees* be amended by the addition of the following paragraph to precede the last paragraph under the section entitled "Mail Ballots" on page 9:

> The President shall vote on a mail ballot.

and be it further

Resolved, that the *Rules of the Board of Trustees* be amended by the addition of the following paragraph to follow the first paragraph under the section entitled "Mail Ballots" on page 8:

> A telephone conference call for consideration on mail ballots, particularly as it pertains to supplemental appropriations, may be utilized at the call of the President and Executive Director or by five members of the Board of Trustees.

Nominations for Honorary Membership: The following resolution presented by the Committee on Rules and Order was adopted:

38-1976-B. Resolved, that in accordance with Chapter VI, Section 8oM of the *Bylaws*, the following be nominated to the House of Delegates for Honorary Membership in the American Dental Association:

Dr. Donald E. G. D. Derrick
Mr. George A. Roose
Lieutenant General George E. Schafer, Surgeon General USAF
Professor Marjorie L. Swartz
Dr. William B. Walsh

Recipient of Distinguished Service Award: The following resolution presented by the Committee on Rules and Order was adopted:

39-1976-B. Resolved, that the Distinguished Service Award of the American Dental Association be made to:

Dr. Percy T. Phillips

For the text of the citations of the five nominations for Honorary Membership and the Distinguished Service Award, see Report 1 of the Board of Trustees to the House of Delegates (pp. 462-465 of this volume).

Nominations for Treasurer: Dr. Jack H. Pfister was nominated for the office of Treasurer by Dr. Floyd E. Dewhirst and the nomination was seconded by Dr. Eugene A. Savoie. Dr. Lloyd J. Phillips was nominated for the office of Treasurer by Dr. John M. Faust and the nomination was seconded by Dr. Joseph P. Cappuccio. President Shira announced that the nominations would be placed on ballot as a special order of business at 9:00 AM on Tuesday, August 17.

Recess: The Board of Trustees recessed in order to permit the reference committees of the Board to meet.

EXECUTIVE MEETING

TUESDAY, AUGUST 17, 1976

Call to Order: An Executive Meeting of the Board of Trustees was convened at 9:00 AM, Tuesday, August 17, President Robert B. Shira presiding.

Roll Call: Those present were the President, President-elect, First Vice-President, Second Vice-President, Executive Director, Treasurer, Editor, Speaker of the House of Delegates, all members of the Board of Trustees and the official reporter.

Appointment of Treasurer: A motion was adopted to elect the Treasurer for a term of one year.

On ballot, Dr. Jack H. Pfister, North Dakota, was appointed Treasurer for a one-year term, beginning with the 1976 annual session and ending with the 1977 annual session.

The Executive Director and Editor were requested to leave the Executive Meeting.

Report of Committee on Salary and Tenure: The Board of Trustees adopted resolutions, presented by the Committee on Salary and Tenure, approving the salary for the Executive Director for fiscal year 1977, approving the salary for the Editor for fiscal year 1977 and approving a one-year extension of the Editor's contract, and approving position descriptions for the Executive Director and the Editor. Other subjects were discussed.

Adjournment: The Executive Meeting was adjourned and the regular meeting of the Board of Trustees convened.

UNFINISHED BUSINESS

Report of the Advisory Committee to the Public Education Program: The Board discussed the report of the Advisory Committee to the Public Education Program which outlined the 1976 Public Education Program and the proposals for the 1977 program with a proposed budget of $1,796,000 in 1977. During the discussion the Board adopted a motion to reaffirm its support of the Public Education Program.

The Board also adopted motions to place the Public Education Program under the purview of the Assistant Executive Director of Communications, Mr. Peter C. Goulding, and to urge the Advisory Committee of PEP to give serious consideration to utilizing Advisory Committee members as spokesmen at constituent and component societies.

After lengthy discussion regarding the 1977 budget for the Public Education Program, the Board adopted a motion to approve a $700,000 budget for PEP in 1977. The negative votes of Drs. Charles D. Carter, John M. Faust, Robert H. Griffiths, John J. Houlihan, Lloyd J. Phillips and Eugene A. Savoie were recorded.

Report of the Chairman of the Public Education Program Advisory Committee: The Board discussed the report of the Chairman of the Public Education Program Advisory Committee, Dr. John J. Houlihan. In the report, Dr. Houlihan commented on various aspects of the Public Education Program.

SPECIAL ORDER OF BUSINESS

Appearance of Dr. Michael D. Spektor, Editor, American Student Dental Association: Dr. Michael D. Spektor, Editor, American Student Dental Association, appeared before the Board of Trustees as a special order of business. Dr. Spektor presented the Association with a $1,000 check as the second installment on a $10,000 promissory note which the Association issued to the American Student Dental Association in 1971.

Recess: The Board of Trustees recessed for luncheon and reconvened at 2:10 PM.

UNFINISHED BUSINESS

Report of the Special Study Commission on the Care of Fully and/or Partially Edentulous Patients: The Board of Trustees considered the report of the Special Study Commission on the Care of Fully and/or Partially Edentulous Patients and, after discussion, adopted the following resolutions presented by the Special Study Commission:

40-1976-B. **Resolved,** that the Council on Dental Laboratory Relations continue after August 1976 the activities of the expired Special Study Commission on the Care of Fully and/or Partially Edentulous Patients with regard to (1) the continuous monitoring of illegal dentistry activities, (2) the continuing consideration of long-term solutions to denture care problems, particularly as they relate to the activities of laymen not trained or otherwise qualified to practice dentistry, and (3) the coordination of activities of other Association agencies to the extent that those activities concern the illegal practice of dentistry, and be it further

Resolved, that $1,900 be added to the Council on Dental Laboratory Relations' 1977 proposed budget for consultant travel and per diem, and be it further

Resolved, that a new position of assistant secretary of the Council on Dental Laboratory Relations be established beginning in 1977 to coordinate and conduct activities related to denture care, as outlined in the proposed job description for the position.

41-1976-B. **Resolved,** that the $21,250 for funding the second year of the Oregon demonstration project on denture care indicated in the Council on Dental Laboratory Relations' 1977 budget be approved.

42-1976-B. **Resolved,** that the Council on Dental Laboratory Relations, in conjunction with appropriate agencies of the Association, be requested to convene a conference in early 1977 devoted to solutions to problems of access to comprehensive oral health care for lower income adults and families where Medicaid monies are not available and that the results of this conference, together with results of the Oregon project, be evaluated.

43-1976-B. **Resolved,** that soon after the workshop the Council on Dental Laboratory Relations, in conjunction with the appropriate agencies of the Associa-

tion, develop a compendium of initiatives that may be taken by organized dentistry at the local, state and national levels to increase access to comprehensive oral health care for lower income adults and families where Medicaid monies are not available.

44-1976-B. Resolved, that a meeting be sought between representatives of the American Association of Dental Examiners and the American Dental Association for the purpose of determining the best ways to encourage state dental boards to evaluate the sections of licensure examinations which test the applicants' proficiency in the technical aspects of removable dental prosthetics and to increase that emphasis where appropriate, and be it further
Resolved, that a report on the progress of discussions with the American Association of Dental Examiners be presented to the Board of Trustees in March 1977.

45-1976-B. Resolved, that the Association determine and adopt the most effective course for urging state boards of dentistry to provide on an ongoing basis summaries of examination results to the Council on Dental Education, and be it further
Resolved, that a report on the progress in this matter be presented to the Board of Trustees in March 1977.

46-1976-B. Resolved, that the "After Care Guidelines: Full Dentures" be transmitted to the House of Delegates with the recommendation from the Board of Trustees that they be approved, and be it further
Resolved, that the Council on Dental Health make every effort to promote the approved guidelines to the profession.

47-1976-B. Resolved, that the "After Care Guidelines: Partial Removable Dentures" be transmitted to the House of Delegates with the recommendation from the Board of Trustees that they be approved, and be it further
Resolved, that the Council on Dental Health make every effort to promote the approved guidelines to the profession.

48-1976-B. Resolved, that the Council on Dental Health survey the appropriate cancer research and treatment centers to determine what information may exist demonstrating a cause-and-effect relationship between oral cancer and ill-fitting dentures, and be it further
Resolved, that the Council report its findings to the March 1977 session of the Board of Trustees.

49-1976-B. Resolved, that an ad hoc committee be established as proposed by the Council on Dental Research to study the feasibility of new forms of ethical denture group practices, and be it further
Resolved, that $20,000 for establishing and operating the ad hoc committee be added to the Council's 1977 budget.

50-1976-B. Resolved, that the Bureau of Dental Health Education proceed immediately to select several key groups outside the dental profession who rep-

resent large numbers of edentulous persons, such as senior citizen organizations, and that the Bureau make personal visits to those organizations to discuss matters of dental health education, publicly funded assistance programs, nursing home care, illegal dentistry and other such concerns, and be it further
Resolved, that $2,000 be allocated from the 1976 contingency fund for the costs of the personal visits.

51-1976-B. **Resolved**, that the Bureau of Dental Health Education proceed with its proposed comprehensive legislative package of materials on oral health care for edentulous patients and on the necessity of that care being provided by trained and qualified professionals, and be it further
Resolved, that $7,600 for development of the legislative package be added to the Bureau's 1977 budget.

52-1976-B. **Resolved**, that the Board direct the appropriate Association agency, as determined by the Executive Director, to study the problems of dental schools finding sufficient numbers and varieties of denture patients for clinical instruction and to seek ways of eliminating this problem, and be it further
Resolved, that a report on the findings and proposed solutions be presented to the Board of Trustees in March 1977.

53-1976-B. **Resolved**, that the Council on Dental Laboratory Relations proceed with its proposed three-day conference on law enforcement and the one-day dental examiner seminar on law enforcement, and be it further
Resolved, that the $2,850 for the three-day conference, as indicated in the Council's 1977 budget, be approved.

The Board of Trustees postponed action on the following resolution until the January 1977 session of the Board:

Resolved, that the Bureau of Dental Health Education proceed with its proposed plan for a two-phase, comprehensive program of health education on denture care--one phase directed to the general public, and the other phase directed to the members of the profession, and be it further
Resolved, that $326,000 for conducting the public and professional education projects be added to the Bureau's 1977 budget.

In addition, the Board of Trustees adopted a motion commending the members and staff on the Special Study Commission for their diligence and efforts in preparing the report and requested that the commendation be communicated to the members and staff of the Special Study Commission.

Recess: The Board of Trustees recessed at 5:15 PM.

WEDNESDAY, AUGUST 18, 1976

Call to Order: The meeting of the Board of Trustees was called to order at 8:00 AM by President Shira.

Roll Call: The officers, members of the Board of Trustees and members of staff were present as previously recorded.

REPORT OF COMMITTEE ON FINANCE AND INVESTMENTS

The Report of the Committee on Finance and Investments was read by Dr. Carter, chairman. The other members of the Committee were Drs. Boucek, Kerr, Shira, Shuler and Etherington, and Dr. Watson, Mr. Noone, Mr. Kleck, Mr. Wisniewski and Mr. Starkey, *ex officio*.

Review of Financial Operations Through May 31, 1976: The Committee reports that Association income for the first five months of 1976 was $11,524,310 and its operating and nonoperating disbursements were $5,030,544, leaving an excess of $6,493,766. The operating expenses and nonoperating disbursements for the first five months of 1976 of $5,030,544 as compared to $6,034,072 for the same period in 1975 represented a decrease of $1,003,528.

Report of Headquarters Building Operations Through May 31, 1976: The Committee reported that for the five month period ended May 31, 1976 the Headquarters Building operations produced income of $485,933 and incurred expenses, excluding depreciation, of $682,014. The Committee also reported that space occupied by the Association increased from 138,500 to 139,450 gross square feet to accommodate a relocation of the Bureau of Audiovisual Services, the Council on Scientific Session and the Council on Hospital Dental Service. Building income, including the value of Association occupied space, for the first five months of 1976 exceeded expense, excluding depreciation, by $239,698.

Report of Treasurer—Reserve Division of General Fund: The Committee reported that during the first five months of 1976 Wright Investors' Service purchased on behalf of the Reserve Division short-term securities for $2,758,495 and common stocks for $143,950. In this period short-term securities either matured or were sold for $2,470,788 and common stocks were sold for $52,305. The securities held in the portfolio of the Reserve Division, exclusive of the investment in Dental Service Plans Insurance Company and cash on hand, are shown at May 31, 1976 on the records of the Association as having a cost value of $4,447,925 and a market value of $4,627,868 for an appreciation of $179,943 (or 4.05 percent) above cost.

In the Committee's review of the portfolio, it noted that the Association's investment in the capital stock of Dental Service Plans Insurance Company continues to remain at $394,480.

Mr. Albert L. Meric, Jr., vice-president of Wright Investors' Service, indicated to the Committee that the pause during the second quarter in the recovery of stock and bond prices was the combined result of three influences: (1) extensive and, what Wright believes, premature profit-taking in issues which had recovered from very depressed price levels during 1973-74, (2) a moderate shift of Federal Reserve policy towards somewhat higher short-term interest rates and slower monetary growth, and

(3) seasonal price weakness. In Wright's opinion, the fact that under these circumstances there was no significant change in market values should be interpreted as a favorable indication which, together with the outlook for rising earnings and dividends, supports Wright's view that a worthwhile further advance in portfolio investment values will be realized before year end.

Analysis of Balance Sheet: The comparative balance sheet presented by the Committee indicated the Association's assets at May 31, 1976 to have been $25,504,561, an increase of $1,070,558 over the comparable period in 1975. Liabilities were $5,566,508, resulting in a surplus of $19,938,053.

Relief Fund: The Committee reported that while the balance sheet of the American Dental Association Relief Fund revealed a net worth of $3,562,447 at May 31, 1976, this net worth reflects the Relief Fund's investments at cost. The net worth, showing the Relief Fund's investments at market value on May 31, 1976 actually was $3,674,559.

Status of Contingent Fund and Supplemental Appropriation Requests: The Committee reported that a Contingent Fund of $400,000 was authorized in the approved 1976 budget and that the Board of Trustees thus far has appropriated $406,880 from the Contingent Fund, leaving a deficit balance of $6,880.

The Committee also reported that since several agencies of the Association indicated that not all of the monies allocated to their 1976 budgets would be spent, these agencies were contacted and asked to surrender voluntarily any portions of their budgets that would not be used this year. As a result, $37,200 is available from certain agency budgets for addition to the Contingent Fund.

The Board of Trustees adopted the following resolution which erased the current deficit balance in the Contingent Fund and provides $30,320 to meet emergency needs:

> 54-1976-B. Resolved, that the following subtractions be made from the 1976 budgets of the indicated Association agencies and accounts and then be added to the Contingent Fund:

Expense Section

Dental Education, Council on		$ 5,000
Advanced Education	$ 1,000	
Salaries	4,000	
Educational Measurements, Division of		$ 9,000
Salaries	$ 9,000	
Hospital Dental Service, Council on		$ 2,000
Hospital Dental Service	$ 2,000	
Legislation, Council on		$ 3,250
Printing	$ 250	
Travel	3,000	
Licensure, Commission on		$ 5,000
Conferences	$ 1,000	
Salaries	4,000	

Nonoperating Disbursements Section

American Dental Association Health Foundation		$12,950
Administration	$ 950	
Research Institute	12,000	
Total		$37,200

The following resolution was adopted by the Board of Trustees:

55-1976-B. **Resolved**, that the following appropriations be made from the Contingent Fund and allocated to the line items in the budgets in accordance with the terms of the supplemental appropriation requests:

Expense Section

Dental Health Education, Bureau of		$ 2,000
Travel	$2,000	
Dental Society Services, Bureau of		$ 5,000
Postage and Mailing	$4,500	
Telephone and Telegraph	500	

Nonoperating Disbursements Section

*National Center for Health Education		$ 3,000
Total		$10,000

Authorization for Opening Bank Account for 1976 Annual Session: The following resolution presented by the Committee was adopted:

56-1976-B. **Resolved**, that Leo Kleck be and he is hereby authorized to open a bank account for the American Dental Association at the First National Bank of Nevada, and be it further

Resolved, that any two of the following persons be and they are hereby authorized to sign checks, drafts, or other orders for the payment of money drawn by the American Dental Association against its account at the First National Bank of Nevada:

C. Gordon Watson
James W. Etherington
Bernard J. Conway
John P. Noone
Leo Kleck

*The Board of Trustees approved the $3,000 grant to the National Center for Health Education with the provision that the National Center for Health Education elect to its Board of Directors a dentist who has been nominated by the ADA Board of Trustees.

Criteria for Awarding Assistance Grants: The Committee reported that at the March 1976 session of the Board of Trustees interim criteria for awarding assistance grants to health-related organizations and interim guidelines for determining the awarding of financial assistance to dental societies in support of litigation were adopted by the Board of Trustees. The Committee reported its opinion that the interim criteria and guidelines are workable documents and recommended their adoption as permanent policy. The Committee also recommended that the criteria and guidelines should be included in Board Report 1 to the House of Delegates.

After discussion, the following resolutions were adopted by the Board of Trustees:

57-1976-B. Resolved, that the following criteria are to be used for grant assistance by the American Dental Association to dental societies and/or other health-related organizations.

1. In the case of health-related organizations, the organization must be making significant contributions to the art and science of dentistry or to the policies and aims of the American Dental Association.
2. The financial aid requested is commensurate with the national benefit reasonably expected to result to the dental profession.
3. The dental society or other health-related organization has made every effort to obtain the funds needed from not only its own resources but other organizations as well, if feasible.
4. The need for additional funds is necessary and immediate.
5. Failure to obtain the requested funds from the American Dental Association would impair seriously the purpose for which the funds are needed.
6. Any request for grant assistance to support a project emanating from a component dental society is to be submitted through the component's constituent dental society, which, in turn, is to indicate the extent to which it is supporting the component's need for financial assistance.
7. A grant budget proposal and a concluding financial statement will be expected of all those applying for grants and those awarded grants.

58-1976-B. Resolved, that the following guidelines are to be used in determining financial assistance to dental societies by the American Dental Association in support of litigation.

1. A dental society has notified the Association of the litigation at a time which permits the agencies of the Association to be of maximum assistance in offering suggestions on the enforcement program or the litigation.
2. The dental society has made every reasonable effort to obtain the funds needed to sustain the litigation from its own resources.
3. The need for additional funds is immediate.
4. Failure to obtain additional funds would seriously impair the dental society's efforts to pursue the litigation to a successful conclusion.
5. The disposition of the issue or issues under litigation would have a direct and substantial impact upon the dental profession nationally.
6. The financial aid requested is commensurate with the benefit reason-

ably expected to result, on a nation-wide basis, from a favorable result of the litigation.

7. Any request for funds to support litigation emanating from a component dental society is to be submitted through the component's constituent dental society which, in turn, is to indicate the extent to which it is supporting the component's need for financial assistance.

8. A grant budget proposal and a concluding financial statement will be expected of all those applying for grants and those awarded grants.

Proposal for Sale and Leaseback of Headquarters Building: The Committee reported on the proposal for the sale and leaseback of the Association's Headquarters Building which was submitted by Chicago Properties Corporation on behalf of the American Farm Investor Services Company. The Committee reported that in its opinion the proposed sale-leaseback presented no advantage to the Association.

The following resolution was adopted by the Board of Trustees:

59-1976-B. **Resolved,** that the proposed sale and leaseback of the Association's Headquarters Building which has been submitted by Chicago Properties Corporation on behalf of American Farm Investor Services Company be rejected, and be it further

Resolved, that the appropriate parties be notified of the Association's decision.

Grant Request of the Women's Auxiliary to the American Dental Association: The following resolution was adopted by the Board of Trustees:

60-1976-B. **Resolved,** that the 1977 Budget be amended to include a $7,000 grant to the Women's Auxiliary to the American Dental Association, and be it further

Resolved, that the Women's Auxiliary to the American Dental Association be encouraged to renew its request annually for funding for the years 1978 and 1979 for such amounts as will be actually needed, based on experience, and be it further

Resolved, that the Women's Auxiliary to the American Dental Association be urged to increase its dues in order to become self-supporting.

Proposal Concerning Payments to Officers and Trustees: The Committee presented the following resolution which was submitted by Dr. Joseph A. Devine, 1976 delegate from Wyoming and past second vice-president of the Association.

Whereas, the officers and trustees of the American Dental Association have received no change in the amount of compensation for their travel, maintenance and other expenses since January 1, 1974 (*Trans.* 1972:500); and

Whereas, the expense of maintaining their private practices and the subsequent loss of personal income has increased dramatically since January 1, 1973; and

Whereas, as a consequence of the Association's officers being willing to make any reasonable sacrifice, the Association has an obligation to see that the sacrifice is just that *reasonable;* therefore, be it

Resolved, that, beginning after the close of the 1976 annual session, the officers and trustees will be compensated as follows, and the *Rules of the Board of Trustees* will be so amended:

A. President and President-Elect

Increase the stipend (from $100) to $250 per day and leave all the other conditions as they presently are allowed by the *Rules*.

B. Vice-Presidents

A stipend of $150 per day and an additional allowance of up to $100 for room, meals, gratuities, etc., as demonstrated by adequate records of the expense.

C Trustees

A stipend of $150 per day and an additional allowance of up to $100 for room, meals, gratuities, etc., as demonstrated by adequate records of the expense.

D. Treasurer and Speaker

A stipend of $150 per day and an additional allowance of up to $100 for room, meals, gratuities, etc., as demonstrated by adequate records of the expense.

and be it further,
Resolved, that the annual stipend for office expenses be increased as follows:

Trustee	Increase (from $2,400) to $5,000
Vice-Presidents	Increase (from $1,400) to $2,500
Speaker and Treasurer	Increase (from $1,400) to $2,500

The Board of Trustees was informed by the Committee that such a proposed stipend increase would cause a budget increase of $239,700. Therefore, the Board of Trustees voted to postpone indefinitely the resolution submitted by Dr. Devine. The negative vote of Dr. Eugene A. Savoie was recorded.

1977 Projected Income and Budget Requests as Presented by Association Agencies: The Committee reported as follows:

Income: In order to meet the Association's financial needs for 1977, income producing agencies were requested to project all realistic growth, if any, for each category of income under their control. Consequently, income for 1977 initially submitted by agencies amounted to $15,943,200, an increase of $582,250 over the 1976 projected income. At the administrative review of all agency budgets, projected income was further increased by $559,550. The total increase in the 1977 recommended income compared to 1976 is $1,141,800, and some of the larger increases are summarized as follows:

	1976 Income	1977 Recommended Income	Increase
Advertising	$ 1,072,000	1,255,000	183,000
Exhibit Space	600,000	675,000	75,000
Membership Dues	9,450,000	9,750,000	300,000
Underwriting	997,500	1,304,350	306,850
All Other Categories	3,241,450	3,518,400	276,950
	$15,360,950	16,502,750	1,141,800

Expenses and Nonoperating Disbursements: The 1977 budget requests submitted by all agencies of the Association totaled $18,269,600, or a 21.7 percent growth over the 1976 approved expenditure budget, resulting in a deficit of $2,326,400. The largest request was for the Public Education Program amounting to $1,796,000. This request was reduced at the budget administrative hearings to $700,000, a reduction of $1,096,000. Further reductions of $684,750 were made, which reduced the total 1977 expenditure requests to $16,488,850, resulting in a small surplus of $13,900. In accordance with the *Rules of the Board of Trustees,* a Contingent Fund of $478,300 representing approximately three percent of the total expenditure budget is included.

Amendment of "Organization and Rules of the Board of Trustees" and the "Standing Rules for Councils": The following resolutions were adopted by the Board of Trustees:

61-1976-B. Resolved, that the section entitled "Reimbursement for Air Travel" of the *Organization and Rules of the Board of Trustees* be amended by the addition of the following paragraph after the second paragraph of that section:

> All officers, members of the Board of Trustees or councils, staff, consultants or advisors are requested to travel by coach rather than first class whenever feasible.

62-1976-B, Resolved, that the section entitled "Reimbursement for Transportation Expense" of the *Standing Rules for Councils* be amended by the insertion of the following paragraph after the first full paragraph of that section:

> All officers, members of the Board of Trustees or councils, staff, consultants or advisors are requested to travel by coach rather than first class whenever feasible.

Recess: The Board of Trustees recessed for luncheon and reconvened at 1:45 PM.

Annual Session—Special Events: The following resolution presented by the Committee was adopted by the Board:

63-1976-B. Resolved, that the ticket price for the President's banquet at the 1977 Annual Session in Miami Beach be increased from $17.50 to $20.

Board of Trustees—FDI Delegates: The following resolution presented by the Committee was adopted by the Board of Trustees:

64-1976-B. Resolved, that the three elected members of the delegation to the *Fédération Dentaire Internationale* be paid on the basis of one hundred dollars ($100) per day for maintenance and the actual cost of transportation in partial reimbursement of their costs of attendance at the 1977 annual session of the FDI notwithstanding anything in the *Organization and Rules of the Board of Trustees* to the contrary, and be it further

Resolved, that the *Organization and Rules of the Board of Trustees* be amended by deleting the words "and the FDI National Treasurer for the United States" from the last paragraph under the section entitled "Delegation of *Fédération Dentaire Internationale*" on page 31 to make that paragraph now read as follows:

> The Board of Trustees shall place annually in the budget an appropriate sum to be allocated proportionally to the three elected members of the delegation in partial reimbursement of their costs of attendance at the annual session of the Fédération Dentaire Internationale when such sessions are held outside of the United States.

and be it further
Resolved, that the United States Section of the FDI be encouraged to pay the expenses of the Treasurer for attendance at the annual session of the FDI.

Committee on Finance and Investments, Supplemental Report—Recapture of Funds from Agency Budgets for Addition to Contingent Fund: The following resolution presented by the Committee was adopted by the Board of Trustees:

65-1976-B. Resolved, that the 1976 annual session opening meeting luncheon and reception for honored guests be cancelled and that the $3,500 saving realized for such cancellation be utilized to defray other 1976 annual session costs.

The Board of Trustees then adopted a motion that suitable arrangements be made for specially invited guests of the Association, including officers and members of the Board of Trustees, attending the annual session opening meeting and that funds be allocated from the annual session budget.

The Board noted that the Committee had requested the Executive Director to make every effort to reduce the number of staff members who were budgeted to attend the 1976 and 1977 annual sessions so that staff members whose attendance would not be absolutely required would be removed from the annual session attendance list for each year and the funds budgeted for their attendance would also be eliminated.

The Board of Trustees adopted the following resolution presented by the Committee:

66-1976-B. Resolved, that the following subtractions be made from the 1976 budgets of the indicated Association agencies and accounts and then added to the Contingent Fund:

Expense Section

Board of Trustees		$3,000
Travel (Board of Trustees reception for new and retiring officers and trustees)	$3,000	
Dental Care Programs, Council on		$ 600
Travel (staff associate's attendance at 1976 annual session)	$ 600	

Dental Health, Council on		$ 700
Travel (secretary's attendance at 1976 annual session)	$ 700	
Dental Society Services, Bureau of		$ 550
Travel (attendance at 1976 annual session of project director of Continuing Education Registry)	$ 550	
Dental Therapeutics, Council on		$ 600
Travel (assistant secretary's attendance at 1976 annual session)	$ 600	
Hospital Dental Services, Council on		$ 550
Travel (coordinator's attendance at 1976 annual session)	$ 550	
Licensure, Commission on		$ 600
Travel (coordinator's attendance at 1976 annual session)	$ 600	
Library Services, Bureau of		$1,100
Travel (attendance at 1976 annual session by the director and assistant director)	$1,100	
Underwriting		$ 600
Travel (one staff member's attendance at 1976 annual session for manning of ADA's publications booth)	$ 600	
Total		$8,300

Proposed Withdrawal from Reserve Division of General Fund to Pay Tax on Advertising Income: The following resolution presented by the Committee was adopted by the Board of Trustees:

> 67-1976-B. Resolved, that monies on hand in the Operating Division of the General Fund be utilized at this time to pay the Association's tax liability on advertising income realized for the period 1970-74, and be it further
> Resolved, that, in the event a cash shortage later appears likely in the Operating Division of the General Fund in 1976, alternate proposals be submitted to the Board of Trustees, through the Committee on Finance and Investments, requesting authority either to borrow the monies from a leading institution at the then current prime rate of interest or transfer monies from the Reserve Division to the Operating Division of the General Fund to satisfy the projected cash shortage.

1976 Grant Request from New Jersey Dental Association to Combat Legislative Efforts Favoring Fourth Party Dental Care Delivery Systems: The Committee reported as follows:

> The Board of Trustees at its August 1975 session authorized a contribution to the New Jersey Dental Association of $9,000 or one-half the legal costs incurred, whichever is less, in both defending and prosecuting court actions and administrative proceedings concerning the allegedly illegal dental and insurance practices of North American Dental Plans, Inc., and other similar fourth party operations (*Trans.* 1975:484). The New Jersey Dental Association's legal costs will exceed $18,000, and, therefore, the ADA will be contributing $9,000.
>
> In addition, a letter from Dr. Herbert N. D. Cahan, president of the New Jersey Dental Association, requesting an additional grant of $5,000 to assist the NJDA in its efforts to

meet legislative challenges, namely bills introduced in the New Jersey legislature at the behest of North American Dental Plans and supported by the AFL-CIO, purporting to exempt NADP and other fourth party programs from the provisions of the dental law and the dental service plan law, was reviewed by the Committee.

The 1975 House of Delegates adopted a resolution declaring that ". . . fourth party franchise dental delivery systems, whose control lies in the hands of non-professionals, are considered to be unethical within the scope of this Association . . ." (*Trans.* 1975:728). North American Dental Plans, Inc. is a fourth party plan under the control of non-professionals. If the proposed North American Dental Plans—AFL-CIO bills become law in New Jersey, a precedent will have been established for other state legislatures to follow in converting what formerly was regarded as illegal dental and insurance operations into legal endeavors. Therefore, the Committee recommends the following resolution for the Board of Trustees approval.

The following resolution was adopted:

68-1976-B. Resolved, that a $5,000 grant or one-half the cost, whichever is less, be made to the New Jersey Dental Association to help defray the expenses being incurred in educating the New Jersey legislature and administration concerning the untoward features of fourth party dental delivery systems whose control lies in the hands of non-professionals.

The negative vote of Dr. Floyd E. Dewhirst was recorded.

Revision to Proposed 1977 Budget of Council on Dental Education: The following resolution presented by the Committee was adopted:

69-1976-B. Resolved, that the proposed 1977 budget of the Council on Dental Education be revised to reflect the following addition:

Conference (workshop to revise guidelines related to teaching of pain and anxiety control) $2,000

Reimbursement of Association Representatives on Board of American Fund for Dental Health: The following resolution was adopted by the Board of Trustees:

70-1976-B. Resolved, that the representatives of the American Dental Association who are elected to the Board of Directors of the American Fund for Dental Health, commencing January 1, 1977, shall seek reimbursement for their expenses incurred when engaged on the business of the Fund from the Fund rather than the Association.

Other Revisions to Proposed 1977 Budget: The following resolution presented by the Committee was adopted:

71-1976-B. Resolved, that the proposed 1977 budgets of the following indicated accounts be revised to reflect the following reductions:

Expense Section

Central Administrative	$16,650
Pensions and Annuities (Association contribution to pension plan)	$16,650

Nonoperating Disbursements Section
Grants

American Association for Accreditation of Laboratory Animal Care	$ 2,500
Total	$19,150

NEW BUSINESS

Request of Washington State Dental Association for a Grant to Combat Anti-Fluoridation Initiative: The Board of Trustees reviewed a request from the Washington State Dental Association for a $15,000 grant for use in helping defeat the public initiative which will be placed on the November 2, 1976 ballot in the State of Washington to make fluoridation of any public water supply in the State of Washington unlawful. It was noted that the estimated cost of the proposed program to educate the public on the merits of fluoridated water is $125,000-$130,000. The Washington State Dental Association is committing $20,000 and the state medical association is contributing $15,000 to the program and additional funds will be sought from other sources.

The Board of Trustees adopted the following resolution:

> 72-1976-B. Resolved, that a grant of $15,000 be made to the Washington State Dental Association to assist the campaign to defeat the proposed initiative to make the fluoridation of any public water supply in the State of Washington unlawful.

EXECUTIVE MEETING

WEDNESDAY, AUGUST 18, 1976

Call to Order: An Executive Meeting of the Board of Trustees was convened at 3:34 PM, Wednesday, August 18, President Robert B. Shira presiding.

Roll Call: Those present were the President, President-elect, First Vice-President, Second Vice-President, Treasurer, Speaker of the House of Delegates, all members of the Board of Trustees and the official reporter.

The Board of Trustees discussed the programs and budget of the American Dental Political Action Committee (ADPAC).

Adjournment: The Executive Meeting was adjourned and the regular meeting of the Board of Trustees convened.

REPORT OF COMMITTEE ON FINANCE AND INVESTMENTS

Approval of Annual Budget for 1977: The following resolution was adopted by the Board of Trustees and ordered transmitted to the House of Delegates with the recommendation that it be approved:

> 87. Resolved, that the 1977 Annual Budget of Income, Expense (excluding depreciation) and Nonoperating Disbursements be approved and transmitted to the House of Delegates, and be it further
> Resolved, that building and building furniture and equipment depreciation in the amount of $286,000 and depreciation on other furniture and equipment of the American Dental Association in the amount of $166,000 be approved and transmitted to the House of Delegates.

Dues Increase for Active Members: The Committee reported as follows:

> During the course of its deliberations over the financial affairs of the Association, the Committee was immediately struck with and constantly reminded of the lack of funds necessary to implement programs vital to the continued progress and well being of organized dentistry. While reviewing the 1977 agency requests and administrative recommendations, the Committee was cognizant of cut backs in existing programs and the inhibition of necessary growth in contemplated future program activities. The comments contained in the Budget modifications demonstrate, to some extent, the effect on the various Councils and agencies of the financial constraints necessary to balance the budget. Exclusive of the Public Education Program the Administrative Review reduced the agency askings by $684,750. The Committee made further reductions in the amount of $52,550. In some instances, such as reducing travel budgets to reflect coach rather than first class accommodations, no adverse effect on Association activities is contemplated, however, in other areas, while the full impact cannot be known at this time, a definite adverse reaction will occur.
>
> Of greater alarm to the Committee, however, is the fact that dramatic changes have and continue to take place in the public's attitude toward the professions. Dentistry is no less affected by this change than the other professions. Regulatory agencies such as the Justice Department, Federal Trade Commission, Internal Revenue Service, Food and Drug Administration and state attorneys general have all reacted to the age of consumerism with greater involvement in the affairs, both external and internal, of professional associations. The explosion of prepaid dental care programs, peer review, manpower legislation and the illegal practice of dentistry are but a few of the challenges dentistry is facing. It is critical to understand that these challenges are part of the present. They are here now and must be faced here and now. Delays in meeting these issues for financial reasons could be calamitous since it is the future of each and every member of the Association that is at stake. It must be recognized that those groups whose interests are incompatible with those of organized dentistry will not declare a moratorium on their activities until such time as dentistry deems fit to meet the challenges. While reasonable minds may differ over the best means to meet the challenges, reasonable minds cannot differ over the necessity to meet them now. . . .
>
> The Committee is of the opinion that a $30 dues increase, to be effective January 1, 1977, is necessary. The Committee is aware that this would require unanimous approval of the

1976 House of Delegates. Additional revenues for the years 1978-1980 will be necessary whether or not the House of Delegates unanimously agrees to a dues increase in 1977. To some extent the amount of additional revenues necessary will depend on the House action regarding the dues increase request for 1977. Therefore, the Committee recommends the following resolutions for the Board of Trustees consideration for transmittal to the House of Delegates.

The following resolution presented by the Committee was postponed indefinitely:

Resolved, that Chapter I, Section 50A of the *Bylaws* be amended by the deletion of the words and figures "one hundred dollars ($100.00)" and insertion in lieu therefor of the words and figures "one hundred thirty dollars ($130.00)" to make the amended section read as follows:

> **A. Active Members.** The dues of active members shall be one hundred thirty dollars ($130.00) due January 1 of each year.

and be it further
Resolved, that increased active members dues become effective January 1, 1977.

After extensive discussion, the following resolution was adopted and ordered transmitted to the House of Delegates with the recommendation that it be approved.

88. **Resolved**, that Chapter I, Section 50A of the *Bylaws* be amended by the deletion of the words and figures "one hundred dollars ($100.00)" and insertion in lieu therefor of the words and figures "one hundred seventy-five dollars ($175.00)" to make the amended section read as follows:

> **A. Active Members.** The dues of active members shall be one hundred seventy-five dollars ($175.00) due January 1 of each year.

and be it further
Resolved, that increased active members dues become effective January 1, 1978.

Dr. Faust abstained from voting.

Recess: The Board of Trustees recessed at 4:40 PM.

THURSDAY, AUGUST 19, 1976

Call to Order: The meeting of the Board of Trustees was called to order at 8:00 AM by President Shira.

Roll Call: The officers, members of the Board of Trustees and members of staff were present as previously recorded.

REPORT OF COMMITTEE B

The report of Committee B was read by Dr. Phillips, chairman. The other members of the Committee were Drs. Dewhirst, Griffiths and Gruber.

Report of Council on Dental Care Programs: The Committee reported as follows:

Report: Committee B has considered the annual report of the Council on Dental Care Programs and wishes to express its appreciation to Dr. Ellwood F. Davidson, retiring vice chairman of the Council, for his many contributions to the advancement and improvement of dental care programs and to the Association.

The Committee was pleased to receive information from its Chairman that, on the basis of attendance at two meetings of the Council since its expansion to fourteen members, the enlarged Council is functioning effectively and conducting its business with appropriate dispatch.

Professional Standards Review Organizations: The Committee noted the continuing pending status of the Association's proposed amendments to the PSRO law, which remain under consideration in the Senate, and urges a sustained effort by all appropriate agencies of the Association to obtain legislative action to correct the discriminatory aspects of this law.

Report of Council on Dental Care Programs, Supplement 1 to Board: The Committee reported as follows:

Medicare/Medicaid: The 1975 House of Delegates (*Trans.* 1975:735) requested the Board of Trustees to study the feasibility of developing a legislative draft for a national program of dental care for indigent persons and to report on that matter to the March 1976 session of the Board of Trustees.

At the March 1976 Board session, Committee D reported that, in its view, preparation of a legislative draft would not be an appropriate approach but that, instead, the Councils on Dental Care Programs and Dental Health should undertake review of existing Association policy relative to Titles XVIII and XIX of the Social Security Act, together with relevant experience under those two Titles with respect to dental care, and propose such actions as they deem appropriate.

Work by the two Councils began in mid-1976. In addition to compilation and review of existing policy, meetings have been held with HEW officials and, in July and August, two pilot conferences on dental problems related to Medicaid in Illinois and Ohio were held under the joint sponsorship of the Association and the Social and Rehabilitation Service Administration of the Department of Health, Education, and Welfare involving representatives of the respective state agencies and constituent dental societies. It is hoped that additional conferences of this type can be held elsewhere in the nation. The Councils submitted a progress report to the August 1976 session of the Board of Trustees and are continuing with their efforts.

Committee B reviewed the progress report submitted by the Council on Dental Care Programs. The Committee concurs with the action of the Council in rejecting the draft resolution studied at its June 30-July 1 meeting because there is not yet definitive information with respect to the economic status of the elderly as a categorical group. The Committee does agree that the question of economic status, particularly with respect to Title XVIII which presently has no provision for a means test, is a substantive issue that deserves the careful study being afforded it by the Council. The Committee notes that the progress report is for the information of the Board.

Report of Council on Dental Care Programs, Supplement 1 to House: The Committee reported as follows:

UCR and Table of Allowance: Committee B reviewed the supplemental report of the Council on Dental Care Programs to the House of Delegates, evaluating the relative merits of the usual, customary and reasonable fee and table of allowance reimbursement mechanisms, which was directed by the 1975 House of Delegates (*Trans.* 1975:661). The Committee was impressed with the comprehensive nature of the study, noting the advantages and disadvantages of each method as reported by representatives of the profession, major purchasers of insurance brokers, as well as the substantial preference for the UCR method, expressed by the profession in the Fall, 1975, *Survey of Dentists.*

The Committee concurs in the view of the majority of respondents to the Council's survey that the UCR method possesses the capability of providing the more substantial benefit to the patient. The Council's observation that any dental prepayment plan, regardless of the reimbursement mechanism utilized, can be ineptly administered and that responsible design, including absolute clarity in presenting the program's benefits and exclusions, is the first essential of a satisfactory plan, is fully supported by Committee B. The Committee stresses that proper administration is always fundamental. This concern is expressed throughout the *Standards for Dental Prepayment Programs* (*Trans.* 1974:639). The Committee does not believe that it need be specifically stated with regard to payment mechanisms. Accordingly, Committee B proposes the following substitute resolution for Resolution 44 of the Council and recommends that it be transmitted to the House of Delegates.

The following resolution was ordered transmitted to the House of Delegates with the recommendation that it be substituted for Resolution 44 and that the substitute resolution be adopted:

44B. Resolved, that the *Standards for Dental Prepayment Programs* (revised November, 1974—*Trans.* 1974:639) be amended by substituting the following standard for Standard 21:

> 21. The usual, customary and reasonable fee reimbursement method is preferred but other methods, such as a table of allowance, are acceptable.

Report of Council on Dental Care Programs, Supplement 2 to House: The Committee reported as follows:

Delta Dental Plans: Committee B wishes to commend the Council on Dental Care Programs for the thorough, exhaustive report it has prepared on the relationship of the Association to Delta Dental Plans, which was directed by the 1975 House of Delegates (*Trans.* 1975:666). The Committee believes that the historical context which the report provides will be of particular value to all members of the profession when dealing with this issue.

The Committee notes further that, while individual members of the Committee may wish to address themselves to one or more particular aspects of the issue, the report provides an exceptionally fine context for overall consideration by all concerned individuals in the Reference Committee hearing and floor discussion at the 1976 House of Delegates.

In reviewing the financial record of loans to Delta Dental Plans from the Association, the Committee is pleased to see that no request for loans, or grants, was made for 1976 or has been made for 1977. In that regard, the Committee would recall the comment made in the Board of Trustees Report 2 in 1975 (*Trans.* 1975:323) that "Delta's achievement of self-supporting status may make possible in the near future a discussion of a repayment schedule of its loans from the Association." The Committee believes that the Association should initiate such discussion soon.

Of the twelve recommendations that are part of the Council report, the Committee was pleased to learn that action has already occurred on the seventh recommendation and that Delta Dental Plans has asked the Council on Dental Care Programs to designate a member to serve in a liaison position with Delta. The Council has, for 1976-77, appointed Dr. William A. Booth to that post. The Committee strongly recommends that Delta Dental Plans now urge all of its member plans to develop a similarly close, formal liaison with the appropriate councils of the respective constituent societies.

> The Committee was most impressed with those aspects of the report which noted that failures in communication were a particularly troublesome source of problems. In order to reinforce the need for timely action to solve this difficulty, the Committee believes that a formal resolution would prove helpful and, consequently submits the following resolution and recommends that it be transmitted to the House of Delegates.

After discussion, the Board of Trustees adopted the following resolution and ordered it transmitted to the House of Delegates with the recommendation that it be adopted:

> 75. **Resolved,** that Delta Dental Plans be urged to expand and improve its program of public and professional relations, the intent of which should be the establishment of thorough and consistent communications between the Delta plan and the members of the profession.

The Board also adopted a motion authorizing the President to contact Delta Dental Plans Association regarding a repayment schedule of the loans Delta has received from the Association.

Report of Council on Dental Care Programs, Supplement 3 to House: The Committee reported as follows:

> Committee B considered, at length, the supplemental report of the Council on Dental Care Programs on its study conducted in response to a directive of the 1975 House of Delegates (*Trans.* 1975:656). The Committee was impressed with the analysis of reimbursement differentials vis-à-vis patients' freedom of choice as delineated in the report. The Committee shares the Council's concern that a differential may become so great as to interfere with the patient's freedom of choice. However, a majority of Committee B supports the Council's conclusion that, in service benefits plans, the services provided by the participating dentist and the obligations that he frequently accepts justify some differential in reimbursement. Accordingly, by a vote of 3 to 1, the Committee recommends that the following resolution be transmitted to the House of Delegates with the recommendation that it be postponed indefinitely.

The following resolution, Resolution 46-1975, was ordered transmitted to the House of Delegates with the recommendation that it be postponed indefinitely:

> 46-1975. **Resolved,** that the freedom of choice statement adopted by the House of Delegates in 1965 (*Trans.* 1965:354) and cited in the 1975 booklet, "Policies on Dental Care Programs," page 14, be amended by deleting the phrases "within the agreed limitations of the plan" and "within the same limitations" and adding the following sentence:
>
> > To assure the patient's freedom of choice of dentist, the Association considers it improper and unacceptable to the dental profession any time a third party limits reimbursement in any way due to a dentist not signing a contractual agreement.
>
> and be it further
> **Resolved,** that this statement be included in all appropriate policy statements of the Association (e.g., in "Policies on Dental Care Programs": General Statements on Prepayment, pages 15-16; Methods of Payment, pages 26-27; and Joint Statement of AFL-CIO and ADA, pages 44-45).

Report of Council on Dental Care Programs, Supplement 4 to House: The Committee reported as follows:

Diverse Prepayment Policy Report: Committee B noted with interest the interim report of the Council on Dental Care Programs concerning its efforts to fulfill the request of the 1975 House of Delegates (*Trans.* 1975:648) "to undertake a study of the prepayment experience of dental practices in states with diverse policies." In the Committee's view, the overall approach taken by the Council was appropriate and could be expected to elicit meaningful information. The Committee regrets that agreement on conduct of the survey in question has not yet been achieved, but it is pleased to note that the Council is continuing discussions with the constituent societies involved in the hope that differences can be satisfactorily resolved. The Committee joins in that hope and expects to receive a further report from the Council for consideration at its November 1976 meeting.

Report of Council on Dental Health: The Committee reported as follows:

Report: Committee B commends the Council for its work as reflected in its annual report and comments on selected issues only.

The Committee wishes especially to commend Dr. James Catchings for his service to the Council during the past six years.

Guidelines on Hypertension Detection: The Committee carefully considered the report of the revision of the guidelines for dentists on hypertension detection as directed by the 1975 House of Delegates (*Trans.* 1975:676) and concluded that the new guidelines are largely responsive to the House directive. However, the Committee believes the guidelines could be further improved by changing item 2 of the revised guidelines in order to make clear that it is "in-service" training that is being discussed, especially with respect to dentists, and to focus on the local chapters of the American Heart Association as a source for consultation. The amended item 2 would then read:

> 2. Dentists and dental auxiliaries desiring in-service training in the technique of taking blood pressure should consult with local chapters of the American Heart Association.

The Board of Trustees adopted a motion to amend item 2 to read as follows:

> 2. Dentists and dental auxiliaries desiring in-service training in the technique of taking blood pressure should consult with local chapters of the American Heart Association or other recognized authorities.

The following resolution was ordered transmitted to the House of Delegates with the recommendation that it be substituted for Resolution 5 and that the substitute resolution be adopted:

> 5B. Resolved, that the *Suggestions for Dentists on Participating in the National High Blood Pressure Education and Screening Program* be approved as amended.

The report of the Committee continued as follows:

National Health Service Corps: The Committee considered the *Statement on National Health Service Corps* and believes that it will prove helpful to local and state dental societies making decisions on placement of Corps personnel, especially when used in conjunction with the guidelines being now formulated by the Council.

Resolution 6 was ordered transmitted to the House of Delegates with the recommendation that it be approved.

Report of Council on Dental Health, Supplement 1 to Board: The Committee reported as follows:

> ADA Liaison with Center for Disease Control: Committee B noted with interest the Council report of its recent liaison meeting with the National Center for Disease Control (CDC) and, in particular, the newly formed dental unit, the Dental Disease Prevention Activity. The Committee is pleased to learn of CDC's commitment to the overall goals of preventive dentistry and its particular commitment to fluoridation but is concerned that the present effort is too little to continue a successful fluoridation campaign throughout the country. The Committee's concern stems, in part, from the fact that the preventive dentistry unit does not have a line item in the CDC budget and recommends to the Board that it may wish to request the Washington Office to investigate it being awarded such status.
>
> The Committee believes fluoridation to be in more difficulty than it has been for some time, one piece of evidence being the upcoming anti-fluoridation referendum in the State of Washington. Committee B urges the Council to continue its liaison activities to ensure that the new dental unit is accorded the resources it must have if it is to carry out its duties fully.

The Board of Trustees adopted a motion requesting the Washington Office to investigate the possibility of a line item in the National Center for Disease Control budget for the preventive dentistry unit and fluoridation.

Report of Bureau of Audiovisual Service: The Committee reported as follows:

> Committee B commends the Bureau for its increased services to both the public and the profession as evidenced by the continuing increase in film circulation. The Committee took special note of the increase in film rentals and the increased television audience.

Report of Bureau of Dental Health Education: The Committee reported as follows:

> Committee B reviewed the Bureau's extensive and comprehensive report and was impressed by the scope of its activities.
>
> The Committee noted that the Bureau has cooperated with the American Society for Geriatric Dentistry which has entered into a contract with the Division of Long Term Care, Department of Health, Education, and Welfare in developing a seminar program on oral health care for geriatric nursing home residents. The Committee was pleased to learn of the liaison among all Association agencies such as the Council on Hospital Dental Service particularly in regard to institutional programs.

Report of Bureau of Economic Research and Statistics: The Committee reported as follows:

> Committee B studied the report of the Bureau, documenting its considerable range of activities and projects. Particular note was made of progress on the *Price Index of Cost of Conducting a Dental Practice,* the manpower research activities and the project concerning redistribution of dentists. The Committee compliments the Bureau on the quality and extent of its activities.
>
> The Committee recommends that a report on the results of the study of the impact on redistribution of dentists resulting from a system of national reciprocity (*Trans.* 1975:720) be presented to the Board in November 1976 so that it may be received by the 1976 House of Delegates.

Report of Bureau of Economic Research and Statistics, Supplement 1 to Board: The Committee reported as follows:

Feasibility Study of Research to Investigate the Effect of Eliminating the Economic Barrier on the Demand for Dental Care: The Committee reviewed the detailed reasons given in this report for the general conclusion that it is not feasible for the Association to undertake an economic barrier study at this time.

It was noted that recent activities of the Department of Health, Education, and Welfare indicate a renewed interest in funding, on a competitive basis, a study to determine the impact of dental prepayment in terms of health and cost benefits and that Association staff is considering possible responses to this request for research proposals. This indication from the federal government that funding of this type of research is potentially available does not materially affect the general recommendation of the Bureau, since a separate effort by the Association alone would still be too costly, time consuming and duplicative of efforts currently being accomplished through other sources.

The Committee agrees that the Bureau must work in close cooperation with outside agencies performing research in this area. One limitation of Bureau research is, of course, the availability of funds. The Committee recommends the placing of a high priority on available funds for these projects.

Report of Bureau of Economic Research and Statistics, Supplement 1 to House: The Committee reported as follows:

Index of Cost of Conducting a Dental Practice: Committee B reviewed with considerable interest the *Index* which it believes will be a significantly useful tool for the profession. The Committee notes that information derived from the *Index* was used by President Shira in testimony on July 20 before the Federal Council on Wage and Price Stability and that it provided valuable documentation for the Association's position. The Committee understands that the *Index* will need continuous evaluation and at least yearly updates to keep it current. Since there are several specific indices that constitute the *Index,* it is the opinion of the Committee that the measurement will reflect a realistic, precise and comprehensive picture of the actual cost of operating a dental practice. The thoroughness of developing the *Index,* as explained in the Appendix, demonstrates the degree of validity the Association can attach to its use. The Committee looks forward to revision and evaluation activities during 1977 since the 1977 *Survey of Dental Practice* will provide additional data for use in the *Index.*

Dental Health Policy Statement of the Fédération Dentaire Internationale: The Committee reported as follows:

Committee B reviewed the Dental Health Policy Statement of the Fédération Dentaire Internationale and believes that several amendments are still necessary in the document. The Committee noted that several recommendations that had been previously made have not been incorporated. These are:

the word "all" not deleted as recommended (footnote 6, Introduction line 16);

the word "Need" not substituted for "Demand" as recommended (footnote 9, paragraph 1);

The word "need" not substituted for the words "growing demand" as recommended (footnote 10, paragraph 1);

the word "public" not deleted as recommended (footnote 22, paragraph 3.3);

the entire paragraph 4.2, not deleted as recommended (footnote 28, paragraph 4.2).

Committee B believes the following additional changes will improve the statement: substitute the words "health authorities" for "governments" (paragraph 6.5); substitute the word "health" for "medical" (Introduction, line 19). The Committee urges the Board to request this further revision of the statement and to ask the Association's delegation to the FDI to pursue these changes during the 1976 FDI meeting.

In view of the discussion the Committee recommends that Resolution 354 be amended by the replacement of the word "final" by "appended" and the replacement of the word "approved" by "received," and that the resolution be approved as amended.

The following resolution was adopted by the Board of Trustees:

73-1976-B. **Resolved**, that the appended version of the Dental Health Policy Statement of the Fédération Dentaire Internationale, as amended by member associations, be received.

DENTAL HEALTH POLICY STATEMENT OF THE FÉDÉRATION DENTAIRE INTERNATIONALE

(Incorporating the amendments received from member associations to the final version produced in Chicago by the Committee of Commission Officers)

Introduction

The Fédération Dentaire Internationale (FDI) founded in 1900, unites at world level national and regional dental organizations and supporting members who wish to advance together the science and art of dentistry and the standing of the dental profession in society.[1]

The Fédération Dentaire Internationale is the only non-governmental international organization of dentists in official relations with the World Health Organization and is a federation of national dental associations.[2] Its major objective is full cooperation with its affiliated organizations, WHO and other bodies, to achieve the highest possible level of oral and general[3] health for all people of the world.

The Fédération Dentaire Internationale promotes, at the same time, the efforts of the national dental organizations[4] from all parts of the world which are voluntary members of the FDI, its affiliated specialist societies, regional secretariats and other institutions to achieve the highest possible level of oral and general health of the peoples[5] of the world. It also welcomes all[6] efforts made through national and international dental programmes and by state and other institutions to improve oral and general health.

The Fédération Dentaire Internationale defines dentistry, a medical profession,[7] as the science and art of preventing, diagnosing and treating diseases and malformations of and injuries to the teeth, mouth and jaws, and of replacing lost teeth and associated structures.

The FDI requests its member associations to bring the following statement of policy to the attention of their individual members and governmental[8] health administrations.

---

[1]Paragraph inserted
[2]The ward "associations" substituted for "organizations"
[3]The words "oral and general" inserted
[4]The word "organizations" substituted for "associations"
[5]The ward "peoples" substituted for "people"
[6]The word "all" not deleted as recommended
[7]The words ", a medical profession," inserted
[8]The word "governmental" substituted for "national"

Policies

1. Demand[9] for Oral Health Care

People everywhere are becoming more and more aware of the significance of oral health care. This leads to a growing demand[10] throughout the world for increased and improved oral health services.[11] The FDI therefore requests:

1.1. All member associations, members of the dental profession and all national and international institutions and persons active in and responsible for health matters, to recognize these changes and aim at providing the best possible level of oral health for the people of the world.

Note: In countries where oral health care is provided by stomatologists, the terms "stomatology", "stomatologist" and "stomatological" are interchangeable for "dentistry", "dentist" and "dental" in the above policy statement, in accordance with the resolution of the FDI General Assembly in 1962 defining the equal competence of dentists and stomatologists.[12]

and

1.2. Member national associations to accept a co-responsibility for sharing as far as possible[13] academic and technical[14] knowledge[15] with developing countries in support of the establishment and growth of oral health care programmes.

2. Dentistry in Relation to General Health

Dentists have a responsibility to promote the general as well as the oral health of the population[16] they serve. Therefore, the FDI encourages dentists to be watchful for oral and general manifestations of ill-health and to refer patients so affected for appropriate care.

3. Prevention

In most countries of the world dental manpower resources are insufficient to provide the volume of dental care[17] needed. Dental services which give priority to the treatment[18] of oral diseases often do not reduce their prevalence. The FDI threfore:

3.1. Requests its member associations to draw the attention of their members and health authorities[19] to the need to promote oral health and prevent[20] oral diseases.

3.2. Encourages member associations and dental personnel to give priority to the broad application of all known procedures for preventing oral diseases and conditions through their own programmes of oral health education or through appropriate community or government sponsored preventive programmes.

3.3 Pledges its support for the development and[21] implementation of public[22] health measures for the prevention of all oral conditions detrimental to health. An example of one such measure is embodied in the following statement from the World Health Organization: "Optimization of the fluoride content of water supplies remains the most effective known means of preventing dental caries."

---

[9]The word "Need" not substituted for "Demand" as recommended

[10]The word "need" not substituted for the words "growing demand" as recommended

[11]Original paragraph read "In view of the growing demand throughout the world for increased and improved oral health services, the increasing awareness of people everywhere of the significance of oral health care, the FDI requests:"

[12]Note inserted

[13]The words "as far as possible" inserted

[14]The words "academic and technical" inserted after the word "sharing" as recommended

[15]The words "and resources" following the word "knowledge" deleted as recommended

[16]The words "communities in which" substituted for "population"

[17]The word "care" substituted for "services"

[18]The words "give priority to the treatment" substituted for the words "concentrate on the consequences"

[19]The words "members and health authorities" substituted for "governments"

[20]The words "promote oral health and prevent" substituted for the words "reduce the prevalence of"

[21]The words "development and" inserted

[22]The word "public" not deleted as recommended

4. Dental Manpower

A shortage or maldistribution of dental manpower in most countries is a major obstacle to bringing to all people[23] the highest possible level of oral health. In providing adequate dental health services there is, therefore, a need to make the most effective use of existing and future manpower by increasing efficiency and productivity under the best possible working conditions.[24]

The FDI requests its member associations to help solve this problem by communicating with their health authorities[25] regarding:

4.1. The pattern, the prevalence and the[26] incidence of oral diseases and malformations[27] in their countries.

4.2. Their respective responsibilities in seeing that services are available to meet the oral health needs of the population.[28]

4.3. The principle that establishment of any dental care programme to meet the effective demand[29] of the population must be based on the provision of adequate physical and financial resources for the education and maximum use[30] of sufficient[31] dental practitioners[32] as leaders[33] of a[34] dental health team.

The FDI affirms that:

4.4. Essential members of the dental health team include dental laboratory technicians and chairside assistants.[35]

4.5. According to local needs, legislation and professional policies, various categories of operating auxiliary personnel may also form part of the team.[36]

4.6. Duties of all auxiliary[37] personnel should be determined according to local conditions and legislation with the approval and sanction of the dental organization concerned.[38]

4.7. Auxiliary[39] members of the dental health[40] team should carry out the tasks for which they are qualified under the responsibility, direction and direct[41] supervision of the dentist.

Note: Operating auxiliaries have restricted rights to operate directly on the patient.[42]

5. Education

The provision of oral health care of the population is influenced by a changing complex of interacting social, medical, technical and economic factors which vary from country to country. The focal point for the interaction of these factors is dental practice. University dental education should take this into account.[43] The FDI therefore:

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[23]The words "of the world" deleted

[24]The words "by increasing efficiency and productivity under the best possible working conditions" inserted

[25]The words "health authorities" substituted for "governments"

[26]The word "the" inserted

[27]The word "malformations" substituted for "disabilities"

[28]Entire paragraph not deleted as recommended

[29]The words "effective demand" substituted for "needs" as recommended

[30]The word "use" substituted for "utilization"

[31]The word "sufficient" inserted

[32]The words "and appropriate auxiliary personnel within the concept" deleted

[33]The words "as leaders" inserted

[34]The word "a" substituted for "the"

[35]Paragraph inserted

[36]Paragraph inserted; deleted the paragraph "4.4. The importance of meeting any shortages and maldistribution of professional manpower by supporting the development and use of auxiliary personnel as members of the dental team."

[37]The word "auxiliary" substituted for the words "non-professionally qualified" as recommended, and the word "all" inserted

[38]The words "with the approval and sanction of organized dentistry" were inserted as recommended, except that "organized dentistry" was changed to "organizations concerned."

[39]The word "Auxiliary" inserted

[40]The words "the dentol health" substituted for the word "that"

[41]The word "direct" inserted as recommended

[42]Note inserted

[43]This sentence substituted for the sentence "The educational systems and content need to reflect this dynamic complex."

5.1. Urges its[44] member associations to work with education and health authorities to design academically sound curricula for undergraduate education. These must prepare dentists to provide services to meet the needs of the population.[45]

5.2. Recommends that new professional, biological, technical, ergonomic, sociopsychological and managerial developments and concepts be continually evaluated for possible inclusion[46] in the dental curricula when appropriate.

5.3. Recommends that member associations develop and foster continuing education and other[47] means for maintaining and improving[48] the[49] professional and managerial competence of dentists.

5.4. Recommends that the dental profession press for the best possible conditions for the provision of dental education.

6. Research

Changes in social, political and economic conditions influence the health needs and demands of populations. Consequently they[50] create a necessity[51] for a continued[52] search for new or[53] improved methods to meet[54] the changing oral health care problems of the world. The FDI therefore:

6.1. Recognizes the essential relationship between oral health care systems and biomedical research.

6.2. Encourages investigations in the medical, biological, physical, chemical, ergonomic, technical and behavioral sciences relevant to dentistry.

6.3. Supports all appropriate research on means of improving manpower development, the organization of oral health care systems, dental health education, specialist education, continuing education and inter-disciplinary cooperation.

6.4. Encourages all member associations to assume leadership in developing research programmes[55] on their own initiative and to participate in the continuous development of systems for evaluating and improving the quality and quantity of oral health care.

6.5. Encourages science and industry to concern itself continuously with the development and standardization of high quality, durable and appropriate equipment, instruments, materials and therapeutic agents.[56] Member associations and governments are requested to support or initiate programmes and procedures that promote this objective.

7. National Planning

Policy decisions by health authorities[57] on matters affecting the oral health of the people should be based upon advice generated from consultation between representatives of all health services and national dental organizations. The FDI recommends that:

7.1. Member associations take the initiative in offering guidance and assistance in the planning of dental care programmes and related activities.

7.2. Official health institutions—national and international—be encouraged to establish[58] an oral health unit headed by a dentist who is responsible for the organization and administration of the oral health programme.

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[44]The word "its" inserted

[45]The words "the needs of the population" substituted for the words "local needs"

[46]The words "for possible inclusion" substituted for the words "and included" as recommended

[47]The words "continuing education and other" inserted

[48]The words "and improving" inserted

[49]The word "continued" deleted

[50]The words "Consequently they" substituted for "and consequently"

[51]The word "necessity" substituted for "need"

[52]The word "continued" substituted for "continuing"

[53]The words "new or" inserted

[54]The words "to meet" substituted for the words "for meeting"

[55]The word "programmes" inserted

[56]The words "and therapeutic agents" substituted for the words "drugs and other aids"

[57]The words "health authorities" substituted for "governments"

[58]The words "Official health institutions—national and international—be encouraged to establish" substituted for "In any public health service there be"; recommended substitution of the word "department" for "service" negated by substitution

7.3. Member associations advise their health authorities[59] on the priorities that should be established not only regarding those who require oral health care, but also on the proper balance between health education, prevention and treatment services and on the type and quality of the services that should be provided.

7.4. Member associations urge health authorities[60] to consider the concept of oral health as a fundamental part of the state of complete physical, mental and social well-being of the individual.

Joint Report of Council on Dental Care Programs and Council on Dental Health on Cosmetic Dentistry: The Committee reported as follows:

> Committee B reviewed the statement of the two Councils concerning the question of cosmetic dentistry and believes that the statement will prove useful to the Association in its continuing attempts to resolve this issue in accordance with sound professional opinion. The Committee believes, however, that it would be more useful if the House of Delegates were asked formally to accept a definition of cosmetic dentistry. Accordingly, the Committee offers the following resolution and recommends that it be transmitted to the House of Delegates.

After discussion, the Board of Trustees adopted the following resolution and ordered it transmitted to the House of Delegates with the recommendation that it be approved:

> 76. **Resolved**, that cosmetic dentistry be defined as "those dental services which are performed solely for the purpose of improving appearance. Treatment performed to improve form or function or to prevent or correct pathologic conditions is not cosmetic," and be it further
>
> **Resolved**, that notice of this action be given to all parties involved in dental prepayment, and be it further
>
> **Resolved**, that this definition be included in the next revision of the Council on Dental Care Programs' Glossary of Dental Prepayment Terms.

Report of Delta Dental Plans Association: The Committee reported as follows:

> **Report:** Committee B reviewed with interest the annual report of Delta Dental Plans Association and noted the progress of DDPA as described therein.
>
> The Committee commends DDPA for its efforts during its first decade of existence to educate and influence the profession, the public and third party carriers on prepaid dental care. Especially noted by the Committee was DDPA's modification of its definition of Reasonable Fee to incorporate a concept under which a "usual" fee exceeding the 90th percentile limitation on the "customary" fee range may be accepted.

Amendment of ADA "Standards for Dental Prepayment Programs"—Arkansas State Dental Association: The Committee reported as follows:

> Committee B reviewed with interest Arkansas Resolution 54 which would amend the *Standards for Dental Prepayment Programs* (revised November 1974—*Trans.* 1974:639) by adding a statement to the effect that schedules of benefits be as uniform as possible, particularly within a single state.
>
> The Committee notes the inequities which are caused by the improper implementation of a multi-level table of allowance plan on a national basis. Further, it observes that reported inequities in several states since implementation of the telecommunications prepayment pro-

[59] The words "health authorities" substituted for "governments"
[60] The words "health authorities" substituted for "governments"

gram in January 1976 are being pursued by the Council on Dental Care Programs. While the Committee questions the appropriateness of placing in the *Standards for Dental Prepayment Programs* the profession's concerns regarding what is essentially an administrative problem, it considers the concerns themselves central to the Council on Dental Care Programs' responsibilities. The Committee, therefore, recommends that Arkansas Resolution 54 be transmitted to the House of Delegates with the recommendation that it be referred to the Council on Dental Care Programs for action and report back in 1977.

The Board was advised that any additional information regarding the Council on Dental Care Programs' activities in this regard would be reported to the Board at its November 1976 session.

Resolution 54 was ordered transmitted to the House of Delegates with the recommendation that it be referred to the Council on Dental Care Programs for action and report back in 1977.

Study of the Dentist in All His Relationships—Florida Dental Association: The Committee reported as follows:

Committee B considered at length Resolution 45 directing the Association to determine the feasibility of undertaking a sociological, medical, behavioral and environmental research project to investigate suicide, divorce and other stress signs related to occupational conditions of dentists.

It notes that the Association is currently pursuing joint activities with the Department of Health, Education, and Welfare to determine the validity of the existing research on which reports regarding the purportedly "high" rates of these conditions are based. The Committee believes that consideration of the validity of existing research is a necessary first step prior to any commitment to determine the feasibility of undertaking additional research.

The Committee notes that the scope of the feasibility study itself is such that associated costs could well amount to $10,000 or more. The larger research project in terms of data availability, measurement tools, methods of gathering additional data and personnel would result in costs and manpower efforts beyond the current capacity of the Association. The Association will continue to work with other private and public agencies on validation of existing reports. These activities may lead to the possibility of feasibility studies with outside funding. The Association will also continue to encourage researchers in other institutions to investigate these topics. The Committee, however, does not consider the feasibility study to be a practicable undertaking by the Association at this time because of the existing heavy commitments of Association funds and staff.

Resolution 45 was ordered transmitted to the House of Delegates with the recommendation that it be postponed indefinitely. The negative vote of Dr. Faust was recorded.

Publication and Distribution of Fee Surveys—Illinois State Dental Society: The Committee reported as follows:

Committee B reviewed Illinois Resolution 48 which requests a reconsideration of the current policy on distribution of fee information. In consideration of the action of the March 1976 Board (p. 616), the Committee refers this resolution back to the Board for it to act as a committee of the whole on it in conjunction with the report submitted by legal staff.

After discussion (see Report 2 of the Board of Trustees to the House of Delegates for the Board of Trustees' comments on Resolution 48), the Board adopted the following resolution and ordered it transmitted to the House of Delegates with the recommendation that it be substituted for Resolution 48 and the substitute resolution adopted:

48B. Resolved, that Resolution 60-1972-H adopted by the 1972 House of Delegates (*Trans.* 1972:680), concerning the conducting of fee and overhead cost surveys and restricting the publication of such data, is hereby revoked, and be it further

Resolved, that the 1975 fee survey data collected by the Association's Bureau of Economic Research and Statistics be published for historical information purposes only, showing national fee summary statistics for given dental procedures, as soon as feasible, in *The Journal of the American Dental Association* and thereafter be distributed to anyone on request, and be it further

Resolved, that the Association's Bureau of Economic Research and Statistics conduct fee and overhead cost surveys in 1977 and every two years thereafter, and be it further

Resolved, that the results of the overhead cost surveys be published in *The Journal of the American Dental Association* as soon as completed and thereafter be distributed to anyone on request, and be it further

Resolved, that the results of the 1977 and subsequent fee surveys be published in *The Journal of the American Dental Association* not earlier than one year after such data has been gathered for historical information purposes only, showing only national fee summary statistics for given dental procedures, and then be distributed to anyone on request.

The negative vote of Dr. Cappuccio was recorded.

Amendment of ADA "Standards for Dental Prepayment Programs"—The Dental Society of the State of New York: The Committee reported as follows:

Committee B evaluated New York Resolution 35, calling for amendment of the *Standards for Dental Prepayment Programs* (revised November 1974—*Trans.* 1974:639) to consider as disadvantageous differentials in levels of reimbursement based on participating and nonparticipating classifications of dentists. The Committee is persuaded by the reasoning of the Council on Dental Care Programs, as expressed in Supplemental Report 3, that some reimbursement differential is justified because of the services provided by the participating dentist and the obligations he accepts. Therefore, it is the Committee's recommendation that New York Resolution 35 be transmitted to the House of Delegates with the recommendation that it be postponed indefinitely.

The Board of Trustees ordered Resolution 35 transmitted to the House of Delegates with the recommendation that it be postponed indefinitely. The negative votes of Drs. Faust, Gruber, Kerr and Phillips were recorded.

Involvement of American Dental Association Delegates with Third Party Programs—Texas Dental Association: The Committee reported as follows:

In considering Resolution 52 from the Texas Dental Association to exclude dentists employed by third party companies from eligibility for election to the House, Committee B was concerned over a series of precedents that could potentially be set that would not, in the long view, be necessarily beneficial to Association members.

The resolution would, first of all, limit the freedom of judgment now exercised by component and constituent societies in deciding who they wished to elect to the Association's House of Delegates. It would, secondly, create a new and lesser class of membership of dentists who would otherwise be entitled to a fully privileged status. Finally, it makes a categorical and a prior judgment about the objectivity and sense of professional concern of a group

of dentists based solely on their occupation. It sweepingly excludes them from participation in the Association's policy-making body not only on matters related to their occupation but on all matters. On the same basis, dentists who are educators or who are engaged in research could be excluded from the House because it takes up matters related to those subject areas or dentists who are members of the military could be excluded because the House deals with military dentistry from time to time.

The history of the House of Delegates, in the Committee's view, makes clear that members listen carefully to the substance of debate and make judgments based on the soundness and pertinence of the arguments, not on the way in which the member offering those arguments makes his professional living. The Committee believes, further, that it is in the best interests of the profession and the Association for component and constituent societies to continue to have as wide a latitude as possible in deciding who it wishes to send to each meeting of the House. It is confident that the House, in the future, will deal responsibly with all questions and will continue to resolve matters based on the merit of the positions expressed. Consequently, the Committee recommends that the resolution be postponed indefinitely.

Resolution 52 was ordered transmitted to the House of Delegates with the recommendation that it be postponed indefinitely. The negative vote of Dr. Dixon was recorded.

UNFINISHED BUSINESS

Distribution of Fees Surveys: The Board of Trustees discussed the report on Distribution of Fee Surveys during the Report of Committee B (see p. 669 of this volume). Following discussion of the report, the Board of Trustees adopted a motion requesting the Executive Director to effect a policy of recovery costs on all materials made available to individuals, agencies and groups.

REPORT OF COMMITTEE C

The report of Committee C was read by Dr. Pfister, chairman. The other members of the Committee were Drs. Boucek, Houlihan and Kearns.

Report of Commission on Accreditation of Dental and Dental Auxiliary Educational Programs: The Committee reported as follows:

Report: The Committee reviewed the report of the Commission and commends the Commission for continuing with the practice of self-review for the purpose of enhancing its accreditation program. Further, it was pleased to note that the Commission is attempting to improve the quality and efficiency of the program without substantial increase in cost to the Association.

The Committee was pleased to note an increase of 5.2 percent in general practice residency program enrollment and a decrease of 1.6 percent in specialty program enrollment, indicating a change in past trends toward over specialization.

In discussing the Commission on Accreditation's forthcoming review by the U.S. Office of Education and the Council on Postsecondary Accreditation, Committee C was apprised of the fact that the Commission is anticipating continued recognition by these two agencies.

Revision of Educational Requirements: Committee C recognizes that, with the establishment of the Commission on Accreditation, the profession relinquished its previous authority to de-

velop and approve educational requirements in those disciplines of dentistry which fall within the Commission's accreditation authority. This responsibility and authority now reside with the Commission.

The Committee was pleased to note that the Commission has determined that it will seek the advice and counsel of the dental profession through its House of Delegates to comment and provide suggestions relative to any revisions in educational standards. When revisions are contemplated, they will be called to the House's attention through *Annual Reports and Resolutions*.

Report of Council on Dental Education: The Committee reported as follows:

Report: Committee C discussed many of the educational activities of the Council on Dental Education identified in its annual report. The Committee was of the opinion that the following Council activities deserve special comment.

Curriculum Study: Committee C reviewed the comprehensive report concerned with the study of dental curriculums of U.S. dental schools. The report details the progress made in implementing the study since the resolution was adopted by the 1974 House requesting that such a study be made (*Trans.* 1974:675).

Although the House requested that a completed report with recommendations be provided to the 1976 House, it was understandable to Committee C that the Council was unable to comply with the timetable for several reasons. Chief among these reasons is the fact that the Council did not receive official notification of funding, and the level of that funding, for the project from the W. K. Kellogg Foundation until late 1975. For this reason, the Council was delayed considerably in the development of the survey instruments needed to collect the data. Coupled with this is the fact that the Council was directed by the 1975 House to complete two other major assignments—the feasibility study relating to the development of an evaluation program for continuing education and the directive that a workshop on delegation of expanded functions to dental auxiliaries be convened.

The Committee noted that what has been identified as Phase II of the curriculum study was reported in the May 1976 issue of *JADA*. It appears that the information will be useful to the Council in the development of recommendations in the broader curriculum study.

It was brought to the Committee's attention also that the Curriculum Study Coordinating Committee had established June 1 as the deadline for institutions to complete the survey instruments and return them to the American College Testing Program. Since a significant number of schools have found it impossible to complete the instruments within the prescribed time-frame the deadline was extended to July 1.

Development of Instructional Guidelines: Committee C commends the Council for the forthright manner in which it plans to cope with ensuring that instruction at the predoctoral level will prepare graduates adequately in all aspects of clinical dentistry. The Committee concurs with the Council's policy statement relative to the development of subject area guidelines when identified weaknesses exist in a majority of the educational programs in the United States. The Committee noted that such guidelines have been developed in pain and anxiety control and that preliminary documents have been developed in physical evaluation and orthodontics.

1966 Waiver of Educational Requirement for American Board of Endodontics: Committee C reviewed the Council's report relating to the 1966 waiver of educational requirements for the American Board of Endodontics and agrees that the existing policy as stated in the resolution adopted by the House (*Trans.* 1966:346) should be clarified to avoid a misinterpretation of the intended action of the House.

The Committee believes that the background information leading to the approval of the educational waiver clearly defines the intent of the House; however, as a free standing resolution it could be misinterpreted and is subject to challenge. The Committee recommends that Resolution 1 be transmitted to the House of Delegates with the approval of the Board of Trustees.

Resolution 1 was ordered transmitted to the House of Delegates with the recommendation that it be adopted.

The report of the Committee continued as follows:

Revision of Requirements for Certifying Boards for Special Areas of Dental Practice: Committee C reviewed the suggested revision contained in the Council's report on *Requirements for National Certifying Boards for Special Areas of Dental Practice* and agrees that the document should be revised specifically to require each board to have, on a continuing basis, a sponsoring organization. The resolution as submitted by the Council is merely of housekeeping nature. The Committee recommends that Resolution 2 be transmitted to the House of Delegates with the approval of the Board of Trustees.

Resolution 2 was ordered transmitted to the House of Delegates with the recommendation that it be adopted.

The report of the Committee continued as follows:

Continuing Education Approval Program: Committee C reviewed the proposed national program for evaluation of continuing education sponsoring organizations, developed by the Council in response to a directive by the 1975 House (*Trans.* 1975:708). The Committee agrees with the Council that establishment of such a program would fulfill an apparent need within the profession, as demonstrated by requests from other dental organizations, results of a survey of constituent societies and dental schools, and the growing trend toward mandatory or voluntary continuing education programs established by the individual states.

The Committee agrees with the Council's statement acknowledging the present lack of evidence to demonstrate a relationship between continuing education and competence of the dental practitioner and/or quality of patient care rendered. Nonetheless, the Committee believes that an effort should be made to standardize the quality of continuing education experiences through some type of evaluation program.

Regarding the structure of the proposed program, the Committee concurs with the Council that a cooperative effort involving constituent societies and the Association offers several advantages in terms of uniform national standards, reduced duplication of effort, enhanced communication, and shared resources. The focus of the proposed evaluation program should be the sponsoring organization and its ability to provide the elements essential to a high quality educational experience, rather than individual courses or activities.

The Committee endorses the concept of a standing national advisory committee under the auspices of the Council, which would develop the national standards for evaluation of continuing education sponsoring organizations, subject to approval by the 1978 House. Voluntary participation in the evaluation program by constituent societies serving as state-level evaluating agencies of the Council also appears to be a workable and useful concept.

The Committee noted that $25,700 would be required from the Contingent Fund to implement the evaluation program for calendar year 1977. These funds, if provided, will assist the Council in development of the national standards for evaluation in accordance with the timetable proposed in the Council's report.

The Committee recommends that Resolution 3 be transmitted to the House of Delegates with the approval of the Board of Trustees.

Resolution 3 was ordered transmitted to the House of Delegates with the recommendation that it be adopted.

The report of the Committee continued as follows:

Educational Standards for Dental Hygiene: The Committee agrees with the Council that recent activities in a few states to enact legislation to recognize preceptor training for dental hygienists are cause for concern. The need for formal education for dentists has been recognized by the profession for over 100 years. American dentistry is distinctive in that development of this system of formal education and the standards which it incorporates have

historically been in the hands of the dental profession itself rather than government agencies. The profession recognized the need for formal education for dental hygienists in the early 1930's and in 1947 the Association established two academic years of college level education with content in basic, biomedical, social and clinical sciences and clinical practice as the educational standards for dental hygiene. The Committee agrees with the Council's observation that the establishment of dental hygiene educational standards by the profession has resulted in development of a category of dental personnel which can supplement efficiently the workforce of dentists, particularly in the areas of oral hygiene, prevention and periodontal disease. Further, the Committee believes that the profession should not yield to pressures to modify or lower standards of education because such changes would inevitably lead to a deterioration of the present high quality of dental health care that has brought great benefits to this nation. For these reasons, the Committee recommends that Resolution 4 be transmitted to the House of Delegates with the approval of the Board of Trustees.

Resolution 4 was ordered transmitted to the House of Delegates with the recommendation that it be adopted.

The negative vote of Dr. Faust was recorded.

Report of Council on Hospital Dental Service: The Committee reported as follows:

Report: Committee C reviewed the various activities of the Council on Hospital Dental Service identified in its annual report. Of particular interest to the Committee were the Council's efforts to enhance its dental service approval program and the continuing campaign for Joint Commission on Accreditation of Hospitals corporate membership.

The Committee also noted with interest the staff addition, the Council's enhanced liaison with allied organizations and the proposed survey of hospital dental practice.

Personnel: Because of the relevance of cooperation in communication and activity between the Council and the advanced dental education office of the Council on Dental Education, the Committee noted with interest the appointment of a coordinator for these two Association agencies.

Approval Program: Committee C reviewed carefully the section of the Council's report dealing with the approval program and implementation of the revised adjudication mechanism. Committee C believes that the Review Committees and biannual Council meetings provide a significantly enhanced dental service approval program.

The Committee reviewed the report on the patient care unit portion of the Council's approval program and recognizes the need to promulgate adequate standards for oral health care in the nation's nursing homes and other long-term care facilities. Committee C supports the moratorium imposed on patient care unit evaluation activities pending completion of the study.

Association Membership Request to the Joint Commission on Accreditation of Hospitals: Committee C reviewed in depth the Council's report on the Association's campaign for JCAH corporate membership. Although Association corporate membership has not yet been realized, the Committee believes that progress is being made as it has received indicated support from three of the four JCAH corporate members. The Committee strongly recommends continuation of the campaign. Committee C further recommends that the Association accept no less than a corporate membership in the JCAH. The Committee is particularly supportive of the Council's request to the Association's House Counsel to draft a document setting forth the various legal reasons why the Association should be granted JCAH membership.

Council Liaison: The Committee is cognizant of the Council's enhanced liaison with allied health organizations and is gratified to note its leadership in focusing hospital dental activities within the Association structure. The Committee believes the proposed combined meetings with the AADS, AAHD, and ASOS will enhance recognition of the Association's eminent role in hospital dental practice activities.

Survey of Hospital Dental Practice. Committee C noted that the Board of Trustees has been requested to fund a national survey of hospital dental practice to be conducted in cooperation with the Bureau of Economic Research and Statistics in 1977. Although the Committee believes the periodicity of resurvey should not be determined until survey data can be compiled, it concurs with the urgent need for such information.

Report of Council of National Board of Dental Examiners: The Committee reported as follows:

Committee C reviewed with interest the report of the Council of National Board of Dental Examiners.

The Committee compliments the Council for its responsiveness to concerns expressed by the American Association of Dental Examiners in establishing an examination review mechanism. It was brought to Committee C's attention that an AADE review committee met after the Council had submitted its annual report.

This review committee discussed Council structure, philosophy and procedures as a prelude to reviewing draft examinations. Committee C anticipates that AADE input into development of National Board examinations will have a positive effect on examination quality. The American Association of Dental Examiners should be complimented for providing this type input.

Committee C noted that the Council is studying National Board eligibility requirements as they relate to foreign-trained individuals in a careful and deliberate manner.

Committee C calls attention to the Council's plan to develop examinations for dental auxiliary expanded functions. The Council's policy not to consider which functions should be delegated is appropriate in view of the Council's service orientation. Constructing a modular examination for each function that has been mentioned for possible delegation, however, seems not to be an efficient use of Association resources. Therefore, Committee C suggests that the Board urge the Council to consult with state boards to assess their needs before beginning this project.

Report of Commission on Licensure: The Committee reported as follows:

Report: Committee C reviewed the report of the Commission on Licensure. Input the Commission received coupled with the Commission's own review of the *Controls Statement* originally presented in the Commission's 1975 report (*Trans.* 1975:181) have, in the Committee's view, had a positive effect. Both clarity and specificity are improved.

The Commission's report emphasizes that licensure is the responsibility of state government. The Commission also indicates that suggestions from the Association to states are appropriate. Committee C strongly supports both points.

Purpose of Licensure: Committee C agrees that licensure is for the protection of the public and for no other purpose as stated in Resolution 25. Having a policy statement to this effect would clarify the Association's interest in licensure. Resolution 26 recommending that states delete extraneous information from licensure applications and Resolution 27 recommending that credentials of all licensure applicants be verified seem to be implications of the purpose of licensure. Committee C suggests that Resolutions 25, 26 and 27 be transmitted to the House of Delegates with the recommendation that they be adopted.

After discussion, Resolution 25, 26 and 27 were ordered transmitted to the House of Delegates with the recommendation that they be approved.

The report of the Committee continued as follows:

Guidelines for Licensure: Committee C endorses sending specific suggestions for documenting current competence included in *Guidelines for Licensure* to state boards as an illustration of an approach. The Committee believes it is important to distinguish between specific suggestions and broad general principles. By including specific suggestions and documenting current competence as guidelines, the Commission has made a clear distinction. Committee

C suggests that Resolution 28 dealing with proposed *Guidelines for Licensure* be transmitted to the House of Delegates with the recommendation that it be adopted.

During discussion, the Board directed that all references to "he," "him" or "user" in the *Guidelines for Licensure* be asterisked and footnoted to imply either gender.

Resolution 28 was ordered transmitted to the House of Delegates with the recommendation that it be approved.

The report of the Committee continued as follows:

State Level Studies: Resolutions 29, 30, 31 and 32 are similar in that each resolution requests each constituent society, in consultation with its state board, to consider a particular licensure issue. Issues addressed in these resolutions—licensure by credentials for dental specialists, active and inactive licenses, state support for enforcement of the state dental practice act and possible use of licensure by credentials in relicensure—merit attention. Discussion in the Commission's report should assist states in beginning work on these issues. Committee C agrees with the Commission that issues covered in Resolutions 29, 30, 31 and 32 should be considered at the state level at least initially. Therefore, Committee C recommends that Resolutions 29, 30, 31 and 32 be transmitted to the House of Delegates with the recommendation that they be adopted.

The Board was advised that Resolution 30 was incorrectly printed in *Annual Reports and Resolutions, 1976* and should read as follows:

30. **Resolved,** that each constituent society, in consultation with its state board of dentistry, be urged to develop a mechanism for issuing active and inactive licenses to enhance public protection.

Resolutions 29, 30, 31 and 32 were ordered transmitted to the House of Delegates with the recommendation that they be approved.

The report of the Committee continued as follows:

Future of the Commission: In view of the thorough study of licensure that the Commission has conducted, Committee C agrees with the Commission that continued, regular operation of such a large study group is no longer needed. Concurring with Commission recommendations, Committee C recommends that the study of licensure matters be assigned to the Council on Dental Education. If this were done, the Council on Dental Education should call on the expertise of former members of the Commission on Licensure as needed. In identifying a permanent agency to study licensure matters, Committee C noted that the Council on Dental Education has educator and examiner members as well as representatives from the general membership and was asked to study licensure issues that came up before 1972. Also, because accreditation has been assigned to the Commission on Accreditation of Dental and Dental Auxiliary Educational Programs, charging the Council on Dental Education with the study of licensure would not create a conflict of interest. Committee C offers the following resolution for transmission to the House of Delegates with the recommendation that it be adopted.

The following resolution presented by the Committee was adopted by the Board of Trustees and ordered transmitted to the House of Delegates with the recommendation that it be approved:

77. **Resolved,** that Chapter IX, Councils, Section 110, Duties, Subsection B, Council on Dental Education of the *Bylaws* be amended by the addition to Subsection B of the following:

(7) Dental licensure and dental auxiliary licensure.

The report of the Committee continued as follows:

Believing that the Commission on Licensure deserves special commendation, Committee C suggests that the following paragraph be incorporated into the report of the Board:

The Board of Trustees extends its sincere appreciation to members of the Commission on Licensure for a job well done. When the Commission was established by the 1974 House of Delegates, few would have anticipated that such a comprehensive approach to licensure issues could have been developed in only two years. Also, the Commission on Licensure takes a unique place in Association history by recommending its own demise. Both in the progress made in studying licensure and in the recognition that the Association cannot support an ever increasing number of separate agencies, the Board finds the Commission's actions commendable.

A motion was adopted to include the commendation of the Commission on Licensure, suggested by Committee C, in Report 2 of the Board of Trustees to the House of Delegates.

Recess: The Board of Trustees recessed at 12:40 PM and reconvened at 2:00 PM.

Special Report on Dental Auxiliary Utilization and Education—Council on Dental Education: The Committee reported as follows:

Committee C studied thoroughly the comprehensive report on dental auxiliary utilization and education. The Council on Dental Education and Advisory Committee on the Study of Dental Auxiliary Expanded Functions are commended for their response to the 1975 House directives that a position statement on functions which should be delegated to auxiliaries be developed and functions which may require formal education be studied and defined further for consideration by the 1976 House of Delegates. The report for the first time brings together pertinent information on dental auxiliary education and utilization and expanded functions. The Committee believes it accurately reflects deliberations of the workshop participants. Also sections on research, manpower and productivity, educational resources and legal provisions which were the basis for the Council's and Advisory Committee's conclusions provide adequate information for the House to make definitive decisions.

The Committee views the controversy over representation at the Workshop on Dental Auxiliary Expanded Functions with concern and concurs with the Council's conclusion that there was adequate opportunity for representation of the practicing profession through the invitations extended to constituent societies and state boards of dentistry. Failure to achieve the desired representation of dental practitioners rests, in the Committee's view, solely with societies and boards of dentistry. The Committee agrees that although there was question about representation, the accommodation of the problem through separate balloting of practicing dentists and the discussions made the workshop a valuable resource for the Advisory Committee and Council.

Committee C noted particularly that acceptance of the report by the House would not constitute a mandate to states. The Council has not taken the position that the identified functions *should* be delegated but has only identified functions which *could* be delegated under certain conditions if a jurisdiction desired to enact legislation or promulgate rules and regulations to enable such delegation. The Committee also believes it is important to note that the position statement presented to the House encourages, but does not require, uniformity among states in the specific functions or number of functions which could be delegated. The statement would however provide to states the Association's position on appropriate limitations of expanded functions delegation. Further, the report emphasizes that the dentist should be utilized fully to meet demands for care and that the potential effect of utilization of traditional assistants and hygienists should be realized before expanded functions are delegated. The Committee noted that the report also emphasizes that a dentist is more than

the sum of given functions and that the practice of dentistry constitutes the synthesis and application of knowledge and skill acquired through professional dental education.

Ramifications of adopting the position statement and consequences of delaying action were discussed at some length by the Committee. Failure of the Association to adopt a comprehensive and consistent position statement on delegation of functions to dental assistants and dental hygienists will, in the Committee's opinion, result in serious consequences.

1. The profession will continue to lose its credibility and its leadership in determining direction for future utilization of dental assistants and dental hygienists.
2. In the absence of a definitive position, decisions which are creating greater diversity among states and increasing controversy will continue to be made. It is this diversity and controversy that allow other agencies to step in and provide direction.
3. Other agencies, private and governmental, will assume even more significant leadership roles in determining the direction and extent of dental auxiliary utilization.

The 1975 House recognized these problems. The Association could continue to base its actions and testimony on existing policy, but in the Committee's view this would result in further erosion of the profession's authority and responsibility for making decisions which relate to utilization of auxiliaries.

The Committee is of the opinion that if a statement on dental auxiliary utilization and education is adopted by the 1976 House it will advance the profession's efforts to reestablish its leadership in determining direction for delegation of functions to auxiliaries. Adoption of a statement would:

1) establish a comprehensive and definitive position for the Association on dental auxiliary utilization and education,
2) identify the principles which underlie the Association's position on dental auxiliary utilization and education,
3) establish, on the basis of study and research, the profession's position on appropriate limits of delegation of expanded functions,
4) provide guidance for delegation of functions to dental assistants and dental hygienists,
5) acknowledge that demand for dental care varies with state and region and reiterate the Association's support of delegation of expanded functions for the purpose of increasing dentists' productivity.

Also, in the Committee's view adoption of a statement is necessary to provide a policy for extending study into areas of highest priority. Areas identified by the Council and Advisory Committee include:

1) study of credentialing dental auxiliary personnel and development of recommendations for consideration by the House,
2) reassessment of the Association's position on categories of personnel and development of recommendations for consideration by the House,
3) study of the effect of expanded functions delegation on traditional dental assistants and dental hygienists,
4) assessment of educational systems' capacity to provide expanded functions training,
5) development of guidelines for expanded function training.

On the basis of its discussion of the report and the position statement the Committee recommends the following amendments of the American Dental Association Statement on Expanded Functions Dental Auxiliary Utilization and Education.

The Committee believes the need for consistency among the states in provisions for delegation of functions should be emphasized. Therefore, it is recommended that principle 2. (lines 34-35) "Individual states or jurisdictions should make the final decisions on which

functions may be delegated and the qualifications for performance of those functions.", be amended by addition of "however, adherence to national standards as defined by the American Dental Association is encouraged as it would provide desirable consistency." The amended principle to read:

> 2. Individual states or jurisdictions should make the final decisions on which functions may be delegated and the qualifications for performance of those functions, however, adherence to national standards as defined by the American Dental Association is encouraged as it would provide desirable consistency.

The Board of Trustees adopted a motion to amend Principle 2 to read as follows:

> 2. Individual states or jurisdictions should make the final decisions on which functions may be delegated and the adherence to the American Dental Association policy statement is encouraged as it would provide desirable consistency.

The report of the Committee continued as follows:

> In the Committee's view a restatement of principle 13. (lines 59-61) which reads: "The need for consistency in identification of auxiliaries, definition of their roles and assurances of competence should be recognized by states or jurisdictions in decisions on provisions for delegation of functions." would add emphasis to the need for national consistency. Therefore, the Committee recommends that the following be substituted for principle 13:
>
> > 13. In decisions on provisions for delegation of functions, states and jurisdictions should recognize the need for consistency in identification of auxiliaries, definition of their roles and assurances of competence.

The amendment to principle 13, as recommended by Committee C, was approved by the Board of Trustees.

The report of the Committee continued as follows:

> The Committee considers it important to emphasize within the position statement that the practice of dentistry constitutes more than performance of funcions. Therefore, the Committee recommends that the following sentence be inserted at the beginning of line 86:
>
> > The practice of dentistry is more than the performance of functions which constitute the technical procedures of dentistry, and a dentist is more than the sum of those functions.

The amendment, as recommended by Committee C, was approved by the Board of Trustees.

The report of the Committee continued as follows:

> The Committee discussed the rationale for including "administering local anesthetic agents in conjunction with root planing and closed soft tissue curettage" in the list of functions which could be delegated to dental hygienists (lines 136-137). The Committee notes that in the rationale for considering delegation of this function to dental hygienists, it is stated that hygienists can acquire the education and training required to perform the function with appropriate precautions. The techniques of and knowledge required for performing this function are the same regardless of the purpose for which a local anesthetic agent is administered and therefore the Committee believes that the limitation on these functions is inappropriate.
>
> The Committee recommends that function 3. (lines 136 and 137) "Administering local an-

esthetic agents in conjunction with root planing and closed soft tissue curettage" be amended to read:

3. Administering local anesthetic agents.

The amendment recommended by the Committee was not approved by the Board of Trustees.

Dr. Carter moved to amend the Statement on Expanded Function Dental Auxiliary Utilization and Education to conform to Resolution 861 adopted by the 1975 House of Delegates and the motion was seconded by Dr. Dixon. The motion was defeated.

A motion was adopted to substitute the following statement for lines 13-18 of the philosophy section of the report:

The purpose of delegating expanded functions to dental auxiliaries is to improve the productivity of the dentist by assigning those functions which will increase the availability of services at a reasonable cost, with assurances of quality control.

The negative vote of Dr. Faust was recorded.

The report of the Committee continued as follows:

Committee C recommends that Resolution 24, as amended, be approved.

The Board of Trustees adopted the following resolution and ordered it transmitted to the House of Delegates with the recommendation that it be substituted for Resolution 24 and that the substitute resolution be approved:

24B. Resolved, that the American Dental Association Statement on Expanded Function Dental Auxiliary Utilization and Education, as amended, be adopted.

Recess: The Board of Trustees recessed at 5:40 PM.

FRIDAY, AUGUST 20, 1976

Call to Order: The meeting of the Board of Trustees was called to order at 8:00 AM by President Shira.

Roll Call: The officers, members of the Board of Trustees and members of staff were present as previously recorded.

REPORT OF COMMITTEE C
(continued)

Complete Utilization of Dentists in the Treatment of Patients—District of Columbia Dental Society: The Committee reported as follows:

The Committee encountered difficulty in interpreting the intent of Resolution 33 submitted by the District of Columbia. For example, it is not clear whether the phrase "in all dental programs" is meant to include private dental practice. After some discussion the Committee agreed that in all probability the resolution endorses full utilization of dentists before delegation of expanded functions to auxiliaries and is supportive of the "philosophy for Utilization and Education of Dental Auxiliaries" statement in the Special Report on Dental Auxiliary Utilization and Education. This statement indicates that expanded functions should be delegated to dental auxiliaries when the demand for specific services exceeds the capacity of dentists to provide them. To avoid duplication of policy and because Resolution 33 is subject to misinterpretation, Committee C recommends that it be transmitted to the House of Delegates with the recommendation that it be postponed indefinitely.

After discussion, the Board of Trustees adopted the following resolution and ordered it transmitted to the House of Delegates with the recommendation that it be substituted for Resolution 33 and that the substitute resolution be approved:

33B. Resolved, that the American Dental Association urges and endorses the fullest utilization of dentists, before delegation of expanded functions to auxiliaries in the treatment of patients.

Classification of Dental Laboratory Technicians—Illinois State Dental Society: The Committee reported as follows:

In considering Resoluion 47 submitted by the Illinois State Dental Society requesting that the Association recognize only the dental laboratory technician actually employed in the dental office as an auxiliary, Committee C noted that both the Councils on Dental Education and Dental Laboratory Relations have considered this issue. Both Councils agree, as stated in their annual reports that regardless of employer, the functions performed by the dental laboratory technician assist the dentist in his provision of patient care. Therefore, individuals providing that service are correctly identified as auxiliary to the dental profession. Further, the Committee concurs with the belief of the Council on Dental Laboratory Relations that a change in policy may lead to dental laboratory groups gaining statutory regulations with separate regulatory boards.

Although Committee C recommends that Resolution 47 be postponed indefinitely, it urges the Board to give priority to a comprehensive study of the profession's relationship with the dental laboratory industry.

Resolution 47 was ordered transmitted to the House of Delegates with the recommendation that it be postponed indefinitely. However, the Board indicated that it will give priority to a comprehensive study of the profession's relationship with the dental laboratory industry.

Termination of TEAM Program—The Dental Society of the State of New York: The Committee reported as follows:

Committee C reviewed Resolution 36 which urges that the TEAM program be discontinued and that no further funding of this program occur. In considering the background material presented with the New York State resolution, it became clear to Committee C that there still remains some confusion regarding the intent and purpose of the TEAM program and its byproduct development of expanded function auxiliaries. In order to clarify this matter for the House of Delegates, Committee C offers this explanation to the Board of Trustees for its review and possible submission to the House of Delegates.

The TEAM program refers *exclusively* to the training of *dentists* to deal effectively in the management of expanded function auxiliaries. The only principle upon which the program is based is that there is a need to acquaint graduating dental students with an ability to

develop and manage a dental health care team that is appropriate for the type of practice, the type of auxiliaries utilized and the relevant legal restraints and requirements of dental practice. The goals of the program require that dental students, upon completion of the training, are able to: (1) demonstrate the ability to delegate duties commensurate with the skills of their auxiliaries and to insure the quality of their clinical performance and products; (2) demonstrate skills in personnel management; (3) demonstrate those skills and office management which relate to operating a TEAM practice; and (4) demonstrate an understanding of the basic principles of facilities and equipment design which are necessary for the implementation of TEAM dentistry in a private practice setting.

The TEAM program is *not* experimental and does not train for external practice purposes expanded function auxiliaries. Every TEAM grant, however, contains *limited* grant monies which may be used to train auxiliaries in expanded functions to the extent that those auxiliaries are needed to function exclusively in the TEAM program. The program does not repeat the training of expanded function auxiliaries for the external work force.

Since dental education programs have an obligation to provide the best education possible for its potential graduates, and since the issue of greater utilization of auxiliaries has clearly been the direction in which dentistry has been moving it is incumbent upon the educational programs to provide a good education for graduates and the management of these auxiliaries. One of the greatest shortcomings of traditional dental education programs has been the aspects of practice management and the provision of an educational experience which would allow a recent dental graduate to feel comfortable in managing an effective and productive practice. Although the Committee is aware of expressed abuses associated with the TEAM program, it believes that this program provides a valuable learning experience for students in managing dental auxiliaries.

Committee C believes that although the Association supports the principle that dentists and their auxiliaries must perform services that are consistent with dental practice acts the Association believes that dental education programs must still provide an adequate educational experience to insure the future practice potential of its graduates and therefore recommends that Resolution 36 be postponed indefinitely.

After discussion, the Board of Trustees adopted a motion to divide Resolution 36. The following resolution (the first resolving clause of Resolution 36) was ordered transmitted to the House of Delegates with the recommendation that it be postponed indefinitely:

36aB. Resolved, that all TEAM experimental programs and their financial support be terminated upon the expiration of existing contracts or grants.

The following resolution (the second resolving clause of Resolution 36, as amended by the Board of Trustees) was ordered transmitted to the House of Delegates with the recommendation that it be approved:

36bB. Resolved, that the results and conclusions of all TEAM and other expanded function auxiliary training programs be collected and collated by the ADA Council on Dental Education for distribution to all state boards for dentistry and all state dental societies for additional consideration and recommendations relative to implementation.

Policy on Functions of Dental Auxiliaries—Washington State Dental Association: The Committee reported as follows:

Committee C reviewed the background information accompanying Resolution 40 which requests amendment of Resolution 861, adopted by the 1975 House of Delegates, relating to the issue of auxiliary utilization and allowable expanded functions (*Trans.* 1975:701). The Committee believes that the Council on Dental Education, in the preparation of its

comprehensive report on auxiliary utilization, education and training, adequately considered the issue suggested by the Washington State Dental Association.

Although the Committee concurs with the Washington State Dental Association's suggested revision of existing policy, it believes that the Council's comprehensive report on auxiliary utilization provides a preferable approach to establishing Association policy in this area. Further, it believes that the comprehensive statement of auxiliary utilization being proposed by the Council, while consistent with the intent of the Washington State Resolution, is preferable to the approval of individual isolated policy resolutions. Therefore, Committee C recommends that Resolution 40 be postponed indefinitely.

Resolution 40 was ordered transmitted to the House of Delegates with the recommendation that it be postponed indefinitely.

Redevelopment of Conference on Expanded Duty of Dental Auxiliaries—Wisconsin Dental Association: The Committee reported as follows:

In considering Resolution 43, Committee C referred to the comprehensive report on dental auxiliary utilization and education submitted by the Council on Dental Education and specifically information on workshop participation. Committee C believes that allocation of invitations for the workshop conformed to the 1975 House dictate that the majority of participants be full-time practicing dentists who utilize dental auxiliaries. Preregistration indicated that the mandate would be met. However, because a significant number of constituent society and state board representatives did not show, the final registration fell just short of a majority representation of full-time practicing dentists. The Committee wishes to point out that 12 constituent societies and 23 state boards of dentistry did not participate in the workshop.

Committee C believes that the Council was right in utilizing results of the workshop as one resource in developing its report to the House. A workshop is not a legislative body but provides opportunity for discussion of opinions on specific subjects. In the Committee's opinion, no group represented at the workshop had undue influence on the report which is being submitted to the House. Further, the Committee believes that it is not in the best interest of the Association to challenge the usefulness of the workshop. The Council's report should be considered on the basis of its merits irrespective of the issue of workshop participation. Therefore, Committee C recommends that Resolution 43 be rejected.

Resolution 43 was ordered transmitted to the House of Delegates with the recommendation that it be postponed indefinitely.

REPORT OF COMMITTEE A

The report of Committee A was read by Dr. Kerr, chairman. The other members of the Committee were Drs. Brown, Carter and Faust.

Report of President: The Committee reported as follows:

The Committee has carefully reviewed the report of the President and would like to express its sincere appreciation for the efforts of the President on behalf of the Association. The President's report contains four resolutions which the Committee reviewed. The Committee presents the following recommendations on the President's resolutions.

Resolution 380: The Committee reviewed Resolution 380 calling for a reevaluation of the State Speakers' Program with the view toward eliminating excessive representation at constituent society meetings. The Committee is in agreement with the intent of the resolution

and further recommends that the Executive Director's travel schedule be sent to members of the Board of Trustees in advance. Therefore, the Committee recommends adoption of Resolution 380.

The following resolution was adopted by the Board of Trustees:

74-1976-B. Resolved, that the State Speakers' Program be reevaluated to insure that excessive representation at constituent associations meetings is avoided.

The report of the Committee continued as follows:

Resolution 381: The Committee reviewed Resolution 381 submitted by the President instructing the Executive Director to evaluate critically all staff requests for travel to non-Association meetings and functions and to curtail such travel as much as feasible. The Committee concurs with the President on the intent of this resolution. Therefore, the Committee recommends the adoption of Resolution 381.

The Board of Trustees adopted the following resolution:

75-1976-B. Resolved, that the Executive Director be instructed to critically evaluate all staff requests for travel to non-Association meetings and functions and to curtail such travel as much as is feasible.

The report of the Committee continued as follows:

Resolution 382: The Committee has reviewed Resolution 382 submitted by the President requesting that American Dental Association certificates presented to constituent society presidents be framed or laminated. The Committee notes that the additional cost for laminating and mounting the certificates on wood will be $6 each or $324 for 54 certificates. The present cost of the certificates is $220 bringing the total certificate cost to $544. This increased cost needs to be considered by the Committee on Finance and Investments for a determination as to whether the printing line item in the Board of Trustees budget needs to be increased or whether the present budget allocation can absorb this additional cost. The Committee recommends the adoption of Resolution 382.

The following resolution was adopted by the Board of Trustees:

76-1976-B. Resolved, that the American Dental Association certificates presented to constituent association presidents he framed or laminated.

The report of the Committee continued as follows:

Resolution 383: The Committee has reviewed Resolution 383 requesting the Board of Trustees to reevaluate the Public Education Program and determine its future direction. The Committee notes that this subject will be taken up in more detail in other reports. However, the Committee concurs with the President that the Public Education Program should be reevaluated and, therefore, recommends that Resolution 383 submitted by the President be approved.

The resolution was withdrawn since its intent had been accomplished.

Report of President-Elect: The Committee reported as follows:

Committee A has reviewed the report of the President-elect and takes this opportunity to express its appreciation for the fine efforts of the President-elect on behalf of the Association. The President-elect's report contains various recommendations for the Committee's review and possible action. The Committee reviewed each of the recommendations offered by the President-elect and commends the President-elect for his thoughtfulness on these issues. The Committee, as a result of its review, offers the following comments and recommendations for the Board of Trustees consideration:

1. The Committee agrees with the intent expressed in recommendation 1 of the report.

2. The Committee has reviewed recommendation 2 of the President-elect calling for expansion of the Association's House of Delegates from 417 to 418 members with the additional delegate representing the American Student Dental Association and having voting privileges. The Committee notes that the Board of Trustees has previously recommended the *Bylaws* be changed to permit the student delegate to have voting privileges. The Committee took notice of the fact that there are currently 14,952 members in the American Student Dental Association. This represents a significant number of future ADA members. The future leadership of the Association is in the hands of these student members. The student consultants to the various councils have made significant contributions to these councils. Therefore, the Committee recommends the following resolution for Board approval.

The following resolution was ordered transmitted to the House of Delegates with the recommendation that it be adopted:

82. **Resolved**, that Chapter V, House of Delegates of the *Bylaws* be amended as follows:

I. Amend the first sentence of Section 10 by substituting the number "four hundred eighteen (418)" for the number "four hundred seventeen (417)" to make the amended section read as follows:

> The House of Delegates shall be limited to four hundred eighteen (418) voting members.

II. Delete the second sentence of Section 10 and substitute therefor the following:

> It shall be composed of the officially certified delegates of each constituent society, one (1) officially certified delegate from each federal dental service which is not organized into a constituent society, and one (1) student member of the American Dental Association who is an officially certified delegate from the American Student Dental Association.

III. Delete the first sentence of Section 20 and substitute therefor the following:

> The secretary of each constituent society, the ranking administrative officer of each federal dental service, and the secretary of the American Student Dental Association shall file with the Executive Director of this Association, at least sixty (60) days prior to the first day of the annual session of the House of Delegates, the names of delegates and alternate delegates designated by his society, service or association.

The report of the Committee continued as follows:

3. The Committee noted that the recommendation contained in item 3 of the President-elect's report will be commented on elsewhere in this report.

4. The Committee reviewed item 4 of the President-elect's report recommending that a special seating section be established in the Visitors Section of the House of Delegates for officials of the ADAA, ADHA and dental technicians. The Committee is aware that quite

often seating space on the floor of the House of Delegates is limited due to the size of the facility. Special credentialing, which would limit the number of seats reserved for these groups, may be required as a result. Further, the number of seats allocated for guests may have to be reduced in order to achieve this objective. Nevertheless, the Committee concurs that such seating arrangements should be provided since these groups represent part of the total dental team. Therefore, the Committee recommends the following resolution for the Board's consideration.

The following resolution was adopted by the Board of Trustees:

77-1976-B. **Resolved**, that the Executive Director of the Association be directed to establish a special seating section in the Visitors Section of the House of Delegates wherever and whenever practicable to do so.

The report of the Committee continued as follows:

5, 6 and 7. The Committee reviewed items 5, 6 and 7 in the President-elect's report recommending that all ADA nominees and/or appointments to the myriad of outside commissions, councils, advisory boards, etc. be required to make quarterly reports to the Board of Trustees; that those outside appointments should be for a specified time of one year and the performance of those individuals then be evaluated prior to reappointment; and, that a list of all ADA appointments to outside agencies be submitted to the Board with a description of the agency's function, the expertise of the person on it, when appointed and length of terms so that the Board is fully informed about the persons filling these appointments and that they are truly representing ADA policy. The Committee concurs with the President-elect that ADA nominees and/or appointments to outside agencies should make quarterly reports to the Board. This will provide the Board with information vital to the evaluation of outside agency program activities. The fact that no meaningful progress or activity has taken place in the outside agency should also be duly reported.

While the Committee is of the opinion that the performance of the persons appointed to the outside agencies should be reviewed on an annual basis, it does not consider the one year appointment limitation practicable in all situations and circumstances since the terms of election are often controlled by the outside agency.

The Committee concurs with the President-elect that a list of all ADA appointments to outside agencies be submitted to the Board with a description of the agency's function, the expertise of the person on it, when he was appointed and his length of term. This information can provide the Board with the input necessary to determine whether the appointee is carrying out the directives of the Board and representing Association policy. Therefore, the Committee recommends the following resolution for the Board's consideration.

The following resolution was adopted by the Board of Trustees:

78-1976-B. **Resolved**, that all Association nominees and/or appointments to outside agencies be required to make quarterly reports on the agencies' activities and progress or lack of same to the Board of Trustees, and be it further

Resolved, that the Board of Trustees Committee on Council Review make an annual evaluation of all persons appointed and/or nominated to outside agencies with report to the Board of Trustees, and be it further

Resolved, that a list of all Association appointments to outside agencies be submitted to the Board of Trustees with information necessary for the Board's evaluation of the individual efforts of the appointee on the Association's behalf. Such information shall include but not be limited to the agency's function, the expertise of the appointee and/or nominee, the date appointed and the length of term of office.

The report of the Committee continued as follows:

8. The Committee has reviewed item 8 of the President-elect's report recommending that Board meetings be extended one day. The Committee is of the opinion that an additional day is essential to the smooth functioning of the Board. The Committee is of the further opinion that the reference committee system be utilized at each meeting of the Board. This will permit for the orderly assimilation of Board committee activities into the full Board meeting. The Committee is aware that this extra day will cause an imposition on Board members in their practice and therefore recommends that every effort be made to schedule Board meetings so as to cause the least amount of interference with individual practices. Therefore, the Committee recommends the following resolution for the Board's consideration.

The Board of Trustees adopted the following resolution:

79-1976-B. **Resolved**, that one additional day be added to the winter and spring sessions of the Board of Trustees and the summer session, if necessary, commencing with its January 1977 session, to permit utilization of the reference committee concept to facilitate the handling of the business of the Board of Trustees.

The report of the Committee continued as follows:

9. The Committee has reviewed item 9 in the President-elect's report recommending that a coordinated filing system be presented to all members of the Board for use in their duties. The Committee concurs with the President-elect's recommendation since it will enable the Board members to locate expeditiously and coordinate Association materials. Therefore, the Committee recommends the following resolution for the Board's consideration.

The following resolution was adopted by the Board of Trustees:

80-1976-B. **Resolved**, that the Executive Director be directed to develop a coordinated filing system for use by all Board members, and be it further
Resolved, that such system be reported to the Board at its January 1977 session.

The report of the Committee continued as follows:

10. The Committee reviewed item 10 in the President-elect's report recommending that all resolutions and/or amendments at Board meetings be presented in writing. The Committee concurs with the intent of this recommendation; however, the Committee is aware that often it is necessary to offer amendments and resolutions after debate has taken place on a particular issue therefore rendering this recommendation impractical. The Committee would urge members of the Board, when offering resolutions or amendments, to speak slowly so that the recording secretary is able to reflect accurately the resolution or amendment. Further, the Committee would also recommend that resolutions and amendments be made in writing whenever feasible to do so.

11. The Committee has reviewed item 11 in the President-elect's report recommending that the Board determine what the top priority or priorities facing the profession in the way of challenges are at the start of each year and then shift programs and resources to meet them. The Committee concurs with the President-elect and would comment that the reference committees of the Board utilizing the additional day could focus on Association priorities.

12. The Committee has reviewed item 12 in the President-elect's report recommending that an evaluation of the Public Education Program be instituted so that judgment decisions can be made for its effectiveness in meeting its goals. The Committee has reported on this elsewhere in this report.

13. The Committee concurs with the President-elect that the challenge of illegal dentistry be recognized as the chief concern of dentistry and that all efforts be put forth to stop its advance.

14. The Committee has reviewed item 14 in the President-elect's report recommending that the Committee on Advance Planning take under its purview the study of consultants to the various councils with the view toward reducing their number. The Committee concurs with the President-elect's recommendation. The Committee is aware that consultants provide a valuable service to the various councils; however, a duplication of efforts may result from an excessive number of consultants. Therefore, the Committee recommends the following resolution for the Board's consideration.

The following resolution was adopted by the Board of Trustees:

81-1976-B. **Resolved**, that the Committee on Advance Planning study the utilization of consultants to the various councils with the objective of recommending reductions where indicated by the Committee's study.

The report of the Committee continued as follows:

15. The Committee concurs with the President-elect that in discussing matters brought before the Board substance is more important than form.

Report of the Executive Director: The Committee reported as follows:

The Committee noted with appreciation the many activities being carried on by the Executive Director.

The Committee, while impressed with the growth in the number of fully privileged members in the Association over the last ten years, is concerned that during the same period the percentage of dentists who are fully privileged has remained static. The Committee believes that the Board of Trustees should adopt as one of its goals an ever-increasing percentage of active members so that the Association remains truly representative as the voice of the dental profession. Therefore, the Committee recommends adoption of the following resolution.

The Board of Trustees adopted the following resolution:

82-1976-B. **Resolved**, that the Executive Director in conjunction with the Bureau of Public Information and the Bureau of Data Processing Services and Membership Records develop and then implement, in cooperation with constituent dental societies, a membership recruitment program.

The report of the Committee continued as follows:

The Committee noted the number of staff changes that have occurred since the March 1976 session of the Board of Trustees. The Committee concurs with the Executive Director that the Board of Trustees in its report to the 1976 House of Delegates call attention to the years of valuable service rendered to the Association by Miss Marian F. Driscoll, secretary, Council on International Relations, 25 years; Miss Eunice Olson, Council on Legislation, 20 years; Mr. Henry M. Koehler, Editorial Office, 20 years; and Miss Lina Salfner, retired manager of the Association's Executive Dining Room, 20 years.

The Committee considered at some length the recommendation of the Executive Director that the general membership be in some manner informed of important issues that have been referred by the House of Delegates for study and report back to a subsequent session of the House. The Committee noted that the 1972 House of Delegates adopted the following restrictive resolution:

Resolved, that all business referred to councils or other agencies of the ADA by the House of Delegates, with explicit instructions to be returned to a future meeting of the House, be submitted to the House before implementation or publication outside of the officers, Board of Trustees, delegates and alternate delegates of the Association and officers of constituent societies.

The Committee recommends that the prohibition against publication be somewhat relaxed. The Committee recommends that, after a matter has been reported back to the House, for example, through promulgation in an issue of *Annual Reports and Resolutions,* the Board of Trustees then be given permission to authorize publication, using its discretion, in reports or articles directed to other interested parties, particularly the general membership. Therefore, the Committee recommends adoption of the following resolution by the House of Delegates.

The following resolution was ordered transmitted to the House of Delegates with the recommendation that it be adopted:

83. **Resolved,** that Resolution 24-1972-H adopted by the 1972 House of Delegates (*Trans.* 1972:620) be rescinded, and be it further
Resolved, that all business referred to councils or other agencies of the ADA by the House of Delegates, with explicit instructions to be returned to a future meeting of the House, be submitted back to the House before implementation and that publication outside the officers, Board of Trustees, delegates and alternate delegates of the Association and officers of constituent societies be left to the discretion of the Board of Trustees.

The report of the Committee continued as follows:

With respect to the Executive Director's observation that the meetings between the liaison committees of the National Dental Association and the American Dental Association and its Board of Trustees are proving less and less productive because substantive differences are seldom, if ever, at issue, the Committee agrees with the Executive Director that matters of mutual concern and interest be handled in the future, as needed, by the Special Committee on Inter-Agency Affairs of the Board of Trustees and officials of NDA.
Therefore, the Committee recommends adoption of the following resolution amending the *Organization and Rules of the Board of Trustees* by deletion of reference to the Liaison Comittee to the National Dental Association on pages 11, 12 and 14.

The following resolution was adopted by the Board of Trustees:

83-1976-B. **Resolved,** that the *Organization and Rules of the Board of Trustees* be amended by deletion of the listing of the Liaison Committee of the National Dental Association on pages 11-12 and by deletion of the subsection entitled "Liaison Committee to National Dental Association" on page 14 of the section entitled "Standing, Reference and Special Committees."

The report of the Committee continued as follows:

The Committee concurs in the recommendation of the Executive Director that the Association recognize the celebration of the 50th anniversary in July 1977 by the American Society of Dentistry for Children by the authorization of a commemorative certificate and, therefore, recommends adoption of the following resolution.

The Board of Trustees adopted the following resolution:

84-1976-B. Resolved, that a commemorative certificate for the following be authorized:

50th anniversary of the American Society of Dentistry for Children, San Francisco, California, July 1977.

The report of the Committee continued as follows:

The various liaison meetings with the auxiliary organizations were noted by the Committee. Interchange of common concerns and ideas, in the opinion of the Committee, can only be beneficial to all.

The present status and operating activities of Dental Service Plans Insurance Company was noted, and the Committee calls attention to the various reports contained in other sections of the *Board Manual* concerned with DSPIC and the Delta system.

Report of Contracts—Executive Director: The Committee reported as follows:

Committee A reviewed the list of contracts reported in accordance with the *Standing Rules of the Board of Trustees* and notes that 18 contracts and leases have been entered into by the Association and one by the American Dental Association Health Foundation since the March 1976 session of the Board of Trustees.

Report of Editor: The Committee reported as follows:

Committee A reviewed the Report of the Editor and took special note of the increased circulation of the publications, and cutting of costs and the improvements in the format and content of *The Journal of the American Dental Association*. The Committee noted that *The Journal* was now more appealing to the practicing dentist. The Committee was also pleased to learn of increased advertising revenues for both *The Journal* and the *ADA News*. The newspaper is well read, particularly the letters to the editor.

"Dental Abstracts": The Committee was pleased to learn that the circulation of *Dental Abstracts* continues to increase and has passed the 10,000 mark. The increase is undoubtedly due in part to the effort being made to aim *Dental Abstracts* toward the needs of clinical dentists.

Advances Series: The Committee supports the change in title of this series to *Update* and is particularly supportive of the plan to make the abstracts more clinically oriented and more visually appealing.

"Journal of Dental Research": The Committee was informed that the contract for production of this journal has not yet been accepted or rejected by the American Association of Dental Research. It was noted that the contract is unchanged for 1976 except for a reduction from $13,000 to $9,000 of ADA support of the AADR editorial office.

Report of Assistant Executive Director (Business Affairs and House Counsel): The Committee reported as follows:

Enforcement of "Principles of Ethics" as Related to "Standards for Dental Prepayment Programs"—Delegate Arthur L. Labelle Resolution 81 to 1975 House of Delegates: The 1975 House of Delegates adopted the following resolution (Resolution 81) which was introduced by Delegate Arthur L. Labelle (*Trans.* 1975:729):

> **Resolved,** that the House of Delegates instructs the Board of Trustees to aggressively pursue means whereby the Association's *Principles of Ethics* as related to *Standards for Dental Prepayment Programs* can be enforced, such activity to occupy a position of top priority in Association programs, with detailed report and analysis of results obtained to be presented to the 1976 House of Delegates.

The Committee calls attention to the fact that the Board of Trustees was advised at its December 1975 session that the aggressive pursuit of means to enforce the Association's *Principles of Ethics* as related to *Standards for Dental Prepayment Programs* could have the effect of attempting to restrain the activities of third parties as distinguished from the mere internal regulation of members of the Association (*Trans.* 1975:577). The Committee is aware from legal advice that it has received that any such attempted restraint could be construed as an illegal boycott, subjecting the Association and those in official positions, including officers, members of the Board of Trustees and councils, and staff, in the Association to civil and criminal penalties and damages under state and federal antitrust statutes. Further, if such enforcement by the Association of the *Principles* as related to the *Standards* whether such be a table of allowances or a usual, customary and reasonable fee arrangement, the Committee also has been advised that such might be interpreted as a prohibited fee fixing scheme in violation of antitrust laws.

The Committee notes that the Association's *Standards for Dental Prepayment Programs* by reason of the careful and consistent use throughout the text of the *Standards* of such a precatory word as "should" rather than such a command word as "shall" are purely advisory as to what the Association believes to be essential to a good dental prepayment program. Such an approach to the *Standards* from a legal and the Committee's viewpoints appears reasonable, and the *Standards,* in and of themselves, should not place the Association in a position of jeopardy with respect to antitrust statutes. However, if the *Principles* were used to impose sanctions, directly or indirectly, as a means of enforcing the *Standards,* the Committee warns that law enforcement agencies or injured parties could allege in complaints that the activities of third parties were being restrained and that such restraints were *per se* violations of the antitrust laws, rendering any good intentions the Association may have had in enforcing the *Principles* irrelevant.

In support of these comments on Dr. Labelle's resolution, the Council on Judicial Procedures, Constitution and Bylaws has requested that specific attention be called to the legal opinion of May 9, 1975, which was submitted in the name of the law firm of Peterson, Ross, Rall, Barber & Seidel by attorney Peter M. Sfikas concerning the antitrust dangers involved in attempting to use the *Principles of Ethics* to require third party agencies to conform to the Association's *Standards for Dental Prepayment Programs* (*Trans.* 1975:148). In addition, the Council also has referred to its comment in its 1975 report on the rights guaranteed by the *First Amendment to the United States Constitution* (*Trans.* 1975:145). The Council cited pertinent paragraphs from the 1964 United States Supreme Court opinion in the case of the *Brotherhood of Railroad Trainmen v. Virginia State Bar,* 277 U.S.1, which vacated as unconstitutional a Virginia Supreme Court injunction against plaintiff's advising union members to obtain legal advice from specified lawyers.

In addition, the Committee was advised that the United States Supreme Court has handed down a number of other decisions of like import, for example, *National Association for the Advancement of Colored People v. Button,* 371 U.S.415 (1963), holding Virginia "running" and "capping" statutes adopted in 1849 violative of First Amendment activities against discrimination; *United Mine Workers v. Illinois State Bar Association,* 389 U.S.217 (1967), setting aside an injunction against a union plan providing salaried attorneys to prosecute members' personal injury and related claims and *United Transportation Union v. State Bar of Michigan,* 401 U.S. 567 (1971), nullifying an injunction against plaintiff's recommending designated attorneys who had agreed to limit their fees.

The Committee concurs in the opinions of the Council on Judicial Procedures, Constitution and Bylaws and the Association's House Counsel that the *Principles of Ethics* are an in-

appropriate and illegal vehicle for the enforcement of standards governing dental prepayment programs and recommends that the 1976 House of Delegates be advised that the Board of Trustees cannot legally "aggressively pursue means whereby the Association's *Principles of Ethics* as related to *Standards for Dental Prepayment Programs* can be enforced."

Other Law Suits: In addition, the Committee reviewed the status report on the various lawsuits in which the Association is either a named party or has a vital interest. The informational report covers the federal and state court actions between the United States Dental Institute and the Association and others; the appeal of the Arizona membership suit; the threatened action by Arizona Attorney General for purported violations of the Arizona Antitrust laws; the complaint filed by a student who claims that his constitutional rights have been violated in that he was required to pay an extra fee because, for religious reasons, he took the Dental Admission Test on a date other than the regularly scheduled date; the settlement of the suit concerning the mailing of cards to one's peers announcing the availability of a service; litigation and pending legislation in New Jersey involving North American Dental Plans, Inc. (a fourth party dental care delivery system controlled by non-professionals); the Association's response to the Federal Trade Commission request for documents relative to the *Principles of Ethics* and their enforcement; the litigation growing out of the ethical proceedings involving Dr. Charles Block; the bankruptcy proceeding of Applied Health Services, Inc. and Metrodent Corporation; the libel suit filed by an advertising dentist against Past President Carlton H. Williams and the Association; the breach of contract action by Dr. Anthony Dietz to gain diplomate status as an endodontist; and the settlement of the suit by two professors growing out of the terminated TEAM project at the Virginia Commonwealth University Dental School.

Report of Council on Insurance: The Committee reported as follows:

The Committee reviewed the annual report of the Council and took note of the increasing participation by membership in the Association sponsored insurance programs. The Council and its staff are to be complimented on their efforts in causing the improvements in the members disability program which went into effect in November 1975.

Report of Council on Insurance, Supplement 1 to Board: The Committee reported as follows:

Association Sponsorship of Survivors Income Benefit Program: The Committee has reviewed Supplemental Report 1 to the Board of Trustees submitted by the Council on Insurance recommending that the Association sponsor a Survivors Income Benefit Program to be administered by the Great-West Life Assurance Company. The Committee is of the opinion that this program will provide a valuable membership benefit when used in conjunction with the present Association sponsored group life program.

The Committee recognizes the need for many members to provide benefits in excess of the current $100,000 maximum allowed by Illinois law and is of the opinion that the SIB program will fulfill this need. Therefore, the Committee recommends approval of Resolution 359 submitted by the Council on Insurance.

The following resolution was adopted by the Board of Trustees:

85-1976-B. Resolved, that the American Dental Association sponsor a Survivors Income Benefit Program to be administered by the Great-West Life Assurance Company in conjunction with the currently sponsored Association Group Term Life Program, and be it further

Resolved, that the Council on Insurance take the necessary steps to implement such program, and be it further

Resolved, that the Executive Director be and hereby is empowered to execute all necessary documents relative to the program.

Report of Council on International Relations: The Committee reported as follows:

Committee A reviewed the report of the Council on International Relations and commends its efforts to relate to and coordinate activities in international dentistry.

Association Membership for U.S. Dentists Overseas: The Committee shares the concern of the Council regarding those United States dentists practicing overseas who cannot retain active membership in the Association under the existing *Bylaws*. In order to make such dentists eligible for direct membership and to extend affiliate membership to those practicing where a national dental association does not exist, Committee A recommends that Resolution 9 be transmitted to the House of Delegates with the approval of the Board of Trustees.

Resolution 9 was ordered transmitted to the House of Delegates with the recommendation that it be adopted.

The report of the Committee continued as follows:

Certificate of Recognition for Volunteer Service in a Foreign Country: The Committee was pleased to learn that the recognition program continues to be so well received with 128 dentists in 26 states receiving commendations this year. In reviewing the criteria for awarding certificates, the Committee agrees with the Council that the significance of the award would be enhanced and the objectives of the program better served by adoption of Resolution 10 and therefore recommends that it be transmitted to the House of Delegates with the approval of the Board of Trustees.

Resolution 10 was ordered transmitted to the House of Delegates with the recommendation that it be adopted.

The report of the Committee continued as follows:

Dental Effort in Guatemala Emergency: The Committee shares with the Council the sense of pride and gratitude resulting from the humanitarian response of American dentistry to those victimized by the recent earthquake in Guatemala. Further, it joins with the Council in commending those individuals and groups who extended their resources to alleviate the suffering of those victimized by this disaster.

Vietnamese Refugee Dentists: Committee A notes with interest the work of the Council to help refugee dentists seeking additional training to become qualified for licensure in this country. The Committee encourages all efforts of the Council as it seeks to aid the 80 Vietnamese dentists of record.

Similarly, foreign dental personnel coming to the United States for study, practice and employment continue to rely upon the expertise of the Council with nearly 800 requests received in 1975.

Annual Session Activities: The Council is to be commended for its many contributions assuring the success of the joint ADA/FDI meeting in Chicago in 1975.

Acknowledgement: Committee A regrets to learn that Dr. Everett C. Claus is completing his final term as a Council member and joins with the Council in recognition of his humanitarian concerns for others and his dedicated service to American dentistry.

Report of Council on Journalism: The Committee reported as follows:

The Committee reviewed the report of the Council on Journalism and is impressed by the apparent influence this Council exerts on upgrading the standards and performance of dental journalism. The Council and its most competent staff should be commended for their work.

Journalism Conference: Committee A wishes to call attention to the fact that although the 25th Journalism Conference held at ADA Headquarters on March 8-9, 1976 enjoyed the success of previous conferences, the attendance was lower, supporting the contention that the policy of meeting in other sections of the country is justified.

The 1977 Journalism Conference will be held in Portland, Oregon, and the 1978 Conference in Atlanta, Georgia.

MSU Dental Editors Seminar: The Dental Editors Seminar continues to enjoy the enthusiastic support and continued praise of all who participate. The cooperative efforts of the Seminar director and his faculty with the representatives of the dental profession once again provided an atmosphere of accomplishment at the Seminar held at Michigan State University in June of this year.

The Committee is aware that, for budgetary reasons, the Finance Committee has found it necessary to recommend that this seminar be eliminated for 1977. Committee A very much hopes that this seminar can again be scheduled in future years when the economic situation improves.

Standards and Guidelines: The Committee reviewed the revised *Standards for Dental Publications* as presented in the report and recommends that Resolution 11 be transmitted to the House of Delegates with the approval of the Board of Trustees. As a procedural matter, the Board of Trustees will have to add a second resolving clause rescinding the *Standards for Dental Publications* which were approved in 1969 by the House of Delegates. Therefore, the Committee proposes the following amended resolution.

The following amended resolution was adopted and ordered transmitted to the House of Delegates with the recommendation that it be adopted:

11B. **Resolved,** that the revised *Standards for Dental Publications* be approved, and be it further

Resolved, that the *Standards for Dental Publications* approved by the House of Delegates in 1969 (*Trans.* 1969:312) be rescinded.

The report of the Committee continued as follows:

Acknowledgement: Committee A notes that Dr. Charles Defever has completed his term on the Council and joins with others in expressing the gratitude of the profession for his long and dedicated service in the cause of dental journalism.

Report of Council on Scientific Session: The Committee reported as follows:

Committee A wishes to commend the Council and its staff for its comprehensive report which demonstrates the Council's dedicated efforts to plan and operate an international scientific program at the 1975 annual session in Chicago. The program included closed circuit television, plaque control, conferences on forensic dentistry and patient education, a table clinic instruction on the care of handpieces, etc. The Committee took special note of the disappointing attendance of 21,895. The Committee does not believe that this was the fault of the Council and its programming and quite clearly it was not the fault of the local committee which was so ably led by Dr. George Kearns. Other factors were involved such as the proximity to the Midwinter Meeting. The Committee firmly believes that a thorough analysis of all such factors should be made before the Association considers holding its annual session in Chicago again.

Acknowledgement: The Committee joins in saluting Dr. J. Frank Chimienti who has served both as a member and as Chairman of the Council and who completes his second three-year term this year.

Report of Council on Scientific Session, Supplement 1 to Board: The Committee reported as follows:

Approval of Section Officers for 1977 Annual Session: Committee A has reviewed the nominations for Chairmen and Vice-Chairmen for the 1977 annual session as submitted by the Council on Scientific Session. The Committee recommends approval of these nominations.

The following resolution was adopted by the Board of Trustees:

86-1976-B. Resolved, that the Section Officers recommended by the Council on Scientific Session for the 1977 annual session be approved.

The report of the Committee continued as follows:

Section Officers Structure: The Committee spent some time discussing the method by which Section Officers are nominated to the Council and then submitted to the Board. It is the Committee's recommendation that a study be made of the entire Section Officers structure and the method of selection. Committee A hopes that the Advance Planning Committee will look at the Section Officers system when the Committee is studying the overall council-bureau structure of the Association.

Report of Bureau of Convention Services: The Committee reported as follows:

Committee A reviewed the annual report of the Bureau of Convention Services and commends the staff on its efficient handling of its many and varied responsibilities.

The Committee calls attention to the importance of a fully coordinated travel program so that officers and trustees may be informed about which staff members are traveling to which meetings. This is especially important to the President or President-elect when he attends a constituent society meeting, and it is equally important to the trustee from that district, to know which staff people plan to participate. Committee A therefore urges the Executive Director to make certain that all personnel make their travel arrangements through the Bureau of Convention Services.

Report of Bureau of Dental Society Services: The Committee reported as follows:

Committee A noted that Mr. Robert Caldwell is the newly appointed director of the Bureau of Dental Society Services and wishes to commend him on the excellent job which he has done since taking this office. The regional conferences as described in the Bureau's report have been highly successful and the Conference on National Dental Organizations was successful in fulfilling the objectives laid down for it.

Continuing Education Registry: It is noted that the Continuing Education Registry has been assigned by administrative decision to the Council on Dental Education. This is an extremely important function and the Committee is pleased to learn of the expanding interest in it by state societies.

Report of Bureau of Library Services: The Committee reported as follows:

The Bureau of Library Services is one of the most efficiently run operations in the Headquarters Building. It is a most important function of the Association and it is widely regarded by librarians as one of the finest special libraries in the country. The library and its package library system provide a very real service to the Association membership and the Bureau's staff is to be commended.

Report of Bureau of Public Information: The Committee reported as follows:

Committee A considered the Bureau's extensive report and continues to be impressed by the scope of its program. Committee A took special note of the services to state societies in which the Bureau provides publicity assistance for the society's annual session. Thus far, the Bureau has assisted 30 state societies; in 1977, Florida, Georgia and South Dakota will receive this assistance.

Dental Mechanics: The Bureau was of particular assistance to the Special Study Commission on the Care of Fully and/or Partially Edentulous Patients during the year by providing staffing throughout this Commission's work. This whole area of illegal dentistry is extremely important today and the Bureau is to be commended for its efforts.

Newspapers, Magazines, Syndicates: Committee A reviewed the work of the Bureau of Public Information with mass media and took special note of the many major dental articles which have appeared during the past year in such magazines as *McCalls, Parents, Good Housekeeping, Redbook,* etc.

Science Writers: Committee A noted that the ADA Science Writers Award is now ten years old and the Committee wishes to express the profession's gratitude to Lever Brothers for its continued support of this program. It is especially pleasing to note that there has been a continued increase each year in the number of entries for this program.

Relief Fund: Committee A commends the Bureau for its assistance to the Council on Relief in conducting the Relief Fund and Disaster Fund campaign. The results speak for themselves: with two months remaining in the campaign, $273,000 had been received, 76 percent above the annual goal.

Report of General Chairman on Local Arrangements for 1976 Annual Session: The Committee reported as follows:

Committee A has reviewed the report of the General Chairman of the Committee on Local Arrangements for the 1976 annual session and wishes to compliment Dr. Hendrickson and his committee. Quite clearly, this will be a highly informative, exciting and most interesting annual session. During the reference committee hearings, Committee A was informed that a contract has now been signed with the Honorable Patrick Moynihan, former ambassador to the United Nations, to be the keynote speaker at the Opening Ceremony in Las Vegas.

Nominations to Committee on Local Arrangements for 1977 Annual Session: The Committee reported as follows:

Committee A has reviewed the names submitted for the 1977 Committee on Local Arrangements by Dr. James W. Cosper, Jr., general chairman, and the Florida Dental Association with the concurrence of the East Coast District Dental Society. The list of Committee officials is impressive, but Committee A was especially impressed by the number of general chairmen of former ADA annual sessions who are represented. Four former general chairmen dating back to the 1954 annual session are being nominated. Each of these men not only helped to shape an effective and enjoyable annual session, but later served on the ADA Board of Trustees as a vice president. Additionally, one man—Dr. Arthur Kellner—also served six years on the Board of Trustees. The Committee salutes them and warmly recommends approval of the following resolution.

The following resolution was adopted by the Board of Trustees:

87-1976-B. Resolved, that the list of nominees submitted by Dr. James W. Cosper, Jr., general chairman, Committee on Local Arrangements, and the

Florida Dental Association with the concurrence of the East Coast District Dental Society, for membership on the Committee on Local Arrangements for the 1977 annual session be approved.

Nomination of General Chairman of Committee on Local Arrangements for 1978 Annual Session: The Committee reported as follows:

Committee A has reviewed the nomination of Dr. Leo E. Young as General Chairman for the 1978 annual session. The Committee notes that this nomination has been submitted by the California Dental Association with the concurrence of the Orange County Dental Society and therefore recommends approval of Resolution 372.

The Board of Trustees adopted the following resolution:

88-1976-B. Resolved, that the nomination of Dr. Leo E. Young as General Chairman of the Committee on Local Arrangements for the 1978 annual session by the California Dental Association with the concurrence of the Orange County Dental Society be approved.

Nomination of General Chairman of Committee on Local Arrangements for 1979 Annual Session: The Committee reported as follows:

Committee A has reviewed the nomination of Dr. Robert D. Londeree, Jr., as General Chairman of the Committee on Local Arrangements for the 1979 annual session. The Committee notes that the nomination has been made by the Texas Dental Association with the concurrence of the Dallas County Dental Society and therefore recommends approval of Resolution 361.

The following resolution was adopted by the Board of Trustees:

89-1976-B. Resolved, that the nomination of Dr. Robert D. Londeree, Jr., as General Chairman of the Committee on Local Arrangements for the 1979 annual session by the Texas Dental Association with the concurrence of the Dallas County Dental Society be approved.

Nomination of General Chairman of Committee on Local Arrangements for 1980 Annual Session: The Committee reported as follows:

Committee A has reviewed the nomination of Dr. Vincent N. Liberto as General Chairman for the 1980 annual session. The Committee notes that this nomination has been submitted by the Louisiana Dental Association with the concurrence of the New Orleans Dental Association and therefore recommends approval of Resolution 362.

The Board of Trustees adopted the following resolution:

90-1976-B. Resolved, that the nomination of Dr. Vincent N. Liberto as General Chairman of the Committee on Local Arrangements for the 1980 annual session by the Louisiana Dental Association with the concurrence of the New Orleans Dental Association be approved.

Association Employees Pension and Life Insurance Program and Long Term Disability Program: The Committee reported as follows:

> While Bankers Life Company of Des Moines as the underwriter of the Association's employee retirement and life insurance plan for the past 29 years and the disability program for the last 10 years has been generally satisfactory, Bankers guidance and annual evaluation has not met the Association's expectations over the past three years. In fact, the Association has looked to Great-West Life Assurance Company for advice on these programs for the past two years, and the Committee believes that Great-West now could better handle these programs for the Association, particularly in light of its handling of other substantial insurance business related to Association membership programs. Therefore, the Committee recommends adoption of the following resolution.

The following resolution was adopted by the Board of Trustees:

> 91-1976-B. **Resolved**, that the American Dental Association Employees Retirement and Life Insurance Plan and Long Term Disability Insurance Plan be transferred from Bankers Life of Des Moines, Iowa to the Great-West Life Assurance Company of Winnipeg, Canada, and be it further
> **Resolved**, that the Executive Director and President of the Association be empowered to execute any and all documents necessary to effect such transfer.

Appeal of Dr. Oscar Malmin: The Committee reported as follows:

> The Committee has reviewed the twenty page letter of July 9, 1976 addressed to the Board of Trustees by Dr. Oscar Malmin and the letter of July 20, 1976 addressed to the Board by the Association of American Dentists. Both letters allege that the following amendment of the *Standing Rules for Councils,* Minutes, page 8, is in violation of the *Bylaws* of the Association and the Illinois General Not-for-Profit Corporation Act of 1974:
>
> > Minutes of councils are available only to members of councils, secretaries of councils, and officers and trustees of the Association when such minutes or portions of such minutes are identified as confidential.
>
> The Committee, being well aware of the prospect of litigation over this issue and the sensitive nature of the membership rights alleged, requested comments on this matter from the legal staff of the Association. Further, for the reasons specified above and to insure impartiality in this matter, the Committee requested outside legal counsel to address the Committee on this issue. Mr. Owen Rall, senior partner in the law firm of Peterson, Ross, Rall, Barber & Seidel, indicated to the Committee that his firm has not been requested to research this issue with the view toward rendering an opinion. Mr. Rall indicated that, because of the circumstances surrounding this issue, it would be in the best interests of the Association to seek such outside legal opinion. The Committee concurs with Mr. Rall and, therefore, recommends the following resolution for the Board's consideration.

The following resolution was adopted by the Board of Trustees:

> 92-1976-B. **Resolved**, that the Association engage outside legal counsel for the purpose of presenting an opinion on the issue of the legality of the Board of Trustees amendment of the *Standing Rules for Councils,* Minutes, which states that:
>
> > Minutes of councils are available only to members of councils, secretaries of councils, and officers and trustees of the Association when such minutes or portions of such minutes are identified as confidential.

and be it further

Resolved, that such opinion be presented to the Board of Trustees at the earliest date possible; however, in no event later than the 1976 annual session of the Board of Trustees.

Report of Committee on Advance Planning: The Committee reported as follows:

Committee A has reviewed the report of the Committee on Advance Planning and is impressed by the thoroughness with which it has accomplished the numerous studies that have been undertaken and brought to resolution for action by the Board of Trustees.

Actions of 1975 House of Delegates: The Committee considered the persuasive arguments related to the creation of an office of Immediate Past President and agrees that the "knowledge and experience" and the "source of wisdom" afforded by the presence of a retiring President would be of benefit to the Association.

Committee A considered both the pros and cons of the proposal and, although not unanimously, supports the recommendation of the Committee on Advance Planning and therefore recommends that the following resolution be transmitted to the House of Delegates with the recommendation that it be approved.

The following resolution was ordered transmitted to the House of Delegates with the recommendation that it be approved:

78. **Resolved**, that the office of Immediate Past President be created and that the Immediate Past President be given a vote on the Board of Trustees.

The report of the Committee continued as follows:

Committee A concurs with the Committee on Advance Planning that the offices of First and Second Vice Presidents can be eliminated and recommends adoption of Resolution 366.

The following resolution was ordered transmitted to the House of Delegates with the recommendation that it be adopted:

79. **Resolved**, that the office of Second Vice President be eliminated.

The report of the Committee continued as follows:

The Committee further agrees that a new office of Vice President should be created with the attendant duties as outlined in the report. Therefore, the Committee recommends adoption of Resolution 367.

The following resolution was ordered transmitted to the House of Delegates with the recommendation that it be adopted:

80. **Resolved**, that the office of First Vice President be changed to Vice President and that the Vice President serve for a term of one year with a vote.

The report of the Committee continued as follows:

Note: Resolutions 78, 79, and 80 are amendments to the *Constitution* and will lay over until the 1977 House of Delegates.

Terms of Trustees and Composition of Trustee Districts: Committee A was pleased to learn that the terms of trustees as well as the geographical distribution of states within trustee districts and certain other inequities are being studied with the plan that these matters might be resolved by the 1976-77 Committee on Advance Planning.

Regarding the matter of officers and trustees serving as Council members concurrent with their terms on the Board of Trustees, the Committee recommends adoption of Resolution 368.

The following resolution was ordered transmitted to the House of Delegates with the recommendation that it be adopted:

81. **Resolved,** that Chapter V, Section 10 of the *Bylaws* be amended by deleting the third and fourth sentences as follows:

> The elective and appointive officers and past trustees of this Association shall be *ex officio* members of the House of Delegates without the power to vote unless designated as delegates. The trustees shall not serve as delegates but shall be *ex officio* members of the House of Delegates without the power to vote.

and substituting therefor the following two sentences:

> The elective and appointive officers and the trustees of this Association shall be *ex officio* members of the House of Delegates without the power to vote. They shall not serve as delegates. Past presidents of this Association shall be *ex officio* members of the House of Delegates without the power to vote unless designated as delegates.

to make the amended section read:

> Section 10. Composition: The House of Delegates shall be limited to four hundred seventeen (417) voting members. It shall be composed of the officially certified delegates of each constituent society and one (1) officially certified delegate from each federal dental service which is not organized into a constituent society. The elective and appointive officers and the trustees of this Association shall be *ex officio* members of the House of Delegates without the power to vote. They shall not serve as delegates. Past presidents of this Association shall be *ex officio* members of the House of Delegates without the power to vote unless designated as delegates.

and be it further

Resolved, that Chapter IX, Section 20, be amended by addition of the following sentence after the second sentence in paragraph A:

> The elective and appointive officers and the trustees of this Association shall not serve as members of councils.

to make the amended section read:

> Section 20. Members, Nominations and Elections:
>
> A. All councils, except as otherwise provided for in these *Bylaws* shall be composed of five (5) members. Nominations for all councils shall be made by the Board of Trustees. Additional nominations may be made by the House of Delegates unless otherwise provided in these *Bylaws*. Members of councils shall be elected by the House of Delegates in accordance with Chapter V, Section 140. The elective and appointive officers and the trustees of this Association shall not serve as members of councils.

The report of the Committee continued as follows:

Study of Association Structure: In response to the many challenges currently being confronted by the organized profession, Committee A finds great merit in the logic "that it is not possible for the profession to dictate solutions. It must through negotiation and demonstration, persuade others to our point of view and have them join us in offering mutually agreeable solutions."

The Committee also agrees that the present structure of the Association could possibly be inadequate to meet these tasks and to relate positively to future problems. Therefore, the continued study of the "structure, management, operation and function of the Association" is justified in the opinion of the Committee with such study to receive highest priority. Thus, Committee A concurs in the *Statement of Purpose* adopted by the Committee on Advance Planning and therefore recommends adoption by the Board of Trustees of Resolution 369.

The Board of Trustees adopted the following resolution:

93-1976-B. Resolved, that the *Statement of Purpose* adopted by the Committee on Advance Planning for its study of the overall "structure, management, operation and function of the Association" be adopted.

The report of the Committee continued as follows:

The Committee on Advance Planning will present recommendations for restructuring the Association to the Board of Trustees at its November 9-12, 1976 session in Las Vegas.

Structure and Operation of the House of Delegates: Committee A agrees that since there has been a considerable increase in the workload of the House of Delegates that all reasonable measures must be employed to expedite the handling of resolutions to assure adequate study. Consequently, the Committee recommends the adoption of Resolution 370.

The Board of Trustees adopted a resolution urging constituent societies and delegates to the 1976 House of Delegates to expedite submission of resolutions to permit full consideration by the Board of Trustees and reference committees of the House of Delegates.

Report of Special Committee to Study the Annual Session: The Committee reported as follows:

The Committee held a special meeting on Sunday, August 15, to consider the recommendations of the Special Committee to Study the ADA Annual Session. Included in these considerations were the *Manual on Annual Session* and the *Manual on Scientific Session* which were referred to Committee A at the spring session of the Board of Trustees.

First, the Committee would like to offer its highest compliments to Dr. James P. Kerrigan and his committee, Dr. Frank P. Bowyer, Dr. J. Frank Chimienti, Dr. Arthur A. Dugoni, Dr. Irving E. Gruber, Dr. George E. Kearns, Dr. Joseph W. Looper and Dr. C. Gordon Watson, *ex officio,* who worked so hard to investigate all aspects of the annual session and to make detailed and highly valuable recommendations. There is clear evidence that the Committee's study has already had a very positive effect on the annual session. Reference Committee A would also like to compliment the Council on Scientific Session for its effort to improve the scientific program and to incorporate the recommendations of the Special Committee. Finally, Reference Committee A compliments the ADA staff which has already taken steps to incorporate many of the recommendations of the Special Committee into the 1976 annual session. Reference Committee A strongly recommends that a commendatory letter be sent to Dr. Kerrigan and each member of his committee for the superlative service

they have rendered the Association.

Following are the recommendations of the Special Committee with the Reference Committee's comments. In cases where the recommendation involves expenditures not now carried in the proposed 1977 budget, Reference Committee A will indicate what additional funds will be necessary. A supplemental appropriation request will be submitted to the November session of the Board of Trustees, if any of these proposals are approved by the full Board at this session.

The following recommendations from the Special Committee to Study the Annual Session, along with amendments proposed by Committee A, were approved by the Board of Trustees, and the comments of Committee A are listed below each recommendation:

Recommendation 1: The ladies activities should be subsidized up to $2,500 to hold down the price of the tickets and encourage greater attendance at their functions.

Comment: Reference Committee A supports this proposal and notes that these funds would have to be placed in the 1977 budget.

Recommendation 2: The honorarium for clergymen should be increased to $75.00.

Comment: Reference Committee A supports this proposal and also recommends that the $75.00 payment be made to the clergyman at the 1976 annual session, an added expenditure of about $100.00.

Recommendation 3: The Council on Scientific Session should be authorized to provide expense reimbursement as necessary for nondentist speakers and for instructors in the Extended Lecture Program of the scientific session.

Comment: Reference Committee A supports the position of the Council on Scientific Session that payments should not be made to U.S. dentists. Therefore, the Committee suggests that this recommendation be changed as follows:

> The Council on Scientific Session should be authorized to provide expense reimbursement as necessary for nondentist speakers.

Recommendation 4: The Council on Scientific Session should be authorized to charge tuition for Extended Lecture Programs.

Comment: Reference Committee A supports this recommendation.

Recommendation 5: Presentation of the following awards should be made at the Opening Ceremony to conserve the time of the House of Delegates: Brookdale Award, Distinguished Service Award, Science Writers Awards, Science Fair Awards, Preventive Dentistry Awards, and all other such awards. Honorary Memberships and Student Clinician Awards should be presented in the House of Delegates.

Comment: Reference Committee A supports this recommendation, noting that the Brookdale Award should be eliminated from the listing since it has been withdrawn by its sponsor.

Recommendation 6: The President of the American Dental Association should give a brief welcoming address at the Board of Trustees Luncheon following the Opening Ceremony.

Comment: Reference Committee A supports the recommendation but notes that this recommendation is moot since the funds for the luncheon have been eliminated from the 1976 and 1977 budgets.

Recommendation 6 was approved because, although the luncheon was eliminated, the Board adopted a motion directing that suitable arrangements be made for specially invited guests, including the officers and members of the Board of Trustees, attending the opening meeting of the annual session (see p. 652 of this volume).

Recommendation 7: Nominations for officers should be scheduled for the first meeting of the House of Delegates on Sunday. Further nominations would still be in order on Wednesday (Amendment to *Manual of House of Delegates*).

Comment: Reference Committee A supports the recommendation and notes that the Committee on Rules and Order of the House of Delegates will be considering an amendment to the *Rules of the House of Delegates* so that this recommendation may be put in force, if the House approves, at this 1976 annual session.

Recommendation 8: If officer nominations take place on Sunday, candidates need not receive lengthy introductions at the caucuses but should simply be presented thereby saving considerable caucus time.

Comment: Reference Committee A supports this recommendation.

Recommendation 9: The "Report of the Committee on Rules and Order" of the House of Delegates should be published in the *Supplement to Annual Reports and Resolutions* and the reading of the "Report" in the House should be discontinued, except for the resolution and changes in the *Rules of the House of Delegates*.

Comment: Reference Committee A supports this recommendation and notes that it is being followed in the 1976 House of Delegates.

Recommendation 11: Chairmen of caucuses should be encouraged to help curb excessive debate by members of their delegations on the floor of the House of Delegates.

Comment: Reference Committee A supports this recommendation and urges each member of the Board of Trustees to transmit it to his caucus.

Recommendation 12: An attempt should be made to limit the number of speakers from the podium and the length of speeches on matters not directly related to the immediate business of the House of Delegates.

Comment: Reference Committee A supports this recommendation and recommends that each member of the Board of Trustees communicate it to his caucus.

The Board of Trustees amended Recommendation 12 to insert the words "from the podium."

Recommendation 13: An investigation should be made of the use of two voting cards of different colors, one for "yes" and one for "no." Each card should have printed on it the word "yes" or "no." In this way, it would be possible on doubtful votes for all persons voting—whether voting yes or no—to raise their cards simultaneously. The Speaker and the Secretary of the House would then be able to make a more accurate judgment and reduce the need for division of the House.

Comment: Reference Committee A supports this recommendation and suggests that it be tried at the 1976 House of Delegates. The additional cost will be about $400 for printing.

Recommendation 14: The General Chairman for the current annual session and the General

Chairman-designee for the following year's session should be consultants to the Council on Scientific Session. Each individual would then serve two years as a consultant.

Comment: Reference Committee A supports this recommendation and further recommends that the General Chairman and General Chairman-designee be invited to participate in the January and May meetings of the Council. It is noted that travel funds of approximately $2,000 will be needed in the 1977 budget for this purpose.

Recommendation 15: The theme for the annual session, which is to be suggested each year by the Council on Scientific Session for approval of the Board of Trustees, should be carried through in the preliminary and official programs, the exhibitor's prospectus and other promotional materials.

Comment: Reference Committee A supports this recommendation, with the amendment that the Council on Scientific Session submit the theme to the President for his approval. This brings the recommendation into conformity with Resolution 524 adopted by the Board of Trustees in 1975 (*Trans.* 1975:467).

> The theme for the annual session which is to be suggested each year by the Council on Scientific Session for approval of the President, should be carried through in the preliminary and official programs, the exhibitor's prospectus and other promotional materials.

Recommendation 16: Further study of the valuable data contained in the survey should be made by the Committee on Advance Planning, the Council on Scientific Session and all agencies concerned with the conduct of the annual session.

Comment: Reference Committee A supports this recommendation and notes that the material has already been circulated to pertinent agencies.

Recommendation 17: Based on the survey results, the annual session should continue to combine the business sessions of the Board of Trustees and House of Delegates and the scientific session.

Comment: Reference Committee A supports this recommendation.

Recommendation 18: Future surveys of dentists' opinions should contain some questions on the annual session; however, the annual session survey itself should be continued, each year if possible, with modifications as needed.

Comment: Reference Committee A supports this recommendation, noting that it contains the words "if possible."

Recommendation 19: Future surveys of the annual session should include a question on whether the dentist comes from a state that has a compulsory continuing education requirement.

Comment: Reference Committee A supports this recommendation and is informed that it is being carried out in the modified survey to be conducted at the 1976 annual session.

Recommendation 25: The officers and trustees of the American Dental Association should promote the annual session in their talks before the membership.

Comment: Reference Committee A supports this recommendation.

Recommendation 26: An interdenominational service should be held, where feasible, at the annual session.

Comment: Reference Committee A supports this recommendation.

Recommendation 27: The President should continue to appoint knowledgeable personnel to reference committees.

Comment: Reference Committee A supports this recommendation.

The Board of Trustees amended Recommendation 27 by inserting the word "knowledgeable" to replace the word "experienced."

The following recommendation from the Special Committee, along with the amendment proposed by Committee A, was not approved by the Board of Trustees:

Recommendation 10: Reference Committee reports should be streamlined to include only that information essential to understanding by the delegates. If the reference committee supports the resolution it is considering, the resolution should be presented in its report with its recommendation for House action, but without further comment. If the Committee submits a revised or new resolution, its reasons should be stated as briefly as possible in the report.

Comment: Reference Committee A suggests an amended version of this recommendation. The recommendation from the Special Committee appears to be too restrictive and, on the other hand, the resolution which is to be proposed to the House Committee on Rules and Order does not seem strong enough:

> Resolved, that background material contained in the reports of reference committees not be read by the chairmen, unless the chairmen and members of the committee feel that it is necessary and important to do so.

Therefore, Reference Committee A suggests the following recommendation:

> Reference Committee reports should be streamlined to include only that information essential to understanding by the delegates. Background material contained in the reports of reference committees should not be read unless requested by a majority vote of the House of Delegates.

The following recommendations from the Special Committee were referred to the Committee on Advance Planning with the recommendation that serious thought be given to establishing a Council on Annual Session:

Recommendation 20: The Council on Scientific Session should be deleted from the *Bylaws* and replaced by a Council on Annual Session consisting of seven members (two of whom shall be the General Chairman and the General Chairman-elect of the Local Arrangements Committee) whose duties and responsibilities include all aspects of the annual session of the American Dental Association presently assumed by the Council on Scientific Session, the Bureau of Convention Services, and the Department of Sales and Advertising. The new Council will coordinate and utilize the expertise of other bureaus and agencies concerned with the conduct of the annual session.

> (Note from the Special Committee: The Committee believes that the Bureau of Convention Services and the Department of Sales and Advertising should remain intact, but that their duties pertaining to the annual session should come under the jurisdiction of the Council on Annual Session.)

Recommendation 21: Five members of the Council on Annual Session shall be elected for a term of three years. The General Chairman of the Committee on Local Arrangements for the current year and the General Chairman-elect for the succeeding year shall serve as *ex officio* members of the Council with the right to vote.

Recommendation 22: The General Chairman of the Local Arrangements Committee for the current and succeeding year, who are members of the Council on Annual Session, shall not be eligible to serve as Chairman of that Council.

Recommendation 23: All members nominated for the Council on Annual Session should have proven expertise in planning and conducting dental meetings.

Recommendation 24: There shall be a secretary who shall coordinate the activity of the Council on Annual Session and of all other staff members involved in the conduct of the annual session. The Special Committee strongly believes that there is sufficient expertise among the present staff members who have been involved with the annual session and that the selection of staff for the Council on Annual Session should be made from among these individuals.

Comment: All of these recommendations hinge on the question of whether a Council on Annual Session should replace the Council on Scientific Session. Reference Committee A discussed the matter at length and concluded that a Council on Annual Session was necessary in order to have more input into the planning of the annual session by dentists who are experienced in the planning of such sessions at the state and local level. However, Reference Committee A is aware that the Committee on Advance Planning will be considering a reorganization of the total council-bureau structure during 1977. Therefore, Reference Committee A suggests referral of this matter to the Committee on Advance Planning with the recommendation that serious thought be given to establishing a Council on Annual Session.

The report of the Committee continued as follows:

Manual on Scientific Session: Reference Committee A supports all of the recommended changes which have been made in the *Manual on Scientific Session* on the suggestion of the Special Committee, with the exception of the payment of honoraria, as indicated in Recommendation 3 above. Therefore, on page 7 the wording should be changed to "Expense reimbursement may be established as necessary by the Council on Scientific Session for nondentists." There is one additional change suggested by Reference Committee A in the recommendations made by the Council and by the Special Committee. On page 17, under the subhead "Lunch and Learn," the third sentence specified the number of persons being seated at a table. Since table size changes from year to year, Reference Committee A suggests the sentence should read "The discussion leaders will host a table seating annual session registrants who have made a luncheon reservation in advance by the purchase of a ticket."

The Board of Trustees adopted motions approving the following changes in the *Manual on Scientific Session:*

Page 7: Amend the wording on expense reimbursement to read:

> Expense reimbursement may be established as necessary by the Council on Scientific Session for nondentists within the limitations of the budget of the scientific session.

Page 17: Amend the wording on table size under "Lunch and Learn" to read:

> The discussion leaders will host a table seating annual session registrants who have made a luncheon reservation in advance by the purchase of a ticket.

The report of the Committee continued as follows:

Finally, Committee A recommends that the amended *Manual on Scientific Session* be approved.

The following resolution was adopted by the Board of Trustees:

94-1976-B. Resolved, that the amended *Manual on Scientific Session* be approved.

The report of the Committee continued as follows:

Manual on Annual Session: This manual was submitted to the Board of Trustees at its spring session. Reference Committee A supports the many recommended changes with three minor exceptions.

On page 13 in the first full paragraph, the last sentence discusses funds for the dinner meeting of the local committee. This sentence should be eliminated since these funds have been dropped from the 1976 and 1977 budgets and the Committee is informed that this item is usually paid for by the local convention bureau.

The Board of Trustees adopted a resolution eliminating the following sentence from the proposed *Manual on Annual Session:*

Funds for this dinner are provided in the annual session budget and dinner expenses will be handled through the Association's Director of the Bureau of Convention Services.

The report of the Committee continued as follows:

On page 14, number 10, the second sentence should be changed to indicate that the theme recommended by the Council on Scientific Session will be submitted to the President for his approval in order to bring this recommendation into line with the resolution adopted by the Board of Trustees in 1975 (*Trans.* 1975:467).

The Board of Trustees adopted a resolution to change the second sentence in number 10 on page 14 of the proposed *Manual on Annual Session* to read as follows:

A theme will be recommended by the Council on Scientific Session to the President for his approval.

The report of the Committee continued as follows:

On page 16, the last sentence in paragraph 2 discusses the subsidy for the ladies' activities. Reference Committee A believes that the specific sum should be eliminated because this might vary from year to year.

The Board of Trustees adopted a resolution to change the last sentence in number 2 on page 16 of the proposed *Manual on Annual Session* to read as follows:

Ladies' activities may be subsidized up to an amount approved by the Board of Trustees.

The report of the Committee continued as follows:

Finally, Committee A recommends that the amended *Manual on Annual Session* be approved.

The following resolution was adopted by the Board of Trustees:

95-1976-B. Resolved, that the amended *Manual on Annual Session* be approved.

Recess: The Board of Trustees recessed at 12:25 PM and reconvened at 1:40 PM.

Commendation to Dr. Lloyd J. Phillips—Indiana Dental Association: The Committee reported as follows:

> Committee A warmly joins with the Indiana Dental Association in saluting Dr. Lloyd J. Phillips and his outstanding service to the dental profession, and recommends that Resolution 49 be transmitted to the House of Delegates with the recommendation that it be approved.

Resolution 49 was ordered transmitted to the House of Delegates with the recommendation that it be approved.

Amendment of "Bylaws" on Scientific Session—New Jersey Dental Association and Rhode Island Dental Association: The Committee reported as follows:

> Since the resolution from the New Jersey Dental Association and the Rhode Island Dental Association are identical, the Committee considered them simultaneously. In its deliberations the Committee also considered a report from the Council on Scientific Session which stated that the Council opposes the creation of a new section on Oral Medicine. The Council points out, and Reference Committee A concurs, that Oral Medicine touches virtually all of the 14 existing sections. It was noted by the Council that the objectives of the American Academy of Oral Medicine are:
>
> > Oral Medicine is that area of special competence in the field of dentistry, relating to the management of the total health of the patient, which is concerned with the diagnosis and nonsurgical treatment of primary and secondary disease involving the oral and paraoral structures.
>
> This subject matter is adequately covered by the existing sections and, therefore, Committee A recommends that Resolutions 34 and 38 be transmitted to the House of Delegates with the recommendation that they be postponed indefinitely.

Resolutions 34 and 38 were ordered transmitted to the House of Delegates with the recommendation that they be postponed indefinitely.

Engagement of Actuary for ADA Insurance Programs—Oregon Dental Association: The Committee reported as follows:

> The Committee has reviewed Resolution 37 submitted by the Oregon Dental Association recommending that the Association be directed to engage an independent actuary who is a Fellow of the Society of Actuaries to review the experience of the sponsored life, disability and health programs and, in addition, to engage an independent actuary who is a Fellow of the Casualty Actuarial Society, to review experience of the sponsored liability programs. The Committee is in agreement with the Oregon Dental Association that ADA insurance programs need to receive continuous and critical evaluation. This evaluation is an ongoing process by the Council on Insurance. The Association renegotiated the disability contract effective November 1975. In the negotiation process, the Association utilized the services of Marsh & McLennan, the administrator of the programs, and the actuarial resources available in that company. The results of that study were carefully analyzed by the Council. The result is a markedly improved contract.

The Council on Insurance has maintained similar vigilance in all other Association sponsored insurance programs. The Council on Insurance, when it deems necessary, can request of the Board an independent actuarial study of any programs sponsored by the Association. In the past the Council on Insurance has made this request of the Board with subsequent approval. Therefore, while the Committee recognizes the need for constant critical evaluation of Association sponsored insurance programs, it recommends that for the above stated reasons Resolution 37 submitted by the Oregon Dental Association be postponed indefinitely.

Resolution 37 was ordered transmitted to the House of Delegates with the recommendation that it be postponed indefinitely.

Nomination for Offices of the American Dental Association—Texas Dental Association: The Committee reported as follows:

As indicated earlier in this report, Committee A has been informed that the House Committee on Rules and Order will be considering an amendment to the "Rules of the House of Delegates" which would place nominations in the first meeting of the House of Delegates on Sunday. Reference Committee A supports such a change and therefore recommends that the Texas Dental Association Resolution 53 be postponed indefinitely.

Resolution 53 was ordered transmitted to the House of Delegates with the recommendation that it be postponed indefinitely.

Introduction of New Business in House of Delegates—Washington State Dental Association: The Committee reported as follows:

Reference Committee A has reviewed the Washington State Dental Association Resolution 39. Committee A strongly supports the intent of Resolution 39 and commends the Washington State Dental Association for submitting it. However, the Committee believes that the resolution is too restrictive. If it were to be passed as currently written, it would cut off resolutions from several state dental societies which meet within 30 days of the annual session and from caucuses which meet in the week prior to the annual session. Having said this, Committee A strongly urges that the House Committee on Rules and Order give consideration to amending the Rules so that there will be a cutoff of introduction of new business at the close of the first meeting of the House of Delegates on Sunday afternoon. Committee A believes that there must be an exception so that urgent matters can be introduced and therefore suggests the House Committee on Rules and Order consider an exception which would require a three-fourths vote of the House of Delegates for the introduction of new business following the close of the first meeting of the House of Delegates. Therefore, the Committee recommends that Washington State Dental Association Resolution 39 be postponed indefinitely.

Resolution 39 was ordered transmitted to the House of Delegates with the recommendation that it be postponed indefinitely.

Position Statement on Advertising—Washington State Dental Association: The Committee reported as follows:

In Committee A's consideration of Resolution 41, which has been submitted by the Washington State Dental Association, calling for the development of a position statement informing legislative and administrative agencies and the public of the reasons why ethical dentists do not advertise, the Committee was aware of the Federal Trade Commission's action against the American Medical Association, the United States Justice Department suit against the American Bar Association, the United States Supreme Court decision in the

spring of 1976 finding that state boards of pharmacy could not proscribe the advertising of prescription drug prices by pharmacies, the threatened antitrust suit by the Arizona Attorney General concerning the advertising prohibitions contained in the ADA's *Principles of Ethics,* and the clamor by consumer groups for the unfettered privilege of advertising by all professionals. In addition, the Committee was also mindful that the Association's Council on Judicial Procedures, Constitution and Bylaws has recommended a moratorium against disciplinary actions involving advertising by dentists except advertising designed to solicit patients and that the Association's Executive Director has appointed a staff committee to develop recommendations to the Board of Trustees at its November 1976 session for possible consideration by the 1976 House of Delegates concerning the issuance of local dental directories by either component and constituent societies or consumer groups with the cooperation of such dental societies. Further, the Committee just learned that two Arizona attorneys who placed blatant advertisements respecting their services in the public press recently were censured by the Arizona Supreme Court instead of having their licenses to practice suspended for two years as recommended by the Arizona Bar Association. Justice Rehnquist of the United States Supreme Court has stayed the censure, pending a decision by the United States Supreme Court whether or not to hear the matter. In this setting, the Committee believes that the Washington State Dental Association resolution, if adopted, could be construed, because of its vigorous language, as a defiant challenge to enforcement agencies such as the FTC and the Justice Department. Therefore, the Committee believes that the objectives of the Washington resolution can be just as easily accomplished by adoption of the following resolution.

The following resolution was ordered transmitted to the House of Delegates with the recommendation that it be substituted for Resolution 41 and that the substitute resolution be approved:

41B. **Resolved,** that the Board of Trustees develop a national policy position on advertising by dentists.

Reconsideration of 1974 Wisconsin Resolution 43 Regarding Modification of Membership Card—Wisconsin Dental Association: The Committee reported as follows:

The Committee has reviewed Resolution 42 submitted by the Wisconsin Dental Association requesting that the House of Delegates approve the issuance of a standard-sized, multipurpose plastic membership card. The submitter contends that such a card would expedite registration at dental meetings and would accurately identify and record the attendance of members at continuing dental educational courses.

The 1974 House of Delegates referred the possible issuance of such a card to the Board of Trustees for study and implementation, if feasible (*Trans.* 1974:603). The Board, among other reasons, learned at that time that the start-up costs to furnish a plastic membership card to each active, life and retired member would be as follows:

Cost of cards for 106,000 active, life and retired members @20¢ ea.	$21,200
Annual average of 24,000 address changes and new members.	7,200
Postage (assuming bulk shipment to constituent dental societies)	2,000
Minimum of 600 imprinters @$50 ea. . . .	30,000
	$60,400

Wisconsin contends that these figures are in gross error. However, the Committee understands that Wisconsin is actually talking about a five-line card while the ADA is required to issue a seven-line card, the additional two lines indicating the member's constituent and component societies. Wisconsin's contemplated five-line card would cost 12¢ and the ADA's seven-line card 20¢. While the Committee is unaware of any other estimated specific differ-

ences in cost projections, the Committee was advised that the Association's Continuing Education Registry currently uses a prepunched IBM card and that the conversion from IBM to the plastic card would be a significant additional cost.

Committee A, to set the record straight, points out that the 1975 Reference Committee on Budget and Administrative Matters had no resolution before it but merely the Board's informational report in which the Reference Committee concurred (*Trans.* 1975:644).

The Committee notes that Wisconsin Resolution 42 is parliamentarily incorrect when it calls for reconsideration of a resolution that was acted on by a previous House of Delegates. The Committee, believing that the Board again could look into the feasibility of issuing a plastic membership card, offers the following substitute resolution for Wisconsin Resolution 42.

The following resolution was ordered transmitted to the House of Delegates with the recommendation that it be substituted for Resolution 42 and that the substitute resolution be adopted:

42B. Resolved, that the Board of Trustees study the feasibility of issuing each active, life and retired member a plastic membership card and, if practicable, arrange for the issuance of such cards commencing in 1978.

Amendment of "Bylaws" to Change Dues Requirement for Active Members Joining After October 1—Odontological Society of Western Pennsylvania Resolution 79 to 1975 House of Delegates: The Committee reported as follows:

The Committee reviewed Resolution 79 which was introduced by the Odontological Society of Western Pennsylvania and received by the 1975 House of Delegates, proposing a *Bylaws* amendment changing the dues obligation for active members joining after October 1 (*Trans.* 1975:629). Since this Resolution 79, if adopted, would change the dues of some active members, the Speaker of the House referred it to the 1976 House for action.

As the Board of Trustees was advised at its December 1975 session, the submitter of Resolution 79 stated in support of the resolution that some prospective applicants in the latter quarter of the year choose to delay joining until the beginning of the following year rather than pay out one-half year's dues for less than a quarter of a year's active membership privileges (*Trans.* 1975:574). The submitter contended that, as a consequence, recruitment activities are hindered and young dentists are thus kept "from enrolling in the various insurance programs available."

Since the Committee was advised that the adoption of the following resolution will not present any insurmountable burdens, the Committee suggests that the Board of Trustees recommend approval of the resolution by the House of Delegates.

The following resolution, Resolution 79-1975, was ordered transmitted to the House of Delegates with the recommendation that it be adopted:

79-1975. Resolved, that Chapter I. Membership, Section 50, Dues and Reinstatements, Subsection H, Members Elected After July 1, be amended by adding the words "and October 1" to the subsection heading and by inserting after the words "current year's dues" in line 310* the words and punctuation, "; and who are elected after October 1, shall pay one-quarter (¼) of the current year's dues;" so that the subsection will read:

*Editorially corrected from reference to "line 303" to reference to "line 310" as a consequence of the revised edition of January 1, 1976, of the *Constitution and Bylaws*.

H. Members Elected After July 1 and October 1. Active members elected to active membership in this Association for the first time, and who are elected after July 1, shall pay one-half (½) of the current year's dues; and who are elected after October 1, shall pay one-quarter (¼) of the current year's dues; except that a student member, upon his classification as an active member by a constituent society shall pay no further dues for the remainder of the calendar year in which he was entitled to the benefits of student membership.

REPORT OF COMMITTEE D

The Report of Committee D was read by Dr. Cappuccio, chairman. The other members of the Committee were Drs. Dixon, Gertler and Savoie.

Report of Council on Dental Laboratory Relations: The Committee reported as follows:

Committee D reviewed the report of the Council on Dental Laboratory Relations and gave attention to the Council's activities in meeting the challenge posed by those engaged in illegal dental practice.

Conference on Illegal Dental Practice: The Committee is pleased to learn that the Council is sponsoring a conference on illegal dentistry on November 13 at Las Vegas. Because the usual seminar for dental laboratory technicians is not feasible in Las Vegas, the Council developed a program on an immediate and critical problem that is particularly acute in the southwest and Rocky Mountain states, namely the effort of illegal dental operators to legalize their activities either through court challenges to the dental laws or through enactment of special licensure laws. This conference should satisfy those constituent societies who are asking for a special conference on the illegal practice of dentistry.

Auxiliary Status for Dental Laboratories: The Committee agrees with the Council that existing policy on auxiliary status for dental laboratories and technicians is completely justified. The Committee believes that the commercial dental laboratory that processes an appliance to the specification of a dentist is itself an auxiliary procedure authorized by the individual dentist.

Denture Care Assignments: The Committee commends the Council for planning and undertaking new and innovative projects relating to denture care. The pilot project in Oregon, a cooperative effort of the Council and the Bureau of Public Information, is progressing satisfactorily and should provide a model for other states threatened with efforts to license unqualified persons for the provision of denture care directly for members of the public. The Council's plan to establish a clearing house of law enforcement information should be implemented as soon as feasible. The Committee wishes to commend the Oregon project on the recent survey on the attitudes of dentists on the illegal practice of dentistry and suggests that a follow-up survey be conducted in a year to see if the attitudes of dentists have changed.

Relation with Commission on Denture Care: The Committee expresses its gratitude to the Commission for its excellent final report and recommendations. The Commission identified the Council as the prime agency for carrying out programs to assist constituent societies in combating the illegal dental operators. The Committee will watch carefully the Council's efforts in this critical area of its responsibilities.

Relation with Dental Laboratory Groups: The Committee suggested that the Board urge the Council to intensify its efforts in maintaining effective and cordial relations with the National Association of Dental Laboratories and the Dental Laboratory Conference. The Committee was dismayed by the NADL attitude toward the dental mechanics movement in Canada and by the results of an NADL survey of United States dental laboratory owners. That

survey reflects a surprising acceptance for legalizing denture care by dental laboratory personnel.

Use of Terms: The Committee urges all agencies of the Association to use "illegal dentistry" or "bootleg dentistry" in referring to the unlicensed practice of denture care.

Acknowledgements: The Committee joins the Council in expressing appreciation to Dr. Robert L. Taylor for his services as a member and chairman and to Dr. John J. Mingenback for his services as a Council member.

Report of Council on Dental Materials and Devices: The Committee reported as follows:

Committee D reviewed the annual report of the Council on Dental Materials and Devices. The Committee noted the extensive amount of work covered by this Council and its ability to attract representatives from the various national organizations that have an interest in dentistry, particularly the Food and Drug Administration, the Bureau of Radiological Health and the National Institute of Dental Research.

The Committee was pleased to note that the Council has started the third year of the five year grant supported by the National Institute of Dental Research to assist in activities of the American National Standards Committee MD156. The amount for the third year is noted to be $110,000 including $45,000 in indirect costs, and is for the purpose of the formulation and evaluation of needed test methodology.

Reports of Complaints and Defects in Dental Materials and Devices: The Committee was pleased to note that the complaint reporting program of the Council has assisted many members in settling complaints with industry. Since the 1975 annual report 430 complaints have been received. All complaints regarding a defect or technical difficulty with a product have been settled to the satisfaction of the dentist. The remainder of complaints regarding non-delivery of prepaid materials and requests for refunds were largely lodged against one company, Applied Health Services. The Company has declared bankruptcy and the Association is active in behalf of those dentists not receiving the prepaid materials or refunds. Mr. J. P. Noone has been named as chairman of a committee to attempt to arrive at a fair settlement for the creditors and company involved. The Council continues to review complaints as received hoping to be able to pinpoint trouble areas associated with the clinical performance of the materials and devices and thereby give guidance to future Council programs.

Implants: Committee D was happy to learn that the Council cosponsored a conference on the very controversial subject of endosseous implants in cooperation with Council on Dental Research. It is noted that the chief purpose was to develop a scientific mechanism for the collecting of clinical data at various stages beginning with the selection of the patient through the post-operative period and that the goal was reached.

Labeling of Dental Materials: The Committee was pleased to note that the requirement for a clear date of manufacture on products accepted by the Council has been instituted. The Committee further noted that the Council is also considering a requirement of content disclosure in the labeling of all dental materials with priority to be given to the various casting alloys used in dentistry. This requirement would assist the dentist in distinguishing between terms such as noble metal based alloys, semi-precious alloys, non-precious alloys and base metal alloys, and assist in the selection of desired products.

Partially Prefabricated Dentures: The Committee noted that on the basis of the available knowledge the Council does not presently recognize the partially prefabricated denture as suitable for the prosthodontic treatment of patients. The reason for this is that the Council is of the opinion that sufficient evaluation of these products and techniques has not been accomplished. The Council believes that adaptation of the physical configuration of prefabricated dentures to a variety of patients, occlusal relations, tooth position over the ridge, dimensional stability, deterioration of the denture, irritation, monilial infection, or other possible changes, should be investigated.

Mercury Hygiene: The House of Delegates in 1975 adopted the following resolution submitted by the Fourth Trustee District (*Trans.* 1975:742):

> **Resolved,** that the Council on Dental Materials and Devices of the American Dental Association recommend certain basic requirements and standards to the manufacturers of mercury and the manufacturers of both manual and mechanical instruments and devices used in handling mercury in dental offices to prevent spillage and contamination.

The Council has implemented the resolution by the establishment of new projects in ANSC MD156 to formulate standards for mechanical amalgamators, capsules and proportioners. Drafts of such standards were reviewed at meetings of ANSC MD156 subcommittees on March 24, 1976 and are being revised in accordance with comments received. Draft documents should be available for review by the Council by the end of 1976.

The Committee was pleased to note that the Council continued its review of this area and published a recommended semi-quantitative mercury vapor survey procedure based upon "film badge indicator" (*JADA* 91:610, September 1975).

Federal Legislation, Medical Devices Amendments 1976: The Committee was pleased to learn that the device legislation discussed in previous reports of the Council which had passed the U.S. Senate in 1975 and the U.S. House of Representatives in 1976 was signed into law on May 28, 1976 by President Ford. The Committee noted that the final legislation contained the inclusion of the dentist in the exemption sections of the bill related to prescriptions of fabrication of custom devices. The Committee noted that the major provision of the legislation for medical devices is in agreement with programs of the Council conducted for dental materials and devices over the past 10 years.

Acknowledgements: Committee D joins the Council in its tribute to Dr. Floyd A. Peyton and wishes to express its sincere appreciation to Dr. Peyton for his many contributions to dentistry. The Committee recommends that Dr. Peyton be cited and recognized by the American Dental Association during the 1976 annual session for his meritorious contributions towards the increased quality of dental products throughout almost 40 years of research and for his administrative accomplishments in leading dental standards development in the United States since 1964. Committee D also joins the Council in expressing its appreciation to Dr. Richard D. Norman for his service on the Council.

Report of Council on Dental Research: The Committee reported as follows:

Committee D reviewed the report of the Council on Dental Research and was sorry to learn that the Council program "Traineeships in Dental Research for Prebaccalaureate College Students" was inactivated in its twelfth year. The Committee was pleased, however, to learn of the excellent results of the program, namely, that 30 percent of the 375 students had either enrolled or graduated from dental school, 33 percent had either enrolled or graduated from medical school and 37 percent were seeking or had obtained a doctorate in the basic sciences.

Biomedical Research Support Grants: Committee D was concerned upon learning that the amount in research grants that a dental school must receive from NIH to qualify for a Biomedical Research Support Grant has been raised from $100,000 in 1975 to $200,000 in 1976. Committee D agrees that this defeats the purpose of the program as far as dental schools are concerned and supports the Council's recommendation that the eligibility level of $100,000 be restored. It is unfortunate that the number of dental schools that are now able to receive such support has been reduced from 34 to 22.

Protection of Human Subjects: Committee D noted with interest that all clinical studies require the informed consent of each patient, regardless of the degree of risk involved. This must be obtained before the subject participates in the study. Committee D agrees that the Council should issue an advisory report to the profession on this aspect of research as soon as all new information has been properly assessed.

Fiftieth Anniversary of the ADA Health Foundation Research Unit, National Bureau of Standards: Committee D was interested to learn that the Research Unit at the National Bureau of Standards which is sponsored by the American Dental Association will celebrate its 50th anniversary in 1978. Committee D concurs with Council members that appropriate plans for celebrating this important event be formulated and presented to the Board of Trustees for approval. It is planned to celebrate this event during the International Association for Dental Research meeting in Washington, D.C. in 1978 and to seek funds from the National Institute for Dental Research for minimal expenses. The American Dental Association would be asked for funding only if other sources fail and it would be an amount less than $5,000.

Report of Council on Dental Therapeutics: The Committee reported as follows:

Committee D reviewed the annual report of the Council on Dental Therapeutics and commends the Council on the pertinent and important activities therein described. The Committee noted the liaison the Council has with the Food and Drug Administration and believes that this should be continued as it will provide considerable value for the Council programs. It is noted that staff members serve in an advisory capacity to the Food and Drug Administration.

Inhalation Anesthetics: Committee D noted that the Ad Hoc Committee on Trace Anesthetic Gases has been assigned to the Council on Dental Therapeutics. The Committee is pleased that the Council has taken on this additional duty and hopes that this problem can be solved in the best interest of the practicing dentist. Committee D was interested to learn that the National Institute of Occupational Safety and Health document which spells out the guidelines for the use of nitrous oxide and halothane in the dental office and hospital operating room has been amended, through the intercession of the ADA Ad Hoc Committee on Trace Anesthetic Gases, so as to omit the dental office. A separate document or addendum to the present document will be prepared for the dental office after projected studies have been completed. The original criteria document imposed stringent requirements on the dental office personnel as well as the hospital operating room personnel. This involves a formal agreement to uphold the standards some of which are:

1. Requirement of pre-employment physical examination and maintenance of medical history on employee for 20 years
2. Upper limits of trace nitrous oxide waste concentration at 30 parts per million
3. The patient's exhaled breath shall be collected by the scavenging system for one hour after administration of the anesthetic agent
4. Repetitive sampling of waste gases in the dental office shall be conducted on a monthly basis

"Hepatitis Workshop": Committee D congratulates the Council upon the excellent publication on this important subject that appeared in *The Journal* (*JADA* 92:153 January 1976). The Committee noted that the carrier state, the prevalence of the disease in dentists, and its transmission and possible prevention are discussed in this paper in a question and answer format which makes it exceedingly easy to read and understand.

Simplified Endodontics: Committee D was pleased to learn that representatives from the Councils on Dental Therapeutics and Dental Research met with representatives of agencies having an interest in the endodontic treatment of teeth in order to identify problem areas and explore approaches to resolve them. The Committee noted that the meeting resulted in an agreement that the protocol for an animal toxicity study would be developed with the help of qualified experts so the results of these studies can be considered valid. The Committee was informed by staff that the American Endodontic Society did agree to be responsible for the development of the protocols for the research studies in this area. After these protocols have been accepted by appropriate authorities, staff, Council members and members from both endodontic societies will seek funding. Committee D learned that the protocols have been submitted and are now being reviewed by recognized experts. Committee D expressed concern about the term "simplified endodontics" and suggested that the Council on Dental Therapeutics look into the matter of a more appropriate term.

Health Screening Program: Committee D noted that the Health Screening Program was well attended in 1975 and commends the Council on this excellent program. The Committee was pleased to learn that the program will be continued in 1976 in spite of the fact that funding for it has become extremely tight. The Committee was advised that the American Fund for Dental Health is providing $10,000 for the program this year and will help staff find additional monies. Time is set aside annually (Tuesday morning 9:00-10:00) for members of the House of Delegates, and Trustees may be examined by appointment.

Periodontal Pathology Research Center: Committee D was interested to learn that the Periodontal Pathology Center which was a joint effort between the American Dental Association and the American Academy of Periodontology has completed its eighth year and processed all the material available into teaching aids. It is understood that due to the fact that there is no longer funding for this activity that it will be phased out at the end of this year, but that the study material will continue to be available.

Acknowledgements: The Committee wishes to express sincere appreciation to Dr. N. Wayne Hiatt for his many contributions during his six years of service to the Council.

Report of Council on Federal Dental Services: The Committee reported as follows:

The Committee calls the Board's attention to the Council's excellent description of the activities of all the federal dental services.

Retention of Army Dental Officers: The Committee joins the Council in expressing concern for the extremely low retention rate within the Army Dental Corps. Recent experience indicates, for example, that only six percent of Army dental officers completing their initial two-year obligation extended their service. The Committee is encouraged, however, by urgent reforms and innovative measures undertaken by the Army Dental Chief, Major General S. N. Bhaskar, to improve facilities and personnel policies. The Committee commends General Bhaskar for his candid assessment of the Army Dental Corps inadequacies and for his commitment to change the situation as soon as possible.

Veterans Administration Reimbursement Arrangements: The Committee noted the Council's concern that V. A. reimbursement arrangements reflect accurate and timely data on usual and customary fees in each state. V. A. fees are established on a regional or state wide basis by negotiations between the constituent societies and the V. A. The Committee believes that it is critical for constituent dental associations to be reminded that the V. A. is prepared to negotiate revised reimbursement arrangements with constituent societies at reasonable intervals. The Committee submits the following resolution to give appropriate emphasis to this concern.

The following resolution was ordered transmitted to the House of Delegates with the recommendation that it be approved:

84. Resolved, that the ADA encourage the Veterans Administration to improve its efforts to obtain timely and accurate data on the cost of dental services in states and localities before entering negotiations on reimbursement arrangements with constituent dental associations.

The report of the Committee continued as follows:

Continuation Pay Entitlement: The Committee supports the Council's effort to expand entitlement of dental officers to receive continuation pay. The Committee, therefore, recommends that Resolution 7 be transmitted to the House of Delegates with the approval of the Board of Trustees.

Resolution 7 was ordered transmitted to the House of Delegates with the Recommendation that it be approved.

The report of the Committee continued as follows:

> **Expanded Function Dental Auxiliaries:** The Committee is pleased with the Council's effort to obtain commitments from the dental chiefs to conform their auxiliary programs to ADA policies. The Committee urges the Council to give special attention to the use of expanded function dental auxiliaries within the Indian Health Service. Committee D agrees with Resolution 8 submitted by the Council and recommends that it be transmitted to the House of Delegates with the approval of the Board of Trustees.

Resolution 8 was ordered transmitted to the House of Delegates with the recommendation that it be approved.

The report of the Committee continued as follows:

> **Veterans Omnibus Health Care Act of 1976:** The Council identified three changes in dental benefits for veterans within this bill that require evaluation in relation to ADA policies. The Committee believes that existing policy should be modified to approve of the V. A. providing to veterans who are hospitalized or who are residing in domiciliary institutions care for dental conditions that are aggravating a medical condition whether or not the medical condition is service connected. Existing policy restricts adjunctive dental care to those who are institutionalized for service-connected medical conditions only. That policy was adopted in 1953 (*Trans.* 1953:232) and is as follows:
>
> > **Resolved,** that nothing in this statement of policy should be construed to apply to the present system for providing dental services in Veterans Administration hospitals and domiciliary institutions or to the present system for providing outpatient dental care (1) to veterans whose dental conditions have been professionally determined to be aggravating a service-connected medical condition, and (2) to veterans whose service-connected dental conditions have been determined to be disabling and compensable.
>
> The language in the V. A. proposal providing care where a dental condition is "associated with" a medical condition conflicts with ADA policy.
>
> The Committee submits the following resolution and recommends that it be transmitted to the House of Delegates for approval.

The following resolution was ordered transmitted to the House of Delegates with the recommendation that it be approved:

> 85. **Resolved,** that the third resolving clause of Resolution 53-1953-H (*Trans.* 1953:232) be amended to strike "service-connected" wherever it appears, the amended resolution to read as follows:
>
> > **Resolved,** that nothing in this statement of policy should be construed to apply to the present system for providing dental services in Veterans Administration hospitals and domiciliary institutions or to the present system for providing outpatient dental care (1) to veterans whose dental conditions have been professionally determined to be aggravating a medical condition, and (2) to veterans whose dental conditions have been determined to be disabling and compensable.

The report of the Committee continued as follows:

Emergency Care: The Committee calls the Board's attention to the Council's request for the Board's determination of whether the following is consistent with ADA principles because it is not covered by specific policy on V. A. dental care entitlement.

> The Veterans Administration would be authorized to provide "emergency" outpatient dental care for a nonservice-connected dental condition, but only to the extent required to relieve pain and/or control infection. Major restorations, therapy, or prostheses would not be allowed under this change.

The Committee believes that a veteran faced with a dental condition requiring emergency treatment should be entitled to V. A. outpatient dental services necessary for relief of pain and control of infection. To support this position, the Committee submits the following resolution and recommends that it be transmitted to the House of Delegates with the approval of the Board of Trustees.

The following resolution was ordered transmitted to the House of Delegates with the recommendation that it be approved:

> 86. **Resolved,** that the Association encourage the Veterans Administration to approve the following extension of dental benefits by the Veterans Administration: emergency outpatient dental care for a nonservice-connected dental condition but only to the extent required to relieve pain and/or control infection. Major restorations, therapy or prostheses would not be included.

Report of Council on Judicial Procedures, Constitution and Bylaws: The Committee reported as follows:

> Committee D commends the Council for its comprehensive report on several critical activities. Although the Committee is not in complete agreement with the Council on enforcement of advertising restrictions within the ADA *Principles of Ethics,* the Committee does appreciate the Council's diligent attempt to cope with difficult and critical issues raised by the Federal Trade Commission, the Justice Department and several private consumer agencies.
>
> **Moratorium on Multi-Specialty Announcements:** The Committee agrees with the Council that the moratorium on ethical announcements in more than one specialty should lapse. The Committee emphasizes, however, that its decision is based on legal implications. The Committee recommends, therefore, that Resolution 12 be transmitted to the House of Delegates with the approval of the Board of Trustees.

Resolution 12 was ordered transmitted to the House of Delegates with the recommendation that it be approved. The negative vote of Dr. Faust was recorded.

The report of the Committee continued as follows:

> **Definitions of Scope of Special Areas:** The Committee agrees with the definitions of the specialty areas as developed by the Council on Dental Education. These definitions are confirmed by representatives of the specialty groups who participated in the January 1976 Workshop Conference on Specialty Practice.
>
> **Referrals to Specialists:** Committee D agrees with the Council's proposed amendment to Section 7 of the *Principles of Ethics* defining the obligations of specialists or consulting dentists on referrals from general dentists. The Committee, therefore, recommends that Resolution 13 be transmitted to the House of Delegates with the approval of the Board of Trustees.

Resolution 13 was ordered transmitted to the House of Delegates with the recommendation that it be approved.

The report of the Committee continued as follows:

Listing of Approved Specialties in "Principles of Ethics": Committee D agrees with the Council that Section 18 of the *Principles of Ethics* should specify the recognized areas of specialty practice and their proper designations. The Committee recommends, however, that the parenthetical phrase "(or pediatric dentistry)" be stricken. The Committee, therefore, recommends that Resolution 14 as amended be transmitted to the House of Delegates with the approval of the Board of Trustees.

The following amended resolution was ordered transmitted to the House of Delegates with the recommendation that it be approved.

14B. Resolved, that Section 18 of the *Principles of Ethics* be amended by the addition of a new paragraph following the first paragraph to read as follows:

The specialty areas of dentistry approved by the American Dental Association and the designation for ethical announcements of limitation of practice are:

Endodontics
Oral Pathology
Oral Surgery
(or Oral and Maxillofacial Surgery)
Orthodontics
Pedodontics
(or Dentistry for Children)
Periodontics
Prosthodontics
Dental Public Health

The report of the Committee continued as follows:

Moratorium on Enforcement of Advertising Restrictions: Committee D reviewed the Council's recommended moratorium in Resolution 15 together with related resolutions from California (Res. 59) and Louisiana (Res. 50). The Committee believes that the Association should reaffirm its position that all advertising by dentists is unethical as urged in Louisiana Resolution 50. The Committee also believes that the Association should seek statutory exemption from the federal antitrust laws as recommended by California Resolution 59 to insure that the professional ethics against advertising are preserved. The Committee recommends, therefore, that Resolution 15 be transmitted to the House of Delegates with the disapproval of the Board of Trustees.

Resolution 15 was ordered transmitted to the House of Delegates with the recommendation that it be approved (see Report 2 of Board of Trustees to House of Delegates for the comments of the Board of Trustees).

The report of the Committee continued as follows:

Reevaluation of Principles of Ethics (Res. 60-1975-H): The Committee understands the Council's reluctance to attempt a reevaluation of the ADA *Principles of Ethics* because of the attacks upon professional ethics from both governmental and private groups. Pending actions against AMA by the Federal Trade Commission are cited by the Council as a specific reason for avoiding an evaluation of the ADA *Principles* now. The Committee believes, however, that the ADA *Principles* are still viable in every respect and that the American Dental Association should take all reasonable affirmative steps to preserve the viability of dentistry's professional ethics. This includes a strong drive to obtain an exemption from the federal

antitrust laws for the professions and intervention in all litigation that threatens the ADA *Principles*.

Revision of Advisory Opinions: Committee D reluctantly agrees with the Council's withdrawal of advisory opinion 9 of Section 12. The Supreme Court of the United States' decision upholding the public's "right to know" compels this Council action. The Committee agrees with the Council's advisory opinion on use of additional degrees in curriculum vitae directed to professional colleagues.

Nomination to Councils: Committee D agrees with the Council's recommended *Bylaws* change on Council nominations emanating in the House of Delegates. The Committee, therefore, recommends that Resolution 16 be transmitted to the House of Delegates with the approval of the Board of Trustees.

Resolution 16 was ordered transmitted to the House of Delegates with the recommendation that it be approved.

The report of the Committee continued as follows:

Appeal from Denial of Admission to ADA Membership: The Committee agrees that dentists denied membership in the Association should have a right under ADA *Bylaws* to appeal that action to the constituent and, if necessary, to the ADA Judicial Council. Recent court decisions support this procedure. The Committee, therefore, recommends that Resolution 17 be transmitted to the House of Delegates with the approval of the Board of Trustees.

Resolution 17 was ordered transmitted to the House of Delegates with the recommendation that it be approved.

The report of the Committee continued as follows:

Student Membership for Dentists in Medical Residencies: The Committee agrees that dentists enrolled in medical specialty programs should be treated as student members and, therefore, recommends that Resolution 18, an appropriate *Bylaws* amendment, be transmitted to the House of Delegates with the approval of the Board of Trustees.

Resolution 18 was ordered transmitted to the House of Delegates with the recommendation that it be approved.

The report of the Committee continued as follows:

Appeal Procedure: Committee D agrees with the Council's proposed *Bylaws* change clarifying the schedule for submitting briefs and the time for hearings. The Committee recommends, therefore, that Resolution 19 be transmitted to the House of Delegates with the approval of the Board of Trustees.

Resolution 19 was ordered transmitted to the House of Delegates with the recommendation that it be approved.

The report of the Committee continued as follows:

Editorial Changes in "Bylaws": The Committee agrees with the editorial changes in Resolutions 20 and 21 and recommends that they be transmitted to the House of Delegates with the approval of the Board of Trustees.

Resolutions 20 and 21 were ordered transmitted to the House of Delegates with the recommendation that they be approved.

The report of the Committee continued as follows:

"Bylaws" Recognition for Disaster Loan Fund: The Committee concurs with the Council that the Disaster Loan Fund should receive specific identification in the ADA *Bylaws* even though it is established under a separate indenture of trust. The Committee, therefore, recommends that Resolution 22 be transmitted to the House of Delegates with the approval of the Board of Trustees.

Resolution 22 was ordered transmitted to the House of Delegates with the recommendation that it be approved.

The report of the Committee continued as follows:

Acknowledgements: The Committee joins the Council in acknowledging the contributions of Dr. Elbert H. "Mike" Smith who served as a Council consultant during the past year after eight years of Council membership, three as Chairman.

Report of Council on Judicial Procedures, Constitution and Bylaws, Supplement 1 to Board: The Committee reported as follows:

Associate Membership for Branch Office Practice: This report is a response to a directive from the Board of Trustees to draft *Bylaws* amendments to implement 1975 House of Delegates Resolutions 829A and 829B. The Committee agrees with the Council that the proposed *Bylaws* amendments be submitted to the constituent societies for their review, comments and suggestions as to which of the alternatives proposed by the Council will be most satisfactory.

Report of Council on Judicial Procedures, Constitution and Bylaws, Supplement 2 to Board: The Committee reported as follows:

Inquiry of Concerned Component Society Officers of California Dental Association: This report explains the Council's actions on two appeals involving California dentists. Since this report was submitted, one of the dentists, Dr. Ayers, violated his probation and in accord with the Council's decision he is automatically expelled from ADA membership.

Report of Council on Legislation: The Committee reported as follows:

Report: The Committee commends the Council for a concise report on major legislation affecting dentistry at both the national and state levels. The Committee calls the Board's attention to the report of the Washington Office that updates the Council's report.

Acknowledgement: The Committee joins the Council in expressing appreciation to Dr. Paul W. Kunkel, Jr. for his contributions during six years of Council membership, four as Chairman.

Report of Council on Relief: The Committee reported as follows:

The Committee calls attention to the excellent description of the Relief Fund activities as well as those of the Disaster Loan Program. The Committee congratulates the Council for achieving another record-breaking collection for both the Relief and Disaster Funds.

Amendment to "Indenture of Trust": The Committee concurs with the Council that the *Indenture of Trust* be amended to achieve a more functional definition of the Committee's duties. The Committee, therefore, recommends that Resolution 23 be transmitted to the House of Delegates with the approval of the Board of Trustees.

Resolution 23 was ordered transmitted to the House of Delegates with the recommendation that it be approved.

Report of Bureau of Data Processing Services and Membership Records: The Committee reported as follows:

The Committee notes that the Bureau's report is informational. The Committee calls attention to the important responsibility of the Bureau in maintaining accurate and up-to-date information on ADA members and their office locations.

Report of Bureau of Data Processing Services and Membership Records, Supplement 1 to Board: The Committee reported as follows:

Application for Associate Membership: The Committee recommends that the Board approve Resolution 355 granting associate membership to Drs. Breneman and Stewart.

The following resolution was adopted by the Board of Trustees:

96-1976-B. Resolved, that the following applicants for associate membership be approved in accordance with Chapter VI, Section 90N, of the *Bylaws:*

Ernest S. Breneman
Greg P. Stewart

Report of Department of Sales and Advertising: The Committee reported as follows:

The Committee commends the Department for its efforts to expand publication advertising and exhibit income. The Department's report is informational.

Report of Washington Office: The Committee reported as follows:

The Committee examined the report of the Washington Office. Committee D commends the Washington Office staff for its many accomplishments this year. The Committee is especially pleased with the joint efforts of the Washington Office and the Council on Legislation in obtaining beneficial amendments to the health manpower legislation. The Committee joins in expressing gratitude to the many ADA members who supported the Association by communicating with their Senators in behalf of the ADA amendments sponsored by Senator Beall of Maryland.

Report of American Dental Association Health Foundation: The Committee reported as follows:

Committee D reviewed the report of the American Dental Association Health Foundation. The Committee noted that awards in the amount of $205,413 had been made from the unencumbered funds of the Health Foundation. One of these was to the American Fund for Dental Health and the other to the American Dental Association Bureau of Economic Research and Statistics.

Patent Policy: Committee D was pleased to note that based on the patent policy of the Foundation approved by the Board of Directors that an application for an Institutional Patent Agreement was submitted to the Patent Adviser of the National Bureau of Standards, U.S. Department of Commerce. This application was patterned after the agreement approved in 1975 by the Assistant Secretary of Health, Department of Health, Education, and Welfare. The Committee was pleased to note that recent communications with the National Bureau of Standards Patent Adviser disclosed that recommendation for approval by him is anticipated and the request will then be forwarded to the Assistant Secretary for Science and

Technology, Department of Commerce, for consideration by the Contracts Invention Committee of that Department.

Novation Agreements: Novation agreements will be presented to the Board of Trustees at the November meeting.

Report of American Dental Association Health Foundation Research Institute: The Committee reported as follows:

The Committee studied the report of the American Dental Association Health Foundation Research Institute. Committee D noted that grants and contracts sponsored by outside agencies were in the amount of $149,465 with $19,488 in indirect costs.

Research Activities: The following research information is of particular significance to dentistry:

1. The technique of intraoral source radiography, supported by a contract from the Food and Drug Administration, is being developed in order to produce an improved image and reduce the exposure of the patient to radiation.

2. A project has been initiated to develop improved, non-radioactive additive materials to dental porcelains to produce optical properties that are similar to natural teeth, in order to eliminate the current need for uranium to produce this effect.

3. A collaborative effort between the Divisions of Developmental Biology and Chemistry is currently evaluating gross and tissue responses of laboratory animals exposed to nitrous oxide during selected intervals of pregnancy in order to provide biological correlates for evaluating this agent as a potential problem or health hazard to the dental profession.

4. Studies in the Division of Chemistry are attempting to determine the biological basis of the adverse gingival responses seen in many patients after diphenylhydantoin administration.

5. Some of the craniofacial malformations seen in humans such as cleft palate, have been produced in monkeys in order to evaluate new techniques of surgical repair and the effect that these lesions have on subsequent postnatal facial growth.

Report of American Dental Association Health Foundation Research Unit at National Bureau of Standards: The Committee reported as follows:

Committee D has reviewed the report of the American Dental Association Health Foundation Research Unit at the National Bureau of Standards. It was noted with considerable interest that the funding received through the granting and the contract mechanism has increased considerably over previous years and is $475,218 for the present reporting period, including indirect costs of $117, 354. Committee D noted that the Research Unit continues to carry on its broad research program which relates chiefly to the prevention of dental disease and to facilitate its treatment through the characterization of dental materials and hard tissues, development of new materials and procedures and improvement of existing materials.

The following research information is of special interest:

1. Research directed toward increasing the resistance to wear of the composite restorations is well under way.

2. There is a research program which involves the study of casting behavior of base metal alloys to displace costly gold alloys for use in dental crowns and bridges.

3. Biological clinical tests are being initiated and patent rights are being sought on the manganese containing amalgam alloy developed by the Research Unit. The manganese additive eliminates the undesirable tin-mercury phase from these alloys and improves the "creep" properties, making this type of alloy a promising candidate for improved dental amalgam.

4. There is a program to develop investment materials that will permit precision casting of dental restorations at the higher temperatures required by base metal substitutes for gold alloys and under the variable conditions found in dental laboratories.

5. Research has led to a discovery that points to possible further improvement of single-step topical fluoride treatments.

6. The Research Unit does goal-directed basic research in addition to development of new materials and improvement of materials already on the market.

The Committee was impressed with the number of excellent publications. The Committee commends Dr. George C. Paffenbarger who was the recipient of the 1976 Hollenback Award from the Academy of Operative Dentistry and a plaque from the faculty and alumni of Ohio State University College of Dentistry "in recognition of and appreciation for his outstanding contributions to the profession and to the art, science, and literature of dentistry." The Committee also commends Dr. M.-S. Tung who won first place in the postdoctoral category of Edward H. Hatton Award at the 1976 meeting of the International Association for Dental Research. Committee D also commends Dr. Walter E. Brown for being the recipient of a grant from the National Institute of Dental Research to sponsor the first international workshop on the cariostatic mechanism of fluorides. The proceedings, to be published, should be a major source of information for future research on this important subject.

Letter from AADS Executive Director, Dr. Harry W. Bruce, Jr., on National Health Program Guidelines: The Committee reported as follows:

Committee D studied the comments on the July 13, 1976 letter from American Association of Dental Schools Executive Director, Dr. Harry W. Bruce, Jr., on National Health Program Guidelines. The Committee appreciates the effort put forth by the American Association of Dental Schools to conform its guidelines on a national health care program with the American Dental Association's counterpart guidelines. The Committee is concerned, however, with the generalities stated in the AADS document. The Committee believes that the ADA's specific and detailed guides are more effective in helping to shape acceptable legislation than are the very general and sometimes vague precepts within the AADS document.

Joint Report of Councils on Dental Care Programs and Legislation on "Guidelines for Dentistry's Position in a Notianal Health Program": The Committee reported as follows:

Format of Committee's Report: The Committee will set out its proposed revisions of the 1971 *Guidelines*. In a prefatory statement before each major heading the Committee will indicate changes from the Councils' proposed revision.

Fundamental Principle: The Committee agrees with the Councils' proposed revision with an editorial addition in the third paragraph, namely the insertion of "in a national health program" after "benefits" in line 3, so that the revision will read as follows:

FUNDAMENTAL PRINCIPLES: It is the dental profession's firm belief that the dental component of any national health program should be founded upon the traditional private system of delivering dental care.

The dental profession is engaged in efforts to ensure that available dental care services are sufficient to the needs of all the people of the nation.

The dental profession would support a national health program which meets these needs, assuring to all equal access to dental care. However, the profession believes that the use of public funds for direct health benefits in a national health program should be limited to the provision of care only for those financially unable to pay for health services themselves.

Beneficiaries and Benefits: Committee D agrees with the Councils' revision of this section of the *Guidelines,* including a change in subject heading from "Priorities" to "Beneficiaries and Benefits" so that the revised section will read as follows:

BENEFICIARIES AND BENEFITS: The following guidelines are recommended in the development of a national health program.

1. Comprehensive dental services for children through 17 and emergency dental services for all eligible for the program should have the highest priority in any national health program. Any deferred inclusion of children that may be necessary should follow a progressive schedule beginning with children six years and under.

2. A professionally sound dental benefits component should begin at the same time any national health program is initiated.

3. There follows a priority listing of other services which we consider appropriate for incorporation as defined:

Emergency dental care services

These services should be available to those eligible for the program from the first day of the program.

—Control of oral and maxillofacial bleeding in any condition when loss of blood will jeopardize the patient's well-being. Treatment may consist of any professionally accepted procedure deemed necessary.

—Relief of respiratory difficulty from any oral and maxillofacial condition which can involve the airway (respiratory system) in a life-threatening manner. Treatment may consist of any professionally accepted procedure deemed necessary.

—Relief of severe pain accompanying any oral or maxillofacial condition affecting the nervous system, limited to immediate palliative treatment only but including extractions where professionally indicated.

—Immediate and palliative procedures for (1) fractures, subluxations and avulsions of teeth, (2) fractures of jaw and other facial bones (reduction and fixation only), (3) temporomandibular joint subluxations and (4) soft tissue injuries.

— Initial treatment for acute infections.

—Emergency dental care services include (1) all necessary laboratory and preoperative work, including examination and radiographs and (2) appropriate anesthesia (local, general, sedative) for optimal management of the emergency.

Preventive dental services

Preventive procedures, including dental health education.

Comprehensive dental health services

—Periodic examination and diagnosis, including radiographs when indicated and detection of oral manifestations of systemic diseases.

—Elimination of infection and life-hazardous oral conditions, for example, oral cancer, cellulitis, fractures of the face and jaws, major handicapping malocclusion and congenital disfiguring oral deformities.

—Treatment of injuries.

—Elimination of disease of bone and soft tissue of the oral cavity and adjacent areas.

—Treatment of anomalies.

—Restoration of decayed or fractured teeth.

—Maintenance or recovery of space between teeth when this service will affect occlusion.

—Replacement of missing permanent teeth.

—Treatment of malocclusion with priority for interceptive treatment and disfiguring and handicapping malocclusions.

4. After three years in operation or before considering expansion of any national health program's dental benefits, a comprehensive study of the program's cost-effectiveness and efficacy in providing dental health services should be accomplished.

Preventive Procedures and Dental Health Education: The Committee concurs with the Councils' revision of this section with the following editorial changes: (1) add "communities and for" after "equipment" in line four of paragraph two, (2) substitute "encourage and assist" for "press" in line one of paragraph three so that the revised section reads as follows:

PREVENTIVE PROCEDURES AND DENTAL HEALTH EDUCATION: The following guidelines are recommended in the development of a national health program:

1. A preventively-oriented dental health educational program should be implemented in conjunction with a national dental health program for the purpose of informing and motivating people on personal oral hygiene care as well as on the most effective use of the program. Emphasis should be placed on reaching school children and their parents.

2. The federal government should institute a national fluoridation program to maximize the cost/effectiveness of dental health benefits for children. Grants should be provided for the purchase and installation of fluoridation equipment for communities and for rural school water supplies. Incentives should be provided to states to take legislative or regulatory action to mandate fluoridation.

3. State dental societies should encourage and assist state legislatures to enact statewide fluoridation laws requiring the fluoridation of all community water supplies.

4. States and communities should be urged to provide dental health education and preventive programs for children in the school setting to maximize the benefits included under a national dental health program. Consideration should be given to providing various types of topical fluoride applications, preventive education, and screening and referral.

Education and Training: The Committee suggests the following changes in the Council's proposed revision of this section: (1) deletion of "expanded function" in paragraph 9 (Committee's paragraph 8), (2) revision of paragraph 11 (Committee's paragraph 10) to read as follows:

10. There should be a significantly greater emphasis within dental education programs on teaching students the use of auxiliaries.

so that the proposed revision of this section reads as follows:

EDUCATION AND TRAINING: In all programs that provide federal funding for dental education this long-standing policy of the Association shall apply: "The government shall not exercise any control over, or prescribe any requirements with respect to, the curriculum, personnel, or administration of any school or the admission of applicants thereto." (*Trans.* 1949:244). The following guidelines are recommended in the development of a national health program.

1. The present program of federal expenditures in partial support of the construction of new dental schools and the expansion of existing schools should be continued and increased.

2. There should be a much larger program of federal financial participation in the construction of new dental auxiliary schools.

3. The federal construction programs should provide earmarked funds for dental educational facilities and the program should be fully funded on the basis of demonstrated need.

4. There should be operating assistance grants to existing and new dental auxiliary schools from the federal government to ensure that all schools are producing qualified dental personnel at full capacity.

5. There should be federal funds to encourage the development of training programs to prepare teachers for dental and auxiliary schools.

6. Dental and dental auxiliary curriculums should be made flexible so that the more talented and motivated students can move through the educational programs at a rate consistent with their learning abilities. Curriculum flexibility should also be encouraged to allow for the integration of current educational methodologies and procedures.

7. Community colleges and post high school technical schools should be encouraged to develop training programs for dental auxiliaries, provided such programs meet accepted educational standards and are accredited by the American Dental Association.

8. There should be a program of federal support for the accelerated development of training programs for auxiliaries, including construction, operational, and faculty training support.

9. The criteria for accreditation of auxiliary training schools should be revised to permit broader experimentation with curriculums, program content, and length of training. Students should have the opportunity to advance from one type of auxiliary program to another.

10. There should be a significantly greater emphasis within dental education programs on teaching students the use of auxiliaries.

11. There should be formal programs of training in the performance of expanded functions for those auxiliaries currently in the work force consistent with the dental practice acts.

12. The federal program of loans and fellowships for dental students should be expanded and funded at a level determined by a survey of need.

13. Funds should be earmarked for fellowships in dental and dental auxiliary education.

14. The student assistance program of the federal government should provide special arrangements for assisting students from minority and other disadvantaged groups to enter careers in dental fields. In so doing, the government should not exercise any control over, or prescribe any requirements with respect to the curriculum, teaching personnel, or administration of any school or the admission of applicants thereto. The program should be designed to encourage young people to enter the dental and auxiliary professions. Every student who meets basic entrance qualifications of educational programs in dental fields should have the right of equal consideration to such education.

15. A national program of recruitment should be developed to attract capable young men and women into the dental and dental auxiliary fields.

16. Entry into training programs for dental auxiliaries should be simplified and coordinated to provide promotional career opportunities.

17. As an additional measure to maintain the quality of dental practice, the Association reaffirms its policy that "constituent dental societies, in consultation with state boards of dentistry, are urged to develop mechanisms to foster the continued education of dentists licensed in their jurisdiction." (*Trans.* 1968:257).

Delivery of Service: The Committee agrees with the Councils' proposed revision of this section with one exception. The Committee proposes that paragraph 8 of the Councils' revised section be stricken. The Committee also proposes deletion of the word "solo" in paragraph 11 (Committee's paragraph 9). The Committee's proposed revision of this section will, therefore, read as follows:

DELIVERY OF SERVICES: The following guidelines are recommended in the development of a national health program.

1. All dental societies should establish emergency dental services that ensure ready accessibility of professional services at all times.

2. Federal legislation should provide reasonable financial arrangements including loan forgiveness features with dental students to pay the total cost of their dental education in return for practicing in underserved areas in the military or health agencies, for a specific period of time.

3. Dentists should be encouraged to practice in underserved areas through federal financial incentives including guaranteed loans and tax benefits.

4. A national health service corps or other federal or federal-state health personnel program should provide dental personnel only in areas where the existing dental work force is insufficient to meet demands generated by a national dental health program. Such arrangements should be contingent on the approval of component and/or constituent dental societies.

5. Community health centers, such as neighborhood health centers or out-patient facilities providing comprehensive health services, should include dental services only if the availability of dental care from the private sector is determined to be inadequate in consultation with constituent and component societies.

6. Extended health care facilities and hospitals should consider providing dental services as an integral part of comprehensive care. Outpatient dental treatment also should be provided.

7. A national health program should provide for research, experimentation, and development of programs to deliver dental care more effectively and efficiently to population groups with special handicapping or confinement problems.

8. There should be a moratorium on licensure, registration, or certification of additional kinds of dental auxiliaries until more definitive information is available about the relative role of the dentist and his expanded function auxiliaries.

9. A national dental health program should provide incentives to practitioners to increase their productivity through the use of multiple dental auxiliaries. Such incentives should include guaranteed loans for capital improvements and equipment and office overhead protection insurance

10. The Association should conduct studies to evaluate various practice patterns of dentists and various methods of payment for services provided.

11. Whenever a prepaid group practice is included in a program, program beneficiaries should be given a choice between the prepaid group practice and care by other practitioners, with options for periodic change and assurance of high quality of care delivered.

12. A national health program that establishes health maintenance organizations for the delivery of comprehensive health services should require that dental care be included as an essential service. The American Dental Association, however, is opposed to HMO legislation or regulations (1) that deny freedom for beneficiaries to choose between HMOs and the traditional private practice fee-for-service system, (2) that award HMOs subsidies and (3) that permit HMOs to advertise in conflict with the unprofessional conduct provisions of state licensure laws.

13. Dental societies or service corporations, or both, should be eligible along with other groups to qualify as dental components in health maintenance organizations.

14. Studies should be conducted to determine the need, utilization and distribution requirements of dental specialties in a national dental care program.

15. The clinical dental specialty organizations should establish an interspecialty committee to study the role and functions of specialists in a national dental health program and to present an appropriate report to the various specialties and the Association.

16. The Association should conduct studies to determine why dentists choose practice locations; what the attrition rates are for auxiliary personnel; why auxiliary personnel leave the field for other occupations; and what the professional and international implications of more liberal admission to practice by graduates of foreign dental schools would be.

Payment Mechanisms: Committee D agrees with the Councils' proposed revision as follows:

PAYMENT MECHANISMS: The following guidelines are recommended in the development of a national health program.

1. Private methods of reimbursement through the use of dental service corporations, insurance companies and other private means should be strongly encouraged.

2. Various methods of reimbursement of dentists should be allowed in the dental component of a national health program so that the most efficient arrangements can eventually be determined by experience and by consumer choice. In the absence of such basis for determining efficiency, the usual, customary and reasonable fee concept should be given priority. The table of allowance concept should be recognized as appropriate for use. The mandating of capitation as the only system should realistically relate to the cost of delivery of dental services and should be clearly explained to all eligible for the program.

3. Patient participation in the costs of care in a dental component of a national health program preferably should be through copayment rather than through deductibles.

4. Deductibles or coinsurance should not be applied to basic services, such as periodic examinations, diagnoses, prophylaxes, fluoride topical applications, plaque control programs and emergency treatment.

5. Programs should be encouraged that provide incentives to continuing maintenance by reducing the patient's coinsurance at stated time intervals, providing he avails himself of the necessary dental services on a regular basis.

Funding: The Committees agrees with the Councils' proposed revision as follows:

FUNDING: The following guidelines are recommended in the development of a national health program.

1. Public funds supporting dental health benefits for the needy should be provided through general revenue and should be clearly earmarked for such purpose.

2. Private funds expended in the private sector should provide the principal financial base for any national health program.

3. In structuring such funding, several methods may be considered, such as tax credits scaled to income, or employer-employee contributions.

Dental and Dental Hygiene Licensure: Committee D agrees with the Councils' proposed revision as follows:

DENTAL AND DENTAL HYGIENE LICENSURE: The following guidelines are recommended in the development of a national health program.

1. Regional examinations for dentists and dental hygienists should be encouraged and tested in all areas of the United States and its territories.

2. It is the right and responsibility of each individual state to protect the health and welfare of its citizens. Therefore, the American Dental Association recognizes the rights of the individual states to determine the professional qualifications of those who practice in the dental health professions.

Program Design and Administration: The Committee agrees with the Councils' proposed revision as follows:

PROGRAM DESIGN AND ADMINISTRATION: The following guidelines are recommended in the development of a national health program.

1. The dental component of any national health program should be developed in consultation with organized dentistry, primarily the American Dental Association.

2. The preferred carriers for the dental component of a national health program should be nongovernmental agencies.

3. The design and administration of the dental component of a national health program should take into consideration the differences between the delivery of dental care and other health services.

4. The dental component of a national health program should make specific provision for conducting research on administrative, economic and cost analysis aspects of dental services in prepayment programs.

5. If a national health program mandates specific health benefits, dental benefits should be clearly delineated and mandated in a manner identical with all other health benefits.

Review of Procedures: Committee D agrees with the Councils' proposed revision as follows:

REVIEW PROCEDURES: The following guidelines are recommended in the development of a national health program.

1. Review of the dental component of a national health program must involve the participation of licensed dentists.

2. Initially, program design and administration should be reviewed. Continuing review should encompass such matters as utilization of services, effectiveness in meeting the dental needs of the population, economy in administration, effect of benefit patterns on dental health and dental practice, provision of uniform forms and procedures, efficiency of administrative requirements, accessibility of dental care, utilization of fluoridation and effectiveness of quality review procedures.

3. Review of dental care in a national health program should include assessment of the quality of services performed, the appropriateness of procedures and whether the services were performed in accordance with professional standards.

4. Dental society review committees should be utilized in the dental component of a national health program for evaluation of professional matters. In the event Professional Standards Review Organizations are designated the review mechanism in a national health program, dentists should be afforded full and equitable participation at all levels of these organizations as they relate to the assessment of dental care.

5. Effective review procedures should include methods to resolve fee questions.

6. Effective procedures should be instituted, wherever necessary, to protect members of review committees.

7. A clear distinction should be maintained between quality assurance and cost control in any national health program.

Representation of Consumers in National Health Programs: Committee D disagrees with the Councils' proposed revision of this section and recommends instead that the 1972-73 "Guidelines for Representatives of Consumers in National Dental Health Programs" be incorporated in these revised guidelines as follows:

REPRESENTATION OF CONSUMERS IN NATIONAL HEALTH PROGRAMS: The Association endorses the concept of consumer representation in any national dental health program. The Association accepts the following definition of consumer: A consumer is a person who might use dental health services, but does not depend upon these services for a livelihood.

The following guidelines for consumer representation set forth some general principles which will be subject to modification depending upon the nature of the national dental health program:

1. Consumer representatives should be involved in an advisory capacity in the development of regulations and procedures during the initial design of the program.

2. Consumer representatives should be selected on the basis of geographic region with particular attention given to appropriate broad representation of all segments of the population.

3. Consumer representatives should be involved at the national level and all state and local levels of operation of the program.

4. Consumer representatives should be retained subject to attendance at meetings and carrying out of assigned functions.

5. Consumer representatives should be involved in an advisory capacity on such issues in any proposed national dental health program as the following: review of the program, education of the public to prevention of dental disease and appropriate utilization of the program, grievance procedures established for the program, and administration and evaluation of the program.

Guidelines for Education and Training in a National Health Program: Committee D recommends that these 1972 guidelines be included within this proposed revision of the national health program *Guidelines* as follows:

GUIDELINES FOR EDUCATION AND TRAINING IN A NATIONAL HEALTH PROGRAM

1. The development of all types of dental and dental auxiliary education programs should be based on the determination of shortage and need in relationship to geographic considerations. Further, the establishment of dental and dental auxiliary education programs shall be restricted to institutions whose programs are eligible for accreditation by the Council on Dental Education.

2. The profession, through its various agencies, should accelerate the training and use of expanded function auxiliary personnel in accordance with state dental practice acts.

3. Programs in continuing education should be developed to prepare practicing dentists to use expanded function auxiliaries in accordance with state dental practice acts.

After discussion, the Board of Trustees deferred action on the proposed revisions until its November 1976 session in Las Vegas. In order to insure that the House of Delegates will have an opportunity to review the proposed revision of the 1971 *Guidelines for Dentistry's Position in a National Health Program,* the Board directed that the revisions, along with the 1971 *Guidelines* for comparison, be printed in the *Supplement to Annual Reports and Resolutions.* The Board also requested the President to appoint a House reference committee to review the *Guidelines.*

Proposal of Academy of General Dentistry for Staff Assistance from ADA Washington Office and Other ADA Services: The Committee reported as follows:

Committee D reviewed carefully the proposal from the Academy of General Dentistry in a letter to ADA President Shira from the Academy of General Dentistry President David Moline. The Committee believes that the Association would have difficulty complying with the Academy's request, especially the commitments from ADA proposed in numbered paragraphs 3 and 4 in Dr. Moline's letter.

Because it is essential that the Association maintain unity within the dental profession and preserve its position as the spokesman for dentists before Congress and the federal executive agencies, the Academy's request deserves consideration. The Committee, therefore, suggests that the Special Committee on Inter-Agency Affairs of the Board of Trustees arrange a meeting with the President of the Academy and his designees to see if an appropriate accommodation can be achieved between both organizations.

The Board of Trustees adopted a resolution directing the ADA President to invite the President of the Academy of General Dentistry and of all other dental organizations with Washington offices and their designees to meet with the Special Committee on Inter-Agency Affairs to discuss the requests in Dr. Moline's June 25, 1976 letter to Dr. Shira.

Wisconsin Resolution on Antitrust Information: The Committee reported as follows:

> The Committee agrees with the resolution submitted by the Wisconsin Dental Association requesting the ADA Board of Trustees to establish a clearinghouse on antitrust litigation and related matters. The Committee suggests, however, that the ADA legal staff present to the November 1976 session of the Board a description of how such a clearinghouse will collect the necessary information, the mechanisms for distributing that information and estimated costs of maintaining the service. The Committee recommends, therefore, that the Wisconsin resolution be postponed until the November 1976 session of the Board.

Action on the following Wisconsin resolution submitted to the ADA Board of Trustees was postponed until the November 1976 session of the Board of Trustees:

> Resolved, that the House of Delegates of the Wisconsin Dental Association urge the ADA Board of Trustees and state associations to take all necessary steps to:
>
> 1. Establish a "clearinghouse" for all relevant information concerning antitrust related litigation and similar matters which affect actions of dentists at the national, state and local level.
>
> 2. Establish a mechanism for communicating such information to state associations on a regular and prompt basis.

Guidelines for Dental Directories—California Dental Association: The Committee reported as follows:

> Committee D recommends that Resolution 55 be transmitted to the House of Delegates with the approval of the Board of Trustees.

Resolution 55 was ordered transmitted to the House of Delegates with the recommendation that it be approved.

Clarification of Terminology in Pedodontics—California Dental Association: The Committee reported as follows:

> Committee D reviewed Resolution 56 submitted by the California Dental Association which proposes to recognize "pediatric dentistry" as an ethical designation for those specializing in children's dentistry. The Committee is opposed to three approved designations for children's dentistry. The Committee recommends that Resolution 56 be referred to the Council on Judicial Procedures, Constitution and Bylaws with direction to consult with the officials of the children's dentistry group to decide upon two acceptable designations for the specialty. Existing ethical designations are "pedodontics" and "children's dentistry." One of these should be eliminated if "pediatric dentistry" is to become an ethical designation. The Committee, therefore, recommends that action on Resolution 56 be postponed until the November 1976 session of the Board of Trustees. In the interim, the Committee proposes that Resolution 56 be referred to the Council on Judicial Procedures, Constitution and Bylaws for appropriate action.

The Board of Trustees postponed action on Resolution 56 until the November 1976 session of the Board of Trustees. In the interim, Resolution 56 was referred to the Council on Judicial Procedures, Constitution and Bylaws with direction to consult with the officials of the children's dentistry group to decide upon two acceptable designations for the specialty.

Military Dependent Care—California Dental Association: The Committee reported as follows:

> The Committee studied Resolution 57 submitted by the California Dental Association. Committee D recommends that Resolution 57 be transmitted to the House of Delegates with the approval of the Board of Trustees.

Resolution 57 was ordered transmitted to the House of Delegates with the recommendation that it be approved.

Remote Status Designations for Military Installations—California Dental Association: The Committee reported as follows:

> The Committee reviewed Resolution 58 submitted by the California Dental Association. Committee D recommends that Resolution 58 be transmitted to the House of Delegates with the approval of the Board of Trustees.

Resolution 58 was ordered transmitted to the House of Delegates with the recommendation that it be approved.

Professional Exemption from Antitrust Legislation—California Dental Association: The Committee reported as follows:

> Committee D studied Resolution 59 submitted by the California Dental Association. The Committee believes that the Association should take a strong posture in reference to the Federal Trade Commission edicts which weaken the status of our profession and compromise the enforcement of our principles and codes of ethics. The Committee recommends that Resolution 59 be transmitted to the House of Delegates with the approval of the Board of Trustees.

Resolution 59 was ordered transmitted to the House of Delegates with the recommendation that it be approved.

Amendment of Section 20 of "Principles of Ethics"—Illinois State Dental Society: The Committee reported as follows:

> Committee D read Resolution 46 submitted by the Illinois State Dental Society. The Illinois resolution would change Section 20 of the ADA *Principles* to permit the use of an assumed name to identify a dental practice. The Committee is aware that the House of Delegates at two recent annual sessions has declined to approve the use of assumed names as an ethical designation of a dental practice. The House of Delegates was concerned with the great difficulty of determining when an assumed name connotes superiority or is otherwise misleading in describing the character of a dental practice. The Committee believes that the concern expressed by the House of Delegates is still valid. The Committee believes further that the use of "Dr. Smith and Associates" or "Dr. Smith, Brown, Jones and Associations" is an adequate means of identifying a large partnership or group practice. The Committee, recommends that Resolution 46 be transmitted to the House of Delegates with the disapproval of the Board of Trustees.

Resolution 46 was ordered transmitted to the House of Delegates with the recommendation that it be postponed indefinitely.

Reaffirmation of Section 12 of "Principles of Ethics"—Louisiana Dental Association: The Committee reported as follows:

The Committee studied Resolution 50 submitted by the Louisiana Dental Association. Committee D recommends that Resolution 50 be transmitted to the House of Delegates with the approval of the Board of Trustees.

Resolution 50 was ordered transmitted to the House of Delegates with the recommendation that it be approved.

Identification of Dental Procedures by Scientific Term—Pennsylvania Dental Association: The Committee reported as follows:

Committee D examined Resolution 51 submitted by the Pennsylvania Dental Association which calls for all dental procedures to be identified by a strictly scientific term and that proprietary terms such as the manufacturers' trade names, personalized description and the like shall not be used to determine or identify a treatment or procedure or method of payment. The Committee noted that no background material was furnished. Because an individual or manufacturer can secure a registered trademark without ADA approval and because some techniques, types of treatment and procedures are identified only by the originator's name it would not be possible to enforce such a resolution. In addition, the passage of such a resolution may have antitrust implications. Committee D recommends that Resolution 51 be transmitted to the House of Delegates with the recommendation that it be postponed indefinitely.

Resolution 51 was ordered transmitted to the House of Delegates with the recommendation that it be postponed indefinitely.

Amendment of "Bylaws" on Disciplinary Penalties—Thirteenth Trustee District: The Committee reported as follows:

Committee D reviewed Resolution 60 submitted by the Thirteenth Trustee District. Committee D recommends that Resolution 60 be transmitted to the House of Delegates with the approval of the Board of Trustees.

Resolution 60 was ordered transmitted to the House of Delegates with the recommendation that it be approved.

Amendment of Section 15 or "Principles of Ethics"—Delegate Paul J. McKenna, Massachusetts: The Committee reported as follows:

The Committee examined Resolution 61 submitted by Delegate Paul J. McKenna, Massachusetts. Committee D agrees with the principle of Dr. McKenna's resolution, namely to permit use of earned degrees on letterheads, cards and other acceptable professional identification mechanisms. But the Committee disagrees with Dr. McKenna's limitation to earned degrees "in health service areas." The Committee believes that the privilege to use earned degrees should not be limited. The Committee therefore recommends that Resolution 61 be amended by substituting "earned" for "additional advanced" wherever that phrase appears and by striking "earned in health service areas" wherever that phrase appears so that the Committee's amended Resolution 61 will read as follows:

The following amended resolution was ordered transmitted to the House of Delegates with the recommendation that it be approved:

61B. Resolved, that Section 15 of the ADA *Principles of Ethics* be amended by inserting the words "any earned academic degrees" after the words "or

D.M.D."; by deleting the words "a dentist who also possesses a medical degree may use this degree in connection with his name on cards, letterheads, office door signs and announcements"; and by deleting the words "if such usage is consistent with the custom of dentists of the community" to make the amended Section 15 read as follows:

> **Use of Professional Titles and Degrees:** A dentist may use the titles or degrees, Doctor, Dentist, D.D.S. or D.M.D., and any earned academic degrees. A dentist who has been certified by a national certifying board for one of the specialties approved by the American Dental Association may use the title "diplomate" in connection with his specialty on his cards, letterheads and announcements. A dentist may not use his title or degree in connection with the promotion of any commercial endeavor.
>
> The use of eponyms in connection with drugs, agents, instruments or appliances is generally to be discouraged.

NEW BUSINESS

Nomination of Council Members to the House of Delegates: The nominations to the councils of the Association were considered. The following nominations were approved by the Board of Trustees:

Dental Care Programs, Council on

Booth, William A., Pennsylvania, 1979
DiStasio, Joseph G., Massachusetts, 1979
Howard, William W., Oregon, 1979
King, Duncan A., Kentucky, 1977
Larson, Gerald A., Wisconsin, 1978
Lentchner, Emil W., New York, 1979
Moran, Bernard J., Nebraska, 1977
Ticknor, Robert C., Arizona, 1977
Truono, Eugene J., Delaware, 1979
Weil, Lewis L., Illinois, 1977

Dental Education, Council on

Brown, William E., Oklahoma, 1979, AADS*
Fortenberry, Marshall M., Mississippi, 1979, ADA**
Freedman, Gerson A., Maryland, 1979, AADE***
Hazen, Stanley P., Illinois, 1979, AADS*
Joseph, Michael J., West Virginia, 1978, AADE***
Nienaber, William B., Minnesota, 1979, ADA**
Wolfsehr, Gerald R., Oregon, 1979, AADE***

Dental Health, Council on

Cabot, Joseph, Michigan, 1979

Dental Labortory Relations, Council on

Flad, Daniel L., Pennsylvania, 1979
Labelle, Arthur L., Jr., California, 1977

Dental Materials and Devices, Council on

Christensen, Gordon J., Utah, 1979
Gilmore, H. William, Indiana, 1978
Vining, Robert V., Nebraska, 1979
Von Der Lehr, William N., Louisiana, 1979

*AADS—American Association of Dental Schools
**ADA—American Dental Association
***AADE—American Association of Dental Examiners
****AMA—American Medical Association

Dental Research, Council on
Forrest, Edward J., Pennsylvania, 1979

Dental Therapeutics, Council on

Corpron, Richard E., Michigan, 1979
Goodson, Jo Max, Massachusetts, 1979
Weaver, Joel Milton, III, Ohio, 1979

Federal Dental Services, Council on

Chavoor, Ashur G., District of Columbia, 1979

Hospital Dental Service, Council on

Iverson, Paul H., North Dakota, 1979

Insurance, Council on

Casey, William L., Arkansas, 1979

International Relations, Council on

Nassimbene, Jack D., Colorado, 1979

Journalism, Council on

Doerr, Robert E., Michigan, 1979

Judicial Procedures, Constitution and Bylaws, Council on

Michelson, Leonard, Alabama, 1979

Legislation, Council on

Henderson, Howard B., Washington, 1979
Ackerman, Frederick W., 1977, AMA****

National Board of Dental Examiners, Council of

Dworkin, Samuel F., Washington, 1979, AADS*
Nishimura, Pete H., Hawaii, 1979, ADA**
Bradshaw, Thomas C., Virginia, 1979, AADE***

Relief, Council on

Podruch, Louis L., Wisconsin, 1979

Scientific Session, Council on

Wolff, Roy M., Missouri, 1979

Appointment of Consultants: The following resolutions, as amended, were adopted:

97-1976-B. **Resolved,** that the list of consultants nominated by the Council on Dental Care Programs be approved for terms ending with the 1977 annual session.

98-1976-B. **Resolved,** that the list of consultants nominated by the Council on Dental Education and Commission on Accreditation of Dental and Dental Auxiliary Educational Programs, amended by the deletion of the names of Mrs. Mary Caldwell George, Chapel Hill, North Carolina, and James E. Herbertson, Kansas City, Missouri, be approved for terms ending with the 1977 annual session.

*AADS—American Association of Dental Schools
**ADA—American Dental Association
***AADE—American Association of Dental Examiners
****AMA—American Medical Association

99-1976-B. Resolved, that the list of consultants nominated by the Councils on Dental Education and Hospital Dental Service and the Commission on Accreditation of Dental and Dental Auxiliary Educational Programs, amended by the inclusion of Jack Neff, Philadelphia, Pennsylvania, be approved for terms ending with the 1977 annual session.

100-1976-B. Resolved, that the list of consultants nominated by the Council on Dental Health be approved for terms ending with the 1977 annual session.

101-1976-B. Resolved, that the list of consultants nominated by the Council on Dental Laboratory Relations be approved for terms ending with the 1977 annual session.

102-1976-B. Resolved, that the list of consultants nominated by the Council on Dental Materials and Devices be approved for terms ending with the 1977 annual session.

103-1976-B. Resolved, that the list of consultants nominated by the Council on Dental Research be approved for terms ending with the 1977 annual session.

104-1976-B. Resolved, that the list of consultants nominated by the Council on Dental Therapeutics be approved for terms ending with the 1977 annual session.

105-1976-B. Resolved, that the list of consultants nominated by the Council on Federal Dental Services be approved for terms ending with the 1977 annual session.

106-1976-B. Resolved, that the list of consultants nominated by the Council on Hospital Dental Service, amended by the deletion of William Kreykes, Minneapolis, Minnesota, and the addition of Michael Lichterman, Dayton, Ohio, be approved for terms ending with the 1977 annual session.

107-1976-B. Resolved, that the following appointments of the Advisory Committee on Dentistry to the Joint Commission on Accreditation of Hospitals be approved for terms ending with the 1977 annual session:

Gruber, Irving E., Baldwin, New York, member
Henny, Fred A., Birmingham, Michigan, chairman
Olsen, Norman H., Chicago, member
Walker, Robert V., Dallas, Texas, member

108-1976-B. Resolved, that the following appointment as a postdoctoral level student consultant representing the American Student Dental Association be approved for the term ending with the 1977 annual session:

Dautel, Stephen, New York, New York

109-1976-B. Resolved, that the list of evaluation consultants nominated by the

Council on Hospital Dental Service be approved for terms ending with the 1977 annual session.

110-1976-B. Resolved, that the list of consultants nominated by the Council on Insurance be approved for terms ending with the 1977 annual session.

111-1976-B. Resolved, that the list of consultants nominated by the Council on International Relations be approved for terms ending with the 1977 annual session.

112-1976-B. Resolved, that the list of consultants nominated by the Council on Journalism be approved for terms ending with the 1977 annual session.

113-1976-B. Resolved, that the list of chairmen of constituent society legislative committees be approved as consultants to the Council on Legislation for terms ending with the 1977 annual session.

114-1976-B. Resolved, that Mr. James Kane of the Loyola School of Dentistry be approved as a consultant to the Council on Legislation for a term ending with the 1977 annual session.

115-1976-B. Resolved, that Mrs. Juanita Thurber, Legislative Chairwoman of the Women's Auxiliary to the American Dental Association, be approved as a consultant to the Council on Legislation for a term ending with the 1977 annual session.

116-1976-B. Resolved, that the list of consultants nominated by the Council of National Board of Dental Examiners be approved for terms ending with the 1977 annual session.

117-1976-B. Resolved, that the list of consultants nominated by the Commission on Licensure be approved for terms ending with the 1977 annual session.

118-1976-B. Resolved, that the list of consultants nominated by the Council on Scientific Session be approved for terms ending with the 1977 annual session.

119-1976-B. Resolved, that the list of consultants nominated by the Bureau of Dental Health Education be approved for terms ending with the 1977 annual session.

Nominations to Commission on Accreditation of Dental and Dental Auxiliary Educational Programs and Commission Appeal Board: The following resolutions were adopted by the Board of Trustees:

120-1976-B. Resolved, that the nominations to the Commission on Accreditation of Dental and Dental Auxiliary Educational Programs, as approved by the Board of Trustees, be transmitted to the House of Delegates.

121-1976-B. Resolved, that the nominations to the Appeal Board of the Com-

mission on Accreditation of Dental and Dental Auxiliary Educational Programs, as approved by the Board of Trustees, be transmitted to the House of Delegates.

Nominations to Commission on Licensure: The following resolution was adopted by the Board of Trustees:

122-1976-B. Resolved, that the nominations to the Commission on Licensure, as presented by the Board of Trustees, be transmitted to the House of Delegates for approval.

Report on U.S. Department of Health, Education, and Welfare's Proposal for Credentialing Health Manpower: The Board of Trustees considered an extensive report on the Department of Health, Education, and Welfare's proposal for credentialing health manpower. The Board directed (1) that $500 be allocated for Association membership on the Steering Committee which will propose the structure and bylaws for a national commission on certification, (2) that a letter reflecting the Board's deliberations on the HEW document "A Proposal for Credentialing Health Manpower" be sent to Dr. Harris S. Cohen, chairman of the Subcommittee on Health Manpower Credentialing, and (3) that a letter responding to the request for comments on the document "A Proposal for Credentialing Health Manpower" and a copy of the report submitted to the Board of Trustees be transmitted to allied dental organizations and constituent dental societies urging them to take a similar position on the proposal.

Consideration of Annual Session Site for 1981: The following resolution was adopted by the Board of Trustees:

123-1976-B. Resolved, that the 122nd annual session of the Association be held in Kansas City, Missouri on October 25-29, 1981.

The Board also adopted a motion selecting Atlanta, Georgia as the site for the 1982 annual session if suitable dates can be arranged.

Amendment of Relief Fund "Rules": The following resolution was adopted by the Board of Trustees:

124-1976-B. Resolved, that the Board of Trustees approves amendment by substitution of Chapter III, Paragraph B of the Relief Fund *Rules* to read as follows:

> B. Distribution of Contributions. Three quarters (¾) of the relief fund sum collected from members of a constituent society in the annual relief fund-disaster fund campaign will be returned to the relief fund of such constituent society; provided, however, that, after July 1, 1965, such refunds may be made only to constituent society relief funds that have been established as charitable organizations having purposes consistent with the purpose of the American Dental Association Relief Fund and that have been accorded tax-exempt status under the Internal Revenue Code.
>
> For the current fiscal year ending June 30, a constituent society will be paid a bonus of one-quarter (¼) of the total amount contributed to the relief fund by members of a constituent society in the annual relief fund-disaster fund campaign, provided that the constituent society (1) attains the annual relief fund quota assigned to it for the

year by the Council on Relief, and (2) pays out in grants during the year, shared on an equal basis with the American Dental Association Relief Fund, a sum greater than three-fourths of the society's assigned relief fund annual quota.

Report on Activities of American Academy of Dental Group Practice: The Board of Trustees considered the report on the activities of the American Academy of Dental Group Practice and adopted the following resolution:

125-1976-B. Resolved, that the Board of Trustees supports the Council on Hospital Dental Service's position that the Association be the sole agency of the profession seeking active participation and membership in the Joint Commission on Accreditation of Hospitals and further believes that no lesser membership level should be accepted prior to receiving full corporate membership for the Association, and be it further

Resolved, that the American Academy of Dental Group Practice be informed that appropriate agencies of the Association are studying an accreditation program for dental group practices.

Request of Minnesota State Board of Dental Examiners for Expansion of ADA Continuing Education Registry Program: The Board of Trustees considered the Minnesota State Board of Dental Examiners' request that Minnesota registered dental assistants be included in the ADA Continuing Education Registry Program and that the Registry be expanded to include all dental auxiliaries who are required to participate in continuing education for renewal of their licensure or registration. The following resolution was adopted by the Board of Trustees:

126-1976-B. Resolved, that the American Dental Association Continuing Education Registry be expanded to include all dental auxiliaries, to accommodate those states requiring continuing education by such dental auxiliaries for renewed licensure or registration.

Request of ADA Commission on Accreditation for Approval of Actions by Mail Ballot: The Board of Trustees, in keeping with the *Standing Rules for Councils*, adopted a motion identifying fifteen (15) as the number of affirmative ballots needed by the Commission on Accreditation for approval of mail ballot actions, with the stipulation that rules relating to mail ballots established for councils also apply to the Commission.

Consumer Directories of Practicing Dentists: The Board of Trustees adopted a motion directing the staff committee to investigate all aspects of consumer directories, including informal contacts with such groups as the Consumer Federation of America, to determine what such groups are seeking from the dental profession. The Board noted that a report will be presented to the Board of Trustees at its November 1976 session.

Request from New Jersey Dental Association to Hold Conference on Illegal Dentistry: The Board of Trustees reviewed the request from the New Jersey Dental Association that the American Dental Association hold a conference on illegal dentistry. It was noted that the Council on Dental Laboratory Relations would be holding such a conference during the 1976 annual session.

Federal Trade Commission Investigation of State Dental Law Requirements for Provision of Prosthetic Dental Care: The Board of Trustees reviewed the informational report on the Federal Trade Commission investigation of state dental law requirements for the provision of prosthetic dental care.

Report of Special Committee to HEW: The Board of Trustees noted that the Special Committee to HEW met with the Chief Dental Officer, PHS and Special Assistant for Dental Affairs, Office of the Assistant Secretary for Health, Department of HEW, on June 28, 1976, and with the Acting Director, Division of Dentistry, and Division staff members on June 29. The first meeting was to orient the Special Committee to activities of the Department of Health, Education, and Welfare and the U.S. Public Health Service and the second meeting was devoted to continuing the dialogue established by the Special Committee with the Division of Dentistry staff on previous occasions. The Board noted that a draft of the Special Committee report was circulated to the Special Committee and to Drs. Greene, Scott and Louden for comment.

The Board approved the Special Committee's recommendation that prior to Board action of the report, it be circulated to Drs. Greene, Scott and Louden once again for comment to provide opportunity for the Board to be sensitive to areas of agreement and disagreement on report content. The final report of the Special Committee with comments from the Department of Health, Education, and Welfare staff will be considered by the Board of Trustees at its November 1976 session in Las Vegas.

Request of California Dental Association Regarding ADA Committee on Advance Planning: The Board of Trustees noted a letter from Mr. Henry L. Ernstthal, executive director of the California Dental Association, requesting that the proceedings of the ADA Committee on Advance Planning be transmitted to the 1976 House of Delegates. Dr. Watson indicated that he had written to Mr. Ernstthal informing him that the Committee on Advance Planning would be meeting in October and that, in all probability, a report from the Committee would be submitted to the House of Delegates.

UNFINISHED BUSINESS

Report of Council on Dental Education on Revised Definitions of Special Areas of Dental Practice: The Board of Trustees reviewed the report of the Council on Dental Education on revised definitions of special areas of dental practice and adopted the following resolution:

> 127-1976-B. Resolved, that the revised definitions for the special areas of dental practice, with the exception of oral surgery which has been approved by the House of Delegates, be substituted for those approved by the Council on Dental Education in 1966 and that the revised definitions be forwarded to the House of Delegates as information.

Prohibition of Smoking: The Board of Trustees considered a letter transmitted from Dr. William Travis, trustee of the Michigan Dental Association, and Dr. Richard Shick, president of the Michigan Dental Association, requesting that smoking be pro-

hibited at all official conferences of the American Dental Association. The Board recommended that a letter be transmitted to Drs. Travis and Shick advising them that while the Board recognizes the dangers inherent in smoking, it feels it is outside the Board's jurisdiction to dictate to other groups concerning matters of their health and it should be the purview of each group to make decisions to ban smoking.

MEETING OF BOARD OF DIRECTORS OF AMERICAN DENTAL ASSOCIATION HEALTH FOUNDATION

Call to Order: The Board of Trustees convened as the Board of Directors of the American Dental Association Health Foundation with President Shira presiding.

Roll Call: All officers, members of the Board of Trustees and members of staff were present as previously recorded.

Recording of Mail Ballot: A resolution was adopted placing in the record the following mail ballot which was taken by the Board of Directors during the period of August 24, 1975 to August 16, 1976:

> Report of Audit: Mail Ballot No. 1 was circulated on March 25, 1976. The following resolution was adopted by a vote of 17 affirmative ballots and 1 missing ballot:
>
> > Resolved, that the *Report of Audit* of the American Dental Association Health Foundation for the year ended December 31, 1975 be placed on file.

Current Budget Status Report: The Board of Directors reviewed the status of programs sponsored and funded through allocation of grants from the Health Foundation's Fund Surplus. The balance sheet which presented the status of unencumbered Health Foundation funds available at June 30, 1976 was also reviewed.

1977 Budget: A resolution was adopted approving the American Dental Association Health Foundation's 1977 annual budget of income, expense (excluding depreciation) and nonoperating disbursements appearing on pages 500-563 of the 1977 Budget Book of the American Dental Association.

Adjournment: The Board of Directors adjourned.

Recess: The meeting of the Board of Trustees recessed at 8:10 PM.

SATURDAY, AUGUST 21, 1976

Call to Order: The meeting of the Board of Trustees was called to order at 10:00 AM by President Shira.

Roll Call: The officers, members of the Board of Trustees and members of staff were present as previously recorded.

REPORTS OF BOARD OF TRUSTEES TO HOUSE OF DELEGATES

Report 1 of Board to House—Association Affairs and Resolutions: Report 1 of the Board of Trustees to the House of Delegates was read by Dr. Pfister, chairman of the Committee on Reports of the Board of Trustees to the House of Delegates. The other members of the Committee were Drs. Cappuccio, Carter, Kerr, Phillips, Shira, Shuler, and Bowyer and Watson, *ex officio*. Various amendments were made during the reading of the report. Report 1 was approved, as amended, and ordered transmitted to the House of Delegates with such editorial changes and corrections as might be necessary.

Report 2 of Board to House—Recommendations on Reports and Resolutions: Report 2 of the Board of Trustees to the House of Delegates was read by Dr. Pfister. Various amendments were made during the reading of the report. Report 2 was approved, as amended, and ordered transmitted to the House of Delegates with such additional editorial changes and corrections as might be necessary.

Report 3 of Board to House—Financial Affairs and Recommended Budget for Fiscal Year 1977: Report 3 of the Board of Trustees to the House of Delegates was read by Dr. Pfister. Various amendments were made during the reading of the report. Report 3 was approved, as amended, and ordered transmitted to the House of Delegates with such additional editorial changes and corrections as might be necessary.

Adjournment: The Board of Trustees adjourned at 12:45 PM.

LAS VEGAS HILTON HOTEL, LAS VEGAS
NOVEMBER 9-12, 1976

Call to Order: The fifth regular session of the Board of Trustees was called to order by President Shira in the Las Vegas Hilton Hotel, Las Vegas, Nevada, at 9:15 AM, Tuesday, November 9, 1976.

Roll Call: The following officers were present: Robert B. Shira, president; Frank F. Shuler, president-elect; I. E. Gruber, first vice-president; George E. Kearns, second vice-president; Frank P. Bowyer, speaker of the House of Delegates; C. Gordon Watson, executive director; James W. Etherington, treasurer; Herbert C. Butts, editor.

The following members of the Board of Trustees were present: George P. Boucek, Weston D. Brown, Joseph P. Cappuccio, Charles D. Carter, Floyd E. Dewhirst, Robert B. Dixon, John M. Faust, Coleman Gertler, Robert H. Griffiths, John J. Houlihan, I. Lawrence Kerr, Jack H. Pfister, Lloyd J. Phillips and Eugene A. Savoie.

Staff members present were: Eric M. Bishop, assistant executive director, dental health; Hal M. Christensen, assistant executive director, Washington Office; John M. Coady, assistant executive director, education and hospitals; Bernard J. Conway, assistant executive director, legislation and legal affairs; Peter C. Goulding, assistant executive director, communications; John P. Noone, assistant executive director, business affairs and house counsel; Richard W. Tiecke, assistant executive director, scien-

tific affairs; Walter E. Wisniewski, associate house counsel; Leo Kleck, comptroller; John B. Goetz, managing editor; Howard I. Wells, assistant to the Executive Director; Susan W. Brock, administrative assistant.

Minutes of August 16-21, 1976 Session: The Executive Director reported that the verbatim transcript of the August 16-21, 1976 session of the Board of Trustees, which totaled 1,485 pages, had been completed by the official reporter and a copy was available for reference purposes to all officers and members of the Board of Trustees during the current session. However, time did not permit completion of the abridged minutes of the session. The Executive Director stated that the minutes would be completed as soon as possible following the current session and would be mailed to the officers and members of the Board of Trustees.

Recording of Mail Ballots: A resolution was adopted placing in the record the following mail ballots which were taken by the Board of Trustees during the period August 22, 1976 to November 7, 1976:

Grant to Oregon Dental Association: Mail Ballot No. 4 was circulated on October 13, 1976. The following resolution was adopted by a vote of 13 affirmative ballots, five negative ballots and no missing ballots:

> Resolved, that $10,000 be appropriated from the 1976 Contingent Fund and allocated to the Grants line item in the budget Grants and Loans to Related Health Group for the Oregon Dental Association to assist that association in combating anti-fluoridation measures which are being considered in the election on November 2, 1976 in Oregon.

Grant to Utah Dental Association: Mail Ballot No. 5 was circulated on October 13, 1976. The following resolution was adopted by a vote of 13 affirmative ballots, five negative ballots and no missing ballots.

> Resolved, that $15,000 be appropriated from the 1976 Contingent Fund and allocated to the Grants line item in the budget Grants and Loans to Related Health Group for the Utah Dental Association to assist that association in combating anti-fluoridation measures which are being considered in the election on November 2, 1976 in Utah.

REPORT OF COMMITTEE ON RULES AND ORDER

The Executive Director read the Report of the Committee on Rules and Order. The other members of the Committee were Drs. Shira, Faust, Griffiths and Savoie, and Dr. Shuler, observer.

Approval of Agenda: A motion was adopted amending the agenda by the addition of several items of business. A resolution was then adopted approving the agenda, as amended, as the official order of business for the current session.

Special Orders of Business: A resolution was adopted establishing the following special orders of business for the current session:

Executive Meeting at the call of the Chair

Meeting of Board of Directors of ADA Health Foundation at the call of the Chair

Appearance of Dr. Louis J. Hendrickson, General Chairman, Committee on Local Arrangements, 1976 Annual Session, Thursday, November 11, 10:15 AM.

Presentations to retiring officers, trustees, and wives, Friday, November 12, 10:30 AM.

Appointment of the Advisory Committee to the Public Education Program (PEP): The Board of Trustees adopted a resolution authorizing the President-elect to appoint the members of the Advisory Committee to the Public Education Program (PEP) in the year prior to his assuming the office of President. President-elect Shuler announced that the chairman of the Advisory Committee to the Public Education Program would be Dr. Eugene A. Savoie.

Recess: The Board of Trustees recessed at 9:55 AM in order to permit the reference committees of the Board to meet and reconvened at 3:45 PM.

UNFINISHED BUSINESS

Final Report of the Advisory Committee to the Public Education Program: The Board of Trustees considered the final report of the Advisory Committee to the Public Education Program and adopted a motion that a Board Report be developed concerning the Public Education Program by Drs. Houlihan, Savoie, Carter and Phillips and Mr. Goulding to be brought back before the current session for transmittal to the House of Delegates.

Consumer Directories of Practicing Dentists: The Board of Trustees reviewed the report regarding consumer directories of practicing dentists. After discussion, the Board of Trustees ordered the report transmitted to the House of Delegates, including the following resolution which was ordered transmitted with the recommendation that it be approved:

115. **Resolved**, that constituent and component dental societies be encouraged to produce or cooperate in producing ethical "consumer directories" of dentists in their areas which will provide meaningful information to the public, and be it further

Resolved, that constituent and component societies consider cooperating with responsible state or local consumer organizations in the production of such directories, and be it further

Resolved, that appropriate agencies of the Association develop guidelines and report these guidelines to the March 1977 session of the Board of Trustees for consideration and promulgation.

Recess: The Board of Trustees recessed at 5:05 PM.

WEDNESDAY, NOVEMBER 10, 1976

Call to Order: The meeting of the Board of Trustees was called to order at 9:00 AM by President Shira.

Roll Call: The officers, members of the Board of Trustees and members of staff were present as previously recorded.

UNFINISHED BUSINESS

Report of Committee on Advance Planning: The Board of Trustees discussed the extensive report of the Committee on Advance Planning and adopted a motion to adopt the report and all of the restructuring proposals contained therein. The Board then ordered the report, including the following resolution, transmitted to the House of Delegates with the recommendation that it be approved:

> 116. **Resolved,** that the Proposal of the Committee on Advance Planning on Structure of American Dental Association Agencies be approved.

Illegal Dentistry: The Board of Trustees reviewed the report on illegal dentistry and, after discussion, ordered the report transmitted to the House of Delegates, including the following resolution which was ordered transmitted to the House of Delegates with the recommendation that it be approved.

> 114. **Resolved,** that all Americans should have access to dental care provided by adequately trained and fully competent health care professionals, and be it further
> **Resolved,** that the responsibility for the provision of denture care rests with the dentist, and the provision of substandard care solely through individuals of lesser training and competence is firmly opposed, and be it further
> **Resolved,** that the American Dental Association and its constituent and component dental societies should take immediate steps to identify the economic and other barriers to full access to professional care within their jurisdictions and to seek remedies that will remove those barriers.

Membership Recruitment Campaign: The Board of Trustees reviewed the informational report concerning a membership recruitment campaign and noted that a detailed proposal will be submitted to the January 1977 session of the Board of Trustees.

American Fund for Dental Health Report to the Board of Trustees on the Status of the Student Loan Program: The Board of Trustees reviewed the status report of the American Fund for Dental Health concerning the Student Loan Program. The Board adopted a motion recommending that in the event the American Dental Association makes a financial commitment to the Student Loan Program, the name of the program be changed to the "Student Loan Guarantee Program Sponsored by the American Dental Association and the American Fund for Dental Health in cooperation with the Robert Wood Johnson Foundation."

Recess: The Board of Trustees recessed at 12:10 PM and reconvened at 1:30 PM.

EXECUTIVE MEETING

Call to Order: An Executive Meeting of the Board of Trustees was convened at 1:30 PM, Wednesday, November 10, 1976, President Shira presiding.

Roll Call: Those present were the President, President-elect, First Vice-President, Second Vice-President, Executive Director, Treasurer, Speaker of the House of Delegates, all members of the Board of Trustees and the official reporter.

Adjournment: The Executive Meeting adjourned at 2:15 PM.

Call to Order: The meeting of the Board of Trustees was called to order at 2:15 PM by President Shira.

Roll Call: The officers, members of the Board of Trustees and members of staff were present as previously recorded.

UNFINISHED BUSINESS

Availability for Inspection of Confidential Minutes of Councils and the Verbatim Record of Executive Meetings of the Board of Trustees: The following resolutions were adopted by the Board of Trustees:

128-1976-B. Resolved, that the *Organization and Rules of the Board of Trustees* (page 10) be amended by the insertion of the following paragraph between the first and second paragraphs of the subsection entitled "Record of Proceedings" of the section entitled "Rules of Procedure":

> The verbatim record of executive meetings of the Board of Trustees shall be available only to officers and members of the Board of Trustees except that such record also shall be available for inspection by any active, life or retired member in person or by his or her agent or attorney for any proper purpose at any reasonable time or times at the Headquarters Office. Matters considered in executive meetings of the Board of Trustees are of a nature which in the opinion of the Board, if disclosed, would adversely affect the interests and affairs of the American Dental Association, including matters of public concern.

129-1976-B. Resolved, that the *Standing Rules for Councils* (page 8) be amended by the deletion of the last sentence of the subsection entitled "Minutes" of the section entitled "Meetings" and the substitution therefor of the following two sentences:

> Minutes or portions of such minutes of a council, when identified as confidential, shall be available only to members and the secretary of that council and the officers and trustees of the Association except that such minutes shall be available for inspection by any active, life or retired member in person or by his or her agent or attorney for any proper purpose at any reasonable time or times at the Headquarters Office. The

term "confidential" in the foregoing sentence can be used by a council to identify its minutes of meetings or those portions of such minutes which include matters and discussions which, in the opinion of the council, if disclosed would adversely affect the interests and affairs of the American Dental Association, including matters of public concern.

REPORT OF COMMITTEE B

The Report of Committee B was read by Dr. Phillips, chairman. The other members of the Committee were Drs. Dewhirst, Griffiths and Gruber.

Acknowledgement: The Committee wishes to express its appreciation to Dr. Lloyd J. Phillips, upon his retirement from the Board of Trustees, for the businesslike, thorough and impartial manner in which he presided at this Committee's meetings during the past year.

Report of Council on Dental Care Programs, Supplement 5 to House: The Committee reported as follows:

Fourth Party Closed Panel Programs: Committee B reviewed with interest Supplemental Report 5 on the Council's activities in the investigation, monitoring and taking of appropriate action toward fourth party closed panel programs as directed by the 1975 House of Delegates. The Committee recognizes that this report comprises data from an initial investigation only and agrees with the Council that it must continue its collection of information and action in this area and report its findings as appropriate to future Houses of Delegates. The Committee fully concurs with the Council's recommendation that Association policy regarding closed panels (*Trans.* 1972:670) be pursued vigorously. The Committee observes, however, that modifications of this policy are proposed in Resolution 324 but that these modifications will not negate the substance of the Council's recommendation.

The Board of Trustees ordered the Council on Dental Care Programs Supplemental Report 5 transmitted to the House of Delegates.

Report of Council on Dental Care Programs, Supplement 6 to House: The Committee reported as follows:

Diverse Prepayment Policies Progress Report: Reference Committee B reviewed the progress report on diverse prepayment policies which provides further activities on the project since the Board meeting in August 1976.

The Committee made particular note of a statement on the status of the project from the Council Chairman in his correspondence to Dr. Robert T. Mayberry, President of the Texas Dental Association:

> The Council feels an obligation to the House of Delegates, and the profession at large, to discharge the duty given it. Our purpose is not to vindicate existing policy of this or any other association. Neither is it our purpose to attack, directly or indirectly, any such policy. What the Council wishes to obtain is factual information concerning the personal attitudes and behavior of individual dentists, chosen through appropriate random sampling techniques and on the basis of confidentiality. The summary statistical information received would, of course, be shared through the House with the full profession. We believe the information elicited will prove most helpful.

The Committee commends the persistence of the Council in attempting to carry out the intent of the House. Considering the general evolutionary movements in policies related to prepayment as well as other activities and projects of the Council, the Committee feels that the pursuance of a specific survey in selected states no longer has the same high priority in implementing the intent of the 1975 House resolution. The Committee recommends that the Council continue to investigate the effects of diverse policies on the practice of dentistry by utilizing existing resources such as national survey data from the Bureau of Economic Research and Statistics.

Reference Committee B believes that the Council and the Bureau are involved in activities that will continue to provide information to further the understanding of the prepayment experience of dental practices in states with diverse policies and recommends that the Board pass the report to the House with a suggestion not to pursue further the specific diverse policy survey.

The Council on Dental Care Programs Supplemental Report 6 was ordered transmitted to the House of Delegates, including the following resolution with the recommendation that it be approved:

126. **Resolved,** that the Council on Dental Care Programs pursue its study of the effect of diverse policies on dentists' practices through normal administrative channels without the use of a special purpose survey.

Report of Bureau of Economic Research and Statistics, Supplement 1 to Board: The Committee reported as follows:

HEW Award to ADA and RTI on Dental Prepayment Contract: Reference Committee B received with pleasure the report from the Bureau indicating that funds had been made available from the Department of Health, Education, and Welfare to study the impact of dental prepayment on the oral health status of beneficiaries. Research Triangle Institute of North Carolina, a research institute established by joint action of University of North Carolina, North Carolina State and Duke University, was awarded a $571,000 contract from which RTI has awarded a subcontract to the Association to assist in all stages of the project, particularly study design and data analysis.

Committee B made special note of the advantage of this working relationship in strengthening the Association's position in monitoring research involving dentists and dental patients and in primary participation in data analysis, interpretation and reporting of this type of research funded by outside agencies.

Reference Committee B recommends that these comments be passed on from the Board to the House as an addition to the statements made in Board Report 2.

The Board of Trustees directed that the additional information contained in the Bureau's report be transmitted to the House of Delegates in Board Report 4 to the House.

Report of Bureau of Economic Research and Statistics, Supplement 2 to House: The Committee reported as follows:

Effect on Dental Distribution of Total Reciprocity: Reference Committee B reviewed the report on the historical patterns of movement of dentists and the discussion of current legislative and licensing restrictions and encouragements of this mobility as called for by the 1975 House of Delegates (*Trans.* 1975:674).

The Committee gave particular attention to the comments in the report that note the complexity of the issues affecting mobility that could not be accounted for in this analysis. It was emphasized by the Committee that this report was informational regarding past trends and should not be used to project future trends.

The Commission also agrees fully with the recommendation in the report that it is not possible to project future conditions under national reciprocity because of the many complex factors other than reciprocity agreements that affect this movement.

The Bureau of Economic Research and Statistics Supplemental Report 2 was ordered transmitted to the House of Delegates.

Fraud and Abuse Under Medicare and Medicaid: The Committee reported as follows:

Committee B reviewed the report of the Council on Legislation relative to Medicare and Medicaid abuse and shares the concern of the Council with regard to such activities.

In the Committee's view a formal expression of the Association's position is the appropriate mechanism to make known the concerns of the dental profession. Therefore, Committee B submits the following resolution to the Board of Trustees and recommends that it be transmitted to the House of Delegates for adoption.

The following resolution was ordered transmitted to the House of Delegates with the recommendation that it be adopted:

129. Resolved, that the American Dental Association pledges its cooperation in the elimination of fraudulent and other illegal practices associated with the Medicare and Medicaid programs.

Study of the Dentist in All His Relationships—Florida Dental Association: The Committee reported as follows:

Reference Committee B reviewed with interest the continued activities of the Bureau of Economic Research and Statistics to determine the reliability of existing data on stress signs related to occupational conditions of dentists. Previous comments on this matter were made by the Board in its Report 2 to the House of Delegates in conjunction with consideration of Resolution 45.

The Committee is pleased to note that the Bureau has received $4,700 from the Division of Dentistry, Department of Health, Education, and Welfare, to convene a workshop meeting of expert consultants to assist in determining the reliability of data on which research of this kind is based.

The group of consultants and Association representatives will meet January 13-14, 1977. A summary report will be prepared, including proceedings and summary recommendations for future research activities of major interested organizations. This workshop is an activity to consider the status of past and current research and is not a feasibility study for future research. This workshop activity in no way alters the Board's previous action that recommended that a full feasibility study funded by the Association is not fiscally advisable at this time.

Rejection of Supplemental Report 2 from Council on Dental Care Programs—Indiana Dental Association: The Committee reported as follows:

In its consideration of Resolution 110 submitted by the Indiana Dental Association, the Committee concluded that it presents two entirely separate questions and, consequently, the Committee recommends that Resolution 110 be appropriately divided.

With respect to the recommendation that the report on Delta Dental Plans Association produced by the Council on Dental Care Programs at the direction of the 1975 House of Delegates be rejected, the Committee is of the view that this would be unwise. In its Board Report 2 to the 1976 House of Delegates, the Board of Trustees commended the Council "for its thorough study" and noted that the report "will be of particular value to all members of

the profession when dealing with this issue." Committee B believes these expressions to be as valid now as they were in August. As Board Report 2 also points out, the delegates themselves will have ample opportunity to evaluate the contents of this report during reference committee hearings and on the floor of the House. For these reasons, Committee B recommends that the call for rejection of the report in the first clause of Resolution 110 be postponed indefinitely and appends an appropriate motion to that effect at the conclusion of these comments.

With regard to the second matter raised by Resolution 110, the Committee would agree that such an overview is both appropriate and prudent. It notes, for the information of the House of Delegates, that steps in this process are already well under way at the request of the Board of Trustees. In the view of the Committee, the intent of the second and third clauses of Resolution 110 can be fully met by a resolution drafted in a more compact manner and thus offers a substitute resolution for the Board's consideration.

The Board of Trustees adopted a motion to divide Resolution 110. The following resolution was ordered transmitted to the House of Delegates with the recommendation that it be postponed indefinitely:

110aB. Resolved, that the Council on Dental Care Programs Supplemental Report 2 not be accepted.

The following substitute resolution was ordered transmitted to the House of Delegates with the recommendation that it be adopted:

110bB. Resolved, that the Board of Trustees arrange for a study of potential antitrust questions involved in the relationship between the American Dental Association and Delta Dental Plans Association and report to the 1977 House of Delegates.

Amendment to "Guidelines on the Use of Radiographs"—Michigan Dental Association: The Committee reported as follows:

Committee B reviewed Resolution 111 which would amend Guideline 11 on the use of radiographs (*Trans.* 1974:653) to permit transmittal of these records to peer review bodies without the written consent of the dentist furnishing them. The Committee understands that the intent of this resolution is to assist constituent and component societies in the effective operation of their peer review mechanisms. Nevertheless, it is the Committee's position that the controlling agent in all decisions on the use of radiographs must remain the attending dentist, the owner of these records. For this reason, the Committee believes existing Guideline 11 properly protects the practicing dentist's prerogatives without imposing any unreasonable administrative requirements upon others. Accordingly, Committee B recommends that the Board of Trustees transmit Resolution 111 to the House of Delegates with a recommendation that it be postponed indefinitely.

Resolution 111 was ordered transmitted to the House of Delegates with the recommendation that it be postponed indefinitely.

Training in Cardiopulmonary Resuscitation—Delegate Ronald I. Maitland, New York: The Committee reported as follows:

Reference Committee B generally agrees with the intent of Resolution 101 which calls attention to the need for the availability of continuing education in cardiopulmonary resuscitation. It notes that the resolution as presented is consistent with existing policy (*Trans.* 1964: 275). After hearing comments on the CPR training that now is a part of the dental school

curriculum, the Committee concluded that a substitute resolution calling for dental societies to make such programs available would be more conducive to accomplishing the intent of the original resolution. Additionally, the Committee requests the Board of Trustees to direct the Council on Dental Health, in concert with other appropriate agencies, to study the limits of dental practice responsibilities as they relate to and overlap with medical conditions that are traditionally and by law the normal responsibility of the physician. It appears to the Committee that the dental profession needs to address the dimensions of the dentist's responsibilities on matters that can relate to dental diagnosis and treatment but are not the normal concern of the dentist.

The Committee presents the following substitute resolution that, it believes, will best implement the intent of Resolution 101.

The following resolution was ordered transmitted to the House of Delegates with the recommendation that it be substituted for Resolution 101 and that the substitute resolution be adopted:

101B. **Resolved**, that constituent and component societies be encouraged to make regularly available to their members continuing education in cardiopulmonary resuscitation.

Reevaluation of Dental Claim Form—Delegate Alex J. McKechnie, Jr., Pennsylvania: The Committee reported as follows:

Committee B reviewed with interest Resolution 89 calling for the reevaluation and redesign of the uniform claim form to reduce repetitious and unnecessary information.

The Committee is sympathetic to the intent of this resolution and observes that the seeking of means to reduce administrative demands brought about by dental prepayment upon the practicing dentist and his staff is a basic function of the Council on Dental Care Programs. It was in the fulfillment of this responsibility, the Committee observes further, that the Council cooperated with major dental prepayment representatives in achieving agreement on a uniform claim form. The Committee notes that the primary objective of this agreement was uniformity for the purpose of ensuring the widest possible acceptance of the form. While the Council on Dental Care Programs continually evaluates this approved form, the Committee understands that the objective of uniformity remains paramount.

In the view of Committee B, universal acceptance of a single claim form is the key to simplified administration for the dentist in that it affords him the opportunity to utilize any of a variety of preprinting techniques in the furnishing of repetitive information. As a consequence, the Committee offers the following substitute resolution for Resolution 89 and recommends that it be transmitted to the House of Delegates for adoption.

The following resolution was ordered transmitted to the House of Delegates with the recommendation that it be substituted for Resolution 89 and that the substitute resolution be adopted:

89B. **Resolved**, that the Council on Dental Care Programs continue to evaluate the currently approved dental claim form, while actively pursuing the goal of uniform acceptance by all third parties, and be it further

Resolved, that the Council on Dental Care Programs provide to practicing dentists information on preprinting techniques in connection with the uniform claim form for the purpose of reducing the administrative workload in dental offices.

Use of Procedure Code—Delegate Alex J. McKechnie, Jr., Pennsylvania: The Committee reported as follows:

Committee B examined with care Resolution 90 which specifies that procedure codes not be required on dental forms submitted by dentists. The Committee observes that the *Code on Dental Procedures and Nomenclature* was originally developed by the Council on Dental Care Programs to promote improved, simplified methods of administering dental prepayment programs (*Trans.* 1969:317). While the Committee believes these codes represent a concise, effective means of identifying dental services on claim forms, it notes that no requirement exists that dentists provide these codes in addition to a description of the procedure. Further, the Committee would point out that narrative descriptions of procedures not specifiaclly identified in the *Code on Dental Procedures and Nomenclature* are always appropriate. For these reasons, the Committee recommends that Resolution 90 be transmitted to the House of Delegates with the recommendation that it be postponed indefinitely.

Resolution 90 was ordered transmitted to the House of Delegates with the recommendation that it be postponed indefinitely.

REPORT OF COMMITTEE C

The Report of Committee C was read by Dr. Pfister, chairman. The other members of the Committee were Drs. Boucek, Houlihan and Kearns.

Report of the American Dental Hygienists' Association: The Committee reported as as follows:

Committee C read with interest the report of the American Dental Hygienists' Association and recommends that it be transmitted to the House of Delegates for information. The Committee compliments the ADHA on its growth and appreciates the opportunity to learn more about the association's programs and activities. Further, it wishes to acknowledge its appreciation for the cooperation shown by ADHA in matters relating to space requirements in the Washington complex. The Committee is hopeful that through the continued cooperation of ADHA and ADA suitable office space within the Headquarters Building can be arranged.

In reviewing the report, however, it was noted that some information is incomplete. The report includes a statement that the Council on Dental Education has "decided to discontinue the meeting of the Committee on Auxiliaries twice a year." While the Commission on Accreditation and Council have determined that the Committee on Auxiliaries, which is comprised of the review committees on dental assisting, dental hygiene and dental laboratory technology, should not be convened at each of the semi-annual Commission/Council meetings, they have not discontinued the joint meeting of the three review committees. Policy matters related to each of the three disciplines which previously have been discussed in the meeting of the Committee on Auxiliaries will be included on the agendas of the semi-annual meetings of the respective review committees. *The three committees will meet together when there are matters of direct interest to all three occupational areas.*

Thus, the liaison between the American Dental Association and the American Dental Hygienists' Association which has existed through the Committee on Auxiliaries will be retained and hopefullly enhanced. *The change in convening committees will result in the involvement of a proportionately greater number of hygienists in formulation of recommendations for ADA policy on dental hygiene matters.* All agencies were informed at the time of the Council's and Commission's decision that they would be invited to participate in that part of the agenda of the respective review committee which relates to policy matters in which they have an interest.

In reaching its decision to convene a joint meeting of the three review committees when indicated, rather than at each semi-annual meeting, the Council and Commission are of the belief that the size of the committee, which is between 30 and 35 individuals, including representatives of the American Dental Hygienists' Association, American Dental Assistants Association and Certifying Board of the American Dental Assistants Association, has in-

hibited discussion. Also, members have been reluctant to comment on issues that do not relate to their area and the majority of agenda items to date have related directly to only one of the auxiliary fields.

Committee C also noted in the report that the ADHA has developed criteria for selecting individuals to recommend as consultants to the Council and Commission, and the statement that the ADHA has urged the Council to adopt similar standards. The Committee is aware, as are other agencies, that the Council on Dental Education has from the time of its inception utilized standards for selecting consultants. These criteria have been conveyed periodically to the ADHA to assist that agency in making recommendations for accreditation consultants. The Council and Commission historically have considered it important that dental hygiene consultants have experience in dental hygiene education and are recognized for their expertise. Recommendations have been accepted on the basis of curriculum vitae which indicate that the individual's qualifications justify recommendation to the ADA Board of Trustees for appointment. The number and distribution of consultants appointed in any given year is based on the accreditation load. That load does not always warrant appointment of all individuals who are recommended. The Committee believes that the Board would oppose appointment of consultants when there is no need. Further, the American Dental Association has the right and responsibility to make the final decision on the selection of individuals who will serve as consultants for various accreditation activities. In seeking individuals with the highest qualifications, it is wise and necessary to solicit recommendations from a variety of sources. The Committee believes that while the Association values and places the highest priority on recommendations received from the American Dental Hygienists' Association, it still must reverse the right to make decisions on consultant appointments.

The American Dental Hygienists' Association's concern about workshop representative selection is one that the Committee seriously questions. In initial letters of invitation to the ADHA, the number of representatives was limited to 15 to assure that the ADA House mandate would be met. At the request of the ADHA, representation of that association was increased to include two additional staff observers. The Council on Dental Education honored the request from the ADHA because it agreed with that association that it was important for their staff to be informed. It was unfortunate that this concession contributed to the concern that practicing dentists were not in the majority at the workshop as directed by the ADA House. However, the Committee believes the Council would, under the same circumstances, again honor such a request from the American Dental Hygienists' Association because the ADA believes it is important for those who are affected by decisions to participate in deliberations leading to the decisions. Further, the ADA believes it important to provide opportunity for staff of related organizations to be fully informed so that they may convey complete and accurate information to their membership. The Committee was particularly disappointed that the comments questioning selection of the workshop representatives appeared in the ADHA report in view of the fact that the issue was discussed at length during the special meeting of the Board of Trustees Committee on Inter-Agency Affairs with ADHA representatives in March 1976. Further, it is difficult to understand why such statements would be made when the ADHA was aware of the stipulations of the ADA House. The Council was certain that individuals selected by the ADHA would be well versed on workshop discussion topics. Finally, the Committee noted that all workshop participants had opportunity to consider and revise reports prepared by group chairmen and recorders—a unique procedure which provided a review mechanism beyond that usually found in workshops.

The Committee believes that comment on the section of the ADHA report related to continuing education is indicated. The ADHA questions the fact that the Council decided to study the feasibility of establishing a national continuing education evaluation program without including an official representative of the American Dental Hygienists' Association on the special study committee. The Council has had several communications with ADHA on this matter and has stated repeatedly that it was charged by the 1975 House of Delegates to study the feasibility of developing a national continuing education evaluation system *for dentists*. The ADHA's position that they should have designated a representative for dental hygiene would have merit if the charge to the committee had been to develop a continuing education program to encompass dental hygienists. If that had been the case, the American Dental Hygienists' Association would have been invited to designate a reprcsentative.

In carrying out its charge the Council believed it important to include individuals with ex-

pertise in providing continuing education and it happened that a dental hygienist who is a past president of the American Dental Hygienists' Association and recognized for her abilities and leadership was selected. Committee C believes the Association must continue to exercise its prerogative of appointing individuals of its choice, including dental auxiliaries to committees, just as the American Dental Hygienists' Association has exercised its prerogative in appointing dentists to committees without requesting official representation from the American Dental Association.

The Committee again noted that the March 1976 meeting of the Inter-Agency Committee of the Board of Trustees, which included American Dental Association and American Dental Hygienists' Association representatives, was positive. The questions raised in the ADHA report were discussed at some length during that meeting. The Committee looks forward to continued improvement of liaison and communication between the two organizations and exchange of complete information on all activities of mutual interest and concern through the Committee on Inter-Agency Affairs.

During its meeting, Committee C was apprised of the fact that arrangements have been made this year to provide identifiable space for ADHA officers in the ADA's House of Delegates. In the spirit of mutual cooperation which has guided both associations during the past years, the Committee is hopeful that similar accommodations will be extended to the ADA during ADHA sessions.

The Board of Trustees directed that the Board report to the House of Delegates indicate that additional space in the Headquarters Building was provided to the American Dental Hygienists' Association to accommodate its expansion program and that the Board is hopeful that when and if ADHA's space requirements escalate the ADA will again be able to meet the office needs required.

Minority Report to "Proceedings, Workshop on Dental Auxiliary Expanded Functions": The Committee reported as follows:

In its consideration of the Minority Report on the "Proceedings, Workshop on Dental Auxiliary Expanded Functions," Committee C found that the report relates to representation of dental practitioners and to opinions of workshop participants on functions which could be delegated to dental assistants and/or dental hygienists. The Board considered both of these matters in August 1976 in its study of the *Special Report on Dental Auxiliary Utilization and Education*. It has taken a position in support of the Council on Dental Education on the question of representation at the workshop and believes the "Proceedings" of the workshop accurately represent the deliberations and decisions.

The Minority Report represents opinions which were heard during the workshop and recorded in the "Proceedings." The workshop was only one source of information for the Advisory Committee and Council in development of the *Special Report*. The report is based on information developed over the past 15 years.

In making its recommendations to the House in August, the Board carefully studied the report and stated its belief that the Council has adequately defended its position on workshop representation and those functions which can be delegated to dental auxiliaries.

Nondiscriminatory Policy for Accepting Dental Students—Indiana Dental Association: The Committee reported as follows:

The Committee reviewed Resolution 109 submitted by the Indiana Dental Association, concurs with the intent of the resolution and notes that the Council on Dental Education adopted a similar policy in the conduct of its accreditation program. National policy required all accrediting agencies to adopt policy standards supporting nondiscrimination in admission of students and employment of faculty and staff and, therefore, in May 1972 the Council on Dental Education adopted the following statement:

> The Council on Dental Education supports the principle which prohibits discrimina-

tion in educational programs on the basis of sex, race, creed, religion or national origin related to the admission of students or the employment of faculty and staff.

When the Commission on Accreditation of Dental and Dental Auxiliary Educational Programs assumed *Bylaws* authority to approve educational standards in 1975, it adopted Council policy which then became an accreditation policy for all areas within the Commission's purview. The policy statement was appended to the *Requirements and Guidelines for Dental Education Programs* and transmitted to all educational programs. Since the House of Delegates transferred the *Bylaws* authority for the approval of educational requirements to the Commission on Accreditation, the Committee recommends that Resolution 109 be amended to conform to Association *Bylaws*.

The following amended resolution was ordered transmitted to the House of Delegates with the recommendation that it be approved:

109B. **Resolved,** that the Commission on Accreditation of Dental and Dental Auxiliary Educational Programs be requested to amend the requirements for an accredited school of dentistry (*Trans.* 1970:54, 437) by adding the following words to the third paragraph under "Admissions":

and that nondiscriminatory policies will be followed in admitting students.

to make the paragraph read as follows:

It is the opinion of the Commission that the selection of students for admission to dental schools should be based on estimates of their capacity for success in the study of dentistry as determined by evaluation of all available and significant information. Consideration of the qualifications of applicants for admission should include information regarding their character, the quality of their preprofessional education, health status and aptitude for and interest in a career in dentistry. The Commission emphasizes that the admission committee has the major responsibility for determining the qualifications of prospective students in the light of educational aims and objectives of the profession and that nondiscriminatory policies will be followed in admitting students.

Problems Existing Between Medicine and Dentistry in the Hospital—Second Trustee District: The Committee reported as follows:

In studying Resolution 113 submitted by the Second Trustee District, the Committee reviewed background correspondence from which the problem first arose. It became readily apparent that this situation is closely related to the request of the American Society of Maxillofacial Surgeons presented in Resolution 94 on use of the term "maxillofacial surgery." Indeed, it was a Trustee of the ASMS who initially raised the question of legality in relation to the practice of oral surgery in the hospital. In addition, the Committee noted that it was the same ASMS Trustee who requested that the New York Board of Medical Examiners be consulted in this regard.

The Committee does not believe that physicians, nor boards of medical examiners, should impose arbitrary and capricious restrictions on the scope of practice of dentistry or its specialty of oral surgery. The scope of practice should be consistent with educational training and the established nature of patient care provided.

The Committee believes that the impetus for implementing undue restrictions on the practice of dentistry is based upon economic rather than professional considerations and are, therefore, entirely indefensible. The Committee strongly believes that the potential implications are of such a nature that the Association must consider amelioration of this problem a high priority. The Committee therefore recommends that Resolution 113 be adopted.

The following amended resolution was ordered transmitted to the House of Delegates with the recommendation that it be adopted:

113B. **Resolved**, that the American Dental Association is strongly urged to assist The Dental Society of the State of New York to ameliorate jurisdictional disputes between medicine and dentistry in the State of New York in order to allow appropriately licensed dentists to practice dentistry within the parameters of their training, experience and demonstrated competence.

ADA Actively Oppose Preceptor Dental Hygiene Training Programs in All States and Territories—Ohio Dental Association/Amendment to Resolution 4—Fifth Trustee District: The Committee reported as follows:

The Committee reviewed Resolution 95 submitted by the Ohio Dental Association which urges the ADA to oppose efforts seeking to train and qualify individuals to practice dental hygiene through methods other than accredited educational programs. The Committee noted the similarities between Resolution 95 and Resolution 4 submitted by the Council on Dental Education. It believes, however, that the second resolving clause of the Ohio resolution clarifies and strengthens the intent of the Council's position. In its discussion of the profession's support of educational standards for dental hygienists, the Committee also considered the Fifth Trustee District's Resolution 4S-1 to substitute the word "preferred" for "essential." The substitution would change completely the intent of the resolution and would reverse Association policy which historically has supported formal education and the educational qualifications established by the profession for dental hygienists' licensure and employment. The serious ramifications of such an action will be, in the Committee's opinion, clear to the House.

The Committee believes the Association should take the strongest possible position in support of the Association's formal education standards for dental hygiene. Therefore, the Committee recommends that Resolution 95 and 4S-1 be postponed indefinitely.

The Committee recommends that the Board present the following resolution as a substitute for Resolutions 4, 95 and 4S-1.

The following resolution was ordered transmitted to the House of Delegates with the recommendation that it be substituted for Resolutions 4, 95 and 4S-1 and that the substitute resolution be adopted:

4B. **Resolved**, that graduation from a dental hygiene program accredited by the Commission on Accreditation of Dental and Dental Auxiliary Educational Programs is the essential educational eligibility requirement for dental hygiene licensure examination, and be it further

Resolved, that the American Dental Association oppose efforts to train and qualify individuals to perform dental hygiene functions who have not completed an accredited dental hygiene education program.

Continued Development of Criteria for Curriculum and Development of an Accreditation Mechanism for Expanded Function Dental Auxiliary Education Programs—Ohio Dental Asssociation: The Committee reported as follows:

Resolution 96 submitted by the Ohio Dental Association suggesting that the House direct the Council on Dental Education to develop criteria for curriculums of expanded function dental auxiliary educational programs and that the criteria be utilized by the Commission on Accreditation of Dental and Dental Auxiliary Educational Programs in designing and implementing an accreditation program was considered carefully by Committee C. The

Committee discussed the fact that the *Commission currently has criteria for evaluating instruction in expanded functions when such instruction is included in curriculums of dental assisting and/or dental hygiene programs.* The Committee also made note of recommendations in the *Special Report on Dental Auxiliary Utilization and Education.* Two recommendations relate to what the Committee interprets as the intent of Resolution 96. Those recommendations are that the Association direct immediate attention to studying and identifying appropriate mechanisms for credentialing auxiliaries for performance of expanded functions (Recommendation 2) and that the Association develop comprehensive educational guidelines for education and training in expanded functions for use by states and educational institutions where need exists (Recommendation 4).

In the Committee's view, adoption of Resolution 96 as it is worded would, in effect, create a new category of auxiliary, as it calls for development of educational standards for an expanded function dental auxiliary program. Currently, it is the Association's position that if expanded functions are delegated, they should be delegated to dental assistants or dental hygienists and that new categories of auxiliaries will not be recognized. Eligibility for accreditation by the Commission on Accreditation does not extend to programs that do not meet the educational standards which have been approved by the Association and the Commission. In the area of dental auxiliary education, three programs are recognized: dental assisting, dental hygiene and dental laboratory technology. The Commission evaluates expanded functions instruction only when it is provided as part of the curriculum in an accredited dental assisting or dental hygiene program.

The Committee shares the Ohio Dental Association's concerns and believes that attention must be directed to those concerns to assure that the profession is doing everything possible to maintain the quality of dental care and provide appropriate assurances of quality to the public. However, the Committee believes extensive study is required before the Association can make a decision regarding educational programs that will, in effect, establish a new category of auxiliary. The Committee believes that, as suggested in the *Special Report on Dental Auxiliary Utilization and Education,* there is need for the Association to study its position on categories of personnel and consider the question of whether an expanded function dental auxiliary should be identified. *In the Committee's view, it would be unwise to adopt the Ohio resolution without thoroughly studying the ramifications of such an action,* including the effect on dental care delivery, the dental practitioner and dental assisting and dental hygiene, and the cost of a new accreditation program. Therefore, the Committee recommends that Resolution 96 be referred to the Council on Dental Education for study with the directive that a complete report on this matter be submitted to the 1978 House of Delegates. That report should include information on the ramifications of identifying an expanded function dental auxiliary; establishing a separate accreditation program and educational standards; and information on the effect of such action on delivery of dental care, dental practitioners, and existing auxiliaries; and statements of cost which would be incurred in launching a new accreditation program.

Resolution 96 was ordered transmitted to the House of Delegates with the recommendation that it be referred to the Council on Dental Education for study and report to the 1978 House of Delegates.

Reinforcement of 1975 Resolution 861—Wisconsin Dental Association: The Committee reported as follows:

Committee C considered Resolution 107 submitted by the Wisconsin Dental Association which supports Resolution 861 adopted by the 1975 House (*Trans.* 1975:701). The Committee believes that the *Special Report on Dental Auxiliary Utilization and Education,* emanating from the special workshop conducted at the direction of the 1975 House, thoroughly addresses the subject of expanded functions. Further, the Committee is of the opinion that a comprehensive statement on auxiliary utilization, as presented in the *Special Report,* is preferable to the approval of individual isolated policy resolutions. The Committee is aware that one resolving clause of the 1975 resolution specifically opposes delegation of certain expanded functions. However, the Committee believes that the *Special Report* with Resolution 24 will provide the Reference Committee on Auxiliary Utilization with appro-

priate information for discussion of specific functions. Therefore, the Committee recommends that Resolution 107 be postponed indefinitely.

Resolution 107 was ordered transmitted to the House of Delegates with the recommendation that it be postponed indefinitely.

Commendation to Commission on Licensure—Fifth Trustee District: The Committee reported as follows:

Committee C considered Resolution 108 submitted by the Fifth Trustee District and agrees that the Commission on Licensure should be recognized for its accomplishments. Therefore, Committee C recommends that Resolution 108 be adopted.

Resolution 108 was ordered transmitted to the House of Delegates with the recommendation that it be adopted.

Substitute for Resolution 26—Fifth Trustee District: The Committee reported as follows:

The Committee considered Resolution 26S-1 submitted by the Fifth Trustee District and agrees that sound moral character is essential for a member of a profession and should be considered in licensure. It, however, does not share the concern of the Fifth Trustee District that the original wording of Resolution 26 circumvents the sound moral character requirement for licensure. Further, the substitute offered is, in the Committee's view, unnecessarily restrictive. There are data not listed in the substitute which would be objectionable on a licensure application. An example would be national origin. It would be unproductive to develop a complete list of all information that would be objectionable on a licensure application. Committee C views asking state boards to review their applications to determine why each data item requested is related to qualifications for licensure to be a better approach. Therefore, Committee C recommends that Resolution 26S-1 be postponed indefinitely.

Resolution 26S-1 was ordered transmitted to the House of Delegates with the recommendation that it be postponed indefinitely.

Amendment to Resolution 25—Fifth Trustee District: The Committee reported as follows:

Committee C considered Resolution 25S-1 submitted by the Fifth Trustee District suggesting that the words "and opposes use of licensure for any other purpose" be deleted. It was recognized that this clause is an implication of the initial portion of the resolution which states that licensure is solely for protecting the public. Nevertheless, Committee C favors retention of the original wording. That the Association opposes use of licensure for any purpose other than protecting the public is significant. A policy statement making this point emphatically, in the view of Committee C, would be in the best interest of the Association. Therefore, Committee C recommends that the Fifth Trustee District amendment to Resolution 25 be transmitted to the House of Delegates with the recommendation that it be postponed indefinitely.

Resolution 25S-1 was ordered transmitted to the House of Delegates with the recommendation that it be adopted.

Substitute for Resolution 28—Fifth Trustee District: The Committee reported as follows:

Committee C considered the amendment to Resolution 28 proposed by the Fifth Trustee District as containing two separate issues. First, the amendment proposed elimination of

guidelines related to licensure by examination. Committee C opposes this change. For a state board to accept current, valid results from examinations conducted by other appropriate agencies would have advantages for both applicants and the state board. State boards are encouraged to use only results of examinations of at least comparable quality and difficulty to their own examination. *Guidelines for Licensure* propose ethical and practice requirements before outside examination results would be accepted. With these restrictions, Committee C viewed the section of *Guidelines for Licensure* that relates to licensure by examination as appropriate.

The second aspect of Resolution 28S-1 involves not recognizing teaching experience for documentation of either current theoretical knowledge or of current clinical skill. Because most dental educators could probably qualify under other proposed provisions, Committee C did not view this proposed change as being significant. Nevertheless, for reasons listed in the Commission's report, Committee C favors retention of guidelines on teaching experience as originally presented. Therefore, the Committee recommends that Resolution 28S-1 be postponed indefinitely.

Resolution 28S-1 was ordered transmitted to the House of Delegates with the recommendation that it be postponed indefinitely. The negative vote of Dr. Faust was recorded.

Substitute for Resolution 24—Fifth Trustee District: The Committee reported as follows:

Committee C considered Resolution 24S-2 submitted by the Fifth Trustee District which recommends approval of the *Special Report on Dental Auxiliary Utilization and Education*. The Board considered lines 13-18 when it reviewed the *Special Report* in August and recommended a clarification of that section of the statement on philosophy and principles.

The Committee believes that the Board's restatement of lines 13-18 meets the intent of the first resolving clause of the Fifth District's substitute resolution by deleting the clause ". . . functions should be identified and delegated to dental auxiliaries when the demand for specific services exceeds the capacity of dentists to provide them. . . ."

The 1975 House directive to the Council on Dental Education (*Trans.* 1975:697) specified that a position statement on functions which should be delegated to dental auxiliaries be prepared and that those functions which would require formal education be identified. The Committee believes that the *Special Report* would not comply with this directive if the section on "Expanded Functions Which Could be Delegated to Dental Assistants and/or Dental Hygienists" and the section on "Educational Requirements for Expanded Functions Which Could be Delegated to Dental Assistants and/or Dental Hygienists" were deleted from the report (lines 75-216).

The Committee reiterates its position that progress cannot be made in resolving the issues related to auxiliary utilization and in identifying appropriate credentialing mechanisms without a specific list of functions and educational requirements. Specific Association policy which specifies designated functions and educational requirements is necessary to provide states with guidance in determining local policy. Therefore, the Committee recommends that Resolution 24S-2 be postponed indefinitely.

Resolution 24S-2 was ordered transmitted to the House of Delegates with the recommendation that it be postponed indefinitely.

Substitute for Resolution 36aB—Fifth Trustee District/Substitute for Resolution 36bB—Fifth Trustee District: The Committee reported as follows:

The Committee considered Resolutions 36(aB)S-1 and 36(bB)S-1 of the Fifth Trustee District to amend Resolutions 36aB and 36bB on the TEAM programs together as they are interdependent. The Committee believes the position the Board took on the New York resolution on termination of TEAM programs during its August 1976 meeting upholds the Association's longstanding position that the individual practitioner ultimately makes the

decision in accordance with dental practice acts on functions which will be performed by dental auxiliaries in his employment. Further, the Board's position upholds the principles often reiterated by the profession that dentists should be prepared to utilize effectively auxiliaries in accordance with the dental practice act in the jurisdiction of their practice. While some may not agree with the functions dental auxiliaries are performing in TEAM programs which are designed to prepare dentists to utilize effectively auxiliaries, those functions are permissible in a number of states. To deprive the dental student of experience in utilizing dental auxiliaries in roles that reflect dental practice acts in jurisdictions where he may elect to practice is contrary to the philosophy of education and advancement that denotes a profession.

The Committee believes that the Board's position that information on TEAM and expanded function dental auxiliary training programs should be provided to state boards of dentistry and dental societies for their consideration and recommendation on implementation is sound and reflects the profession's commitment to obtaining all available information, studying that information and determining whether it indicates action or rejection. To adopt a resolution that the Association would not consider any information on methods of dental practice and dental auxiliary utilization would be parallel to adopting a resolution that the profession did not want to consider information on research in any other areas. For these reasons, the Committee recommends that Resolutions 36(aB)S-1 and 36(bB)S-1 of the Fifth Trustee District be postponed indefinitely.

Resolutions 36(aB)S-1 and 36(bB)S-1 were ordered transmitted to the House of Delegates with the recommendation that they be postponed indefinitely. Dr. Faust requested that his concurrence with the Board recommendation be recorded.

Terminology Used to Describe Duties in the Mouth by Dental Auxiliaries—Delegate Harry W. F. Dressel, Jr., Maryland: The Committee reported as follows:

The Committee carefully considered Resolution 104 submitted by Delegate Harry W. F. Dressel, Jr., Maryland, regarding the need for substituting a new term for "expanded" or "extended" functions and the reasons for change presented with the resolution. In the Committee's view, legislators, consumers, dental auxiliaries, dental educators and dental practitioners have over the past 15 years become familiar with the meaning of the term "expanded" or "extended." They have a specific connotation which is important in communication. While the term "intraoral" has merit, it is not as precise. Historically the functions performed by dental hygienists have been "intraoral" and thus the term would not differentiate between those functions and the new functions which have been delegated to dental hygienists in recent years. As the resolution is stated, "intraoral" duties would also include some that chairside assistants have performed historically. The dental assistant has in carrying out chairside responsibilities used her hands and some instruments in the mouth particularly in four-handed dentistry procedures.

In the Committee's view, a change in terminology would not reduce, but could create, confusion as it merely replaces one term for another. The problem is understanding that the term "expanded" or "extended" functions means that there has been lack of definition of the functions. A substitution of terms would not negate the need for a definition of the functions. The Council on Dental Education's *Special Report on Dental Auxiliary Utilization and Education* presents a definition or listing of the functions for consideration by the House. The Position Statement, if adopted by the House, will define the term. For these reasons, the Committee recommends that resolution 104 be postponed indefinitely.

Resolution 104 was ordered transmitted to the House of Delegates with the recommendation that it be postponed indefinitely. Dr. Cappuccio requested the recording of his concurrence with the recommendation of the Board.

Classification System for Traditional and Non-Traditional Duties—Delegate Harry W. F. Dressel, Jr., Maryland: The Committee reported as follows:

The Committee considered Resolution 105 submitted by Delegate Harry W. F. Dressel, Jr., Maryland, and discussed at some length whether it would be feasible and beneficial to classify traditional and non-traditional dental assisting and dental hygiene functions. It was noted that prior to 1970 there was significant difference in practice acts throughout the country. Some acts included a list of functions which could be delegated or a list of functions which could not be delegated; some did not identify functions and some included rules and regulations provisions and lists of functions.

It would be necessary for each state to interpret the practice act in effect in 1970 and provide a list of functions which were delegatable at that time. Development of such information has been attempted, but data are inaccurate. The Committee could not identify a need for such a classification which in its view introduces still another term for expanded functions.

The Committee believes there is general understanding of what historically has been delegated to the dental assistant and the dental hygienists and again notes that the problem is not the term that is used but the lack of identification of the functions which are considered "expanded" or "non-traditional." The Committee is of the opinion that developing an additional classification system which could not be accurate would make any discussion of expanded functions unnecessarily complex and create the need to refer to several definitions and classifications in discussing matters related to utilization and education of dental assistants and dental hygienists. The Position Statement developed by the Council on Dental Education defines what is meant by expanded functions and the House will determine, ultimately, what the definition will be. The position will be on record and will establish a common language for communication. Therefore, the Committee recommends that Resolution 105 be postponed indefinitely.

Resolution 105 was ordered transmitted to the House of Delegates with the recommendation that it be postponed indefinitely.

Amendment to Resolution 24—Delegate Eugene J. Fortier, Jr., Louisiana: The Committee reported as follows:

In considering Resolution 24S-1 submitted by Delegate Eugene J. Fortier, Jr., Louisiana, to amend the *American Dental Association Statement on Expanded Function Dental Auxiliary Utilization and Education,* the Committee did not find justification for changing the position taken by the Board during its August 1976 meeting. The *Statement* was developed by the Advisory Committee and Council on Dental Education on the basis of extensive background and intensive study. The workshop was *only one source* of information and the opinions of the minority of participants were recorded in proceedings of the workshop. The Advisory Committee, Council and the Board have been fully aware of the opinions of the minority in development of their recommendations.

The Board has made a recommendation for amendment of principle 2 (lines 34-35) (p. 479) which, in the Committee's view, meets the intent of the revision of that principle proposed by Delegate Fortier.

The Committee believes that deletion of the word "expanded" and substitution of "additional" would only cause confusion. The problem in use of the word "expanded" has been that it has not been defined in terms of functions. The *Statement* presented by the Council on Dental Education identified expanded functions. A change in term would, in the Committee's view, introduce a new word for one that has universal connotation.

The *Special Report* includes extensive background and rationale which the Committee believes justifies the Board's recommendations on sections of the *Statement* related to educational requirements and functions which could be delegated. Justification for changes are not presented in Resolution 24S-1; therefore, the Committee finds no reason for the Board to change the recommendations it made in August. It believes, however, that there will be opportunity for complete discussion of the *Special Report* and presentation of reasons for the resolution and other proposed revisions in the reference committee hearing.

For these reasons the Committee recommends that Resolution 24S-1 be postponed indefinitely.

Resolution 24S-1 was ordered transmitted to the House of Delegates with the recommendation that it be postponed indefinitely. The negative votes of Drs. Dixon and Faust were recorded.

Amendment of "Principles of Ethics" Regarding Oral and Maxillofacial Surgery—American Society of Maxillofacial Surgeons: The Committee reported as follows:

In carefully studying Resolution 94 submitted by the American Society of Maxillofacial Surgeons (ASMS), the Committee reviewed background correspondence and positions of various organizations involved in this issue. The ASMS defines "maxillofacial surgery" to be the practice of medicine and not within the scope of training, experience or practice of educationally qualified oral surgeons. In addition, the ASMS states that "maxillofacial surgery" is a specialty of medicine.

The Committee is of the opinion that the American Society of Maxillofacial Surgeons has misinterpreted the intent and actions of the American Dental Association House of Delegates adoption of a revised definition of oral surgery and the provision of the ethical announcement of limitation of practice in oral and maxillofacial surgery.

In 1952 the House of Delegates authorized the Board of Trustees to appoint a special committee for the purpose of studying and making recommendations on the topics covered in a special report on the problem relating to oral surgery, hospital dental service and interprofessional relations (*Trans.* 1952:171). The report of the Special Committee to the 1953 House indicated in part that, despite the provisions of dental practice acts and despite the accumulation of many years of surgery, a frequent cause of misunderstanding was the lack of a clear definition of terms of the desire of some to solve all problems at the national level without regard for local conditions and customs. One of the specific factors leading to the establishment of the Special Committee was an effort on the part of the House of Delegates of the American Medical Association to place unilateral and national limits and interpretations on the practice of oral surgery. As a result of the study, the Committee recommended and the House subsequently approved the following definition for the area of oral surgery.

> The specialty of oral surgery is that part of dental practice which deals with the diagnosis, the surgical and adjunctive treatment of the diseases, injuries and defects of the human jaws and associated structures.
>
> The scope of the specialty of oral surgery shall include the diagnosis, the surgical and adjunctive treatment of the diseases, injuries and defects of the human jaws and associated structures within the limits of the professional qualifications and training of the individual practitioner and within the limits of agreements made at the local level by those concerned with the total health care of the patient (*Trans.* 1953:143).

The adoption of a revised definition is a result of a Board of Trustees directive that each of the eight dental specialty definitions be reviewed. The definitions have been under discussion for several years; specifically, however, the revised definition of oral surgery was presented to and adopted by the 1975 session of the House of Delegates. The current definition of the specialty of oral surgery is not designed to change the traditional practice of oral surgery. Rather, it was an attempt to represent and clarify the legitimate, current scope of clinical activity.

The definition as adopted by the 1975 House of Delegates is as follows:

> Oral surgery is that part of dental practice which deals with diagnosis, the surgical and adjunctive treatment of diseases, injuries and defects of the oral and maxillofacial region (*Trans.* 1975:29).

The Association believes that the special area of practice in which a dentist announces himself should be consistent with the identification of the specialty and the established nature of patient care provided. Educational requirements do and have required extensive training and experience in surgery of the oral and maxillofacial region. In addition, Association policy related to ethical announcement of limitation of practice was revised in 1971 to

assure that all dentists announcing in the area of oral surgery, have successfully completed an accredited education program of at least three years duration.

The *Essentials of an Advanced Educational Program in Oral Surgery* state that a resident's training must include operations such as removal of teeth; corrective hard and soft tissue surgery; biopsy and excision of lesions; open and closed reduction of fractures of the mandible, maxilla and zygomatic complex; condylectomy; arthroplasty of the temporomandibular joint; intra and extraoral incision and draining of odontogenic infections; sequestrectomy and saucerization of osteomyelitis; sialolithotomy; peripheral neurectomy, closure of oral-antral and oro-nasal fistulae; and the surgical correction of congenital, developmental, and acquired deformities of the mouth and jaw regions. Certainly, these procedures fall within the oral and maxillofacial region. By permitting utilization of the term "oral and maxillofacial surgery," the Association permits a suitably trained specialist to more accurately describe the services which he is legally, ethically and professionally qualified to provide to the public.

The Committee also noted the claim of the American Society of Maxillofacial Surgeons that "maxillofacial surgery" is a specialty of medicine and is being usurped by the dental profession. It should be emphasized that the House of Delegates has never authorized oral surgeons to identify themselves as "maxillofacial surgeons." Nor has any report been received that this identification has been used by oral surgeons. Rather, members of the specialty of oral surgery may announce that their practice is limited to oral surgery, or "oral and maxillofacial surgery."

The Committee believes that the ASMS confuses the recognition of medical specialties with the manner in which limitation of medical practice may be announced. In medicine, there exist 22 specialty certifying boards recognized by the American Medical Association. However, the medical profession identifies some 65 acceptable forms of announcement of limitation of practice. Announcement of limitation of practice in an area of medicine does not connote, necessarily, specialization in a special area recognized by the American Medical Association. Furthermore, dentistry has more specifically delineated the manner in which limitation of practice may be announced than has the medical profession. The specialty areas of dentistry approved by the American Dental Association and the designation of ethical announcement of limitation of practice are: endodontics; oral pathology; oral surgery, or oral and maxillofacial surgery; orthodontics; pedodontics, or dentistry for children; periodontics; prosthodontics; and dental public health. Resolution 14 to the 1976 House of Delegates proposes that pedodontics be further recognized as pediatric dentistry.

The ASMS states that "maxillofacial surgery" is a specialty of medicine requiring a medical degree and five years of postgraduate training. The American Medical Association is not supportive of this claim. "Maxillofacial surgery" is not recognized by the AMA as a specialty of medicine; there is not an AMA approved residency in "maxillofacial surgery," nor are there AMA recognized examining boards in medical specialties or subspecialties limited to "maxillofacial surgery."

The ASMS proposes that the House of Delegates rescind its previous actions amending the *Principles of Ethics* and the definition of oral surgery, and suggests that such action would eliminate public confusion and would continue to allow for the medical and dental professions to provide optimal care. The Committee does not believe the ASMS to be correct in its position. The Committee is not persuaded by the background to Resolution 94 that the 1975 House action should be reversed. Such action would, in fact, adversely affect the dental profession and its specialty of oral surgery and, furthermore, would confuse the public and denigrate the oral surgeons' established right to appropriately identify the nature of services they provide to the American public.

The Committee understands that ADA and AMA officials have discussed the convening of a series of conferences, alternately sponsored, to address the several problems existing between medical and dental specialties. Although "maxillofacial surgery" is not a recognized specialty of medicine, the Committee believes it might be advantageous for the ASMS to seek participation during the proposed meetings. The Committee strongly believes that the only appropriate arena in which to address these issues of dispute between medicine and dentistry is in that forum.

The Committee therefore recommends that Resolution 94 be postponed indefinitely.

By unanimous vote, Resolution 94 was ordered transmitted to the House of Delegates with the recommendation that it be postponed indefinitely.

Following the Report of Committee C, the Board of Trustees adopted a motion requesting the Executive Director to send a letter of commendation to Miss Margaret M. Ryan for her service to the Association and, particularly, for her contribution to the Council on Dental Education's *Special Report on Dental Auxiliary Utilization and Education.*

Recess: The Board of Trustees recessed at 5:50 PM.

THURSDAY, NOVEMBER 11, 1976

Call to Order: The meeting of the Board of Trustees was called to order at 8:05 AM by President Shira.

Roll Call: The officers, members of the Board of Trustees and members of staff were present as previously recorded.

REPORT OF COMMITTEE A

The Report of Committee A was read by Dr. Kerr, chairman. The other members of the Committee were Drs. Brown, Carter and Faust.

Report of Executive Director: The Committee reported as follows:

General Comment: The Committee reviewed the report of the Executive Director. The Committee took note of the fact that the Executive Director was receiving more invitations to speak at dental society meetings, but was refusing some in order to keep his travel schedule at a reasonable level. The Committee was particularly complimentary about the new publication *Current Policies, Adopted 1954-75* which a Committee member characterized as "one of the best publications which we have ever issued."

Fédération Dentaire Internationale: The Committee discussed the comments on the recent FDI annual session with the Executive Director and indicated that recommendations for Board action would be presented later in this report, after review of additional comments from the President and President-elect.

Conference on Legal and Legislative Issues: The Committee reviewed the request from New Jersey for a conference on legal and legislative issues and strongly supported the suggestion of the Executive Director for linking such a conference to the Annual Management Conference. The many excellent conferences which are sponsored by the Association each year are of great value to state and local dental societies, but they do place a financial burden on these societies and perhaps prevent many of the medium and smaller societies from attending.

Board Manuals: Committee A reviewed the request of the Executive Director for a consensus of the Board on the question of re-using Board Manuals. The Committee not only supported

the current policy of re-use but strongly suggested that the policy be extended to include budget books. The dollar savings would be considerable.

Report on Contracts: Committee A reviewed the list of contracts reported in accordance with the *Standing Rules of the Board of Trustees.*

Report of President: The Committee reported as follows:

Visits: Committee A noted the extremely heavy travel schedule which the President was able to maintain during the past two years. His ability to represent the profession so effectively and so articulately in such varying situations and under many intense pressures has been quite extraordinary. The profession and especially the practicing dentists are very much in Dr. Shira's debt.

Coordination of Travel: The Committee was informed that the Executive Director has placed into operation procedures which will coordinate information on travel of ADA Officers, Trustees and staff to local, state, regional or national dental meetings. Once the system is fully operative, information will be sent routinely to the trustee and to the officer who is to speak at a meeting as to which ADA officials and staff are to be in attendance. This will be true whether the travel and per diem are paid by the ADA or an outside agency.

Office of Treasurer: The Committee reviewed the comments of the President on the office of Treasurer and noted that the matter would be covered later in this report.

Dr. Oscar Malmin: The Committee reviewed with the President his concerns about the statements and charges of Dr. Oscar Malmin. The Committee noted that the subject would be fully discussed by the full Board of Trustees under agenda item "I" in New Business.

Report of President-Elect: The Committee reported as follows:

Fédération Dentaire Internationale: Committee A discussed extensively the report on the Fédération Dentaire Internationale. The Committee was extremely grateful to the President-elect, the President and the Executive Director for the issues which they raised and for the new facts which they presented.

After extensive discussion, the Committee came to the conclusion that the entire subject should be examined in considerable detail by the Board Committee on Inter-Agency Affairs. In this way, a thorough, dispassionate examination can be made of the Association's role in international affairs, its relation to the Fédération Dentaire Internationale, the funding of the Fédération, the Association's voice in the Fédération's policy-making apparatus, etc. Committee A, therefore, recommends that the Board refer the entire matter to the Committee on Inter-Agency Affairs and submits the following resolution.

The following resolution was adopted by the Board of Trustees:

130-1976-B. **Resolved,** that the entire question of the relationship of the American Dental Association and the Fédération Dentaire Internationale be referred to the Board's Committee on Inter-Agency Affairs for detailed study and report back to the Spring 1977 session of the Board of Trustees, and be it further

Resolved, that the Committee on Inter-Agency Affairs be requested to give special attention to the reports of the Executive Director (November 1976 *Board Manual*:400) and President (November 1976 *Board Manual*:436), and particularly to the recommendations of the President-elect (November 1976 *Board Manual*:408).

The report of the Committee continued as follows:

> Committee A does believe, however, that the Board of Trustees can and should take action in one area related to the leadership level in the Fédération. The Committee fully agrees with the President-elect that all nominations of U.S. dentists to become members of FDI commissions, officers, councillors, *et al,* should be cleared through the ADA Board of Trustees. Therefore, the Committee fully supports the following resolution.

The Board of Trustees adopted the following resolution:

> 131-1976-B. Resolved, that the following recommendations on nominations of U.S. dentists to the Fédération Dentaire Internationale be approved:
>
> 1. Individuals being nominated for any of the positions of leadership within the FDI should be members of the ADA—active, life, retired—and should be approved by the ADA Board of Trustees before they are placed in nomination; if not, the names should be withdrawn from nomination.
>
> 2. All individuals should have a complete curriculum vitae submitted to the ADA Board of Trustees at the time of the Board's consideration. The curriculum vitae should have as top priority: status of ADA membership; type of practice—general, specialist, school faculty member, etc.; citizenship; present professional responsibilities.
>
> 3. Current individuals serving the FDI from the USA should have curriculum vitae similar to item #2 developed and presented to the Board at the earliest opportunity.
>
> 4. The Board's Committee on Inter-Agency Affairs should be responsible for FDI relations and recommendations to the Board.

Committee on Advance Planning—California Dental Association: The Committee reported as follows:

> Committee A reviewed the purpose of California Dental Association Resolution 106 and pointed out that the request was already being met. The report of the Committee on Advance Planning is being submitted to the House of Delegates for its approval. In light of this, Committee A recommends that Resolution 106 be transmitted to the House of Delegates with the recommendation that it be postponed indefinitely.

Resolution 106 was ordered transmitted to the House of Delegates with the recommendation that it be postponed indefinitely.

Reconsideration of Funding for Dental Editors' Seminar—Illinois State Dental Society: The Committee reported as follows:

> Committee A is aware that the Committee on Finance and Investments has reviewed Illinois State Dental Society Resolution 93 and has reiterated its support of the Board action in suspending the editors' seminar for one year. Committee A fully supports this position. Committee A members pointed out that it is not a question of the value or the popularity of the seminar; the decision to suspend it, along with many other effective programs, was made purely on economic necessity which had to be faced in balancing the 1977 budget. The Committee, therefore, recommends that Resolution 93 be transmitted to the House of Delegates with the recommendation that it be postponed indefinitely.

Resolution 93 was ordered transmitted to the House of Delegates with the recommendation that it be postponed indefinitely. The affirmative vote of Dr. Dewhirst and the negative votes of Drs. Gertler, Griffiths, Kearns and Savoie were recorded.

Commendation to Dr. Charles D. Carter—Kentucky Dental Association: The Committee reported as follows:

> Committee A reviewed the background statement and Resolution 92 submitted by the Kentucky Dental Association. Needless to say the Committee fully and warmly supports the resolution. Committee A is privileged to recommend that Resolution 92 be transmitted to the House of Delegates with the recommendation that it be approved.

Resolution 92 was ordered transmitted to the House of Delegates with the recommendation that it be adopted.

Insurance Program for ADA Members—Michigan Dental Association: The Committee reported as follows:

> Committee A has carefully reviewed Resolution 112 submitted by the Michigan Dental Association requesting the Council on Insurance to distribute the experience statistics by state, relative to the Professional Protector Plan, 90 days before renewal dates of the program for analysis and discussion with that constituent society, prior to a rate increase, and further requiring the Council to forward all information pertaining to proposed changes in coverage to constituent societies for their input prior to definitive action on those changes. The Committee is sympathetic to the intent of the Michigan resolution; however, the Commitee must point out that the establishment of premium rates for professional liability and casualty coverages on a national level is a highly technical and complex procedure requiring consideration of many factors. In order to have the program operate in the best interest of all plan participants, a balance in premium rates is required. The Council on Insurance is currently undertaking a study for the purpose of determining the most equitable method of applying rate increases.
>
> The Committee would also point out that the Professional Protector Plan is not a true group program. It does not have a single contract with a common expiration rate, but rather each participant is issued an individual policy, as required by individual state law, with policy expirations taking place throughout the year. The Committee also takes notice of the changed climate in professional liability and casualty insurance. The insurance industry, as a result of severe financial losses resulting from these coverages, is no longer freely writing this business. Indeed, on any large scale business the number of companies willing to write this business at all has dwindled to no more than a handful. The implementation of Resolution 112 without a thorough study of its implications and ramifications could prove to be detrimental to the entire program. Therefore, Committee A recommends that Resolution 112 be transmitted to the House of Delegates with the recommendation that it be referred to the Council on Insurance for study and report back to the 1977 House of Delegates.

Resolution 112 was ordered transmitted to the House of Delegates with the recommendation that it be referred to the Council on Insurance for study and report back to the 1977 House of Delegates.

Formation of Self-Insured Malpractice Program—New Jersey Dental Association: The Committee reported as follows:

> Committee A has carefully reviewed Resolution 100 submitted by the New Jersey Dental Association requesting that a study be made of the feasibility of the Association forming a self-insured malpractice program. The Committee was made aware of the fact that the Council on Insurance has already undertaken such a study. The magnitude of such a study

was pointed out to the Committee and it was advised that the Board of Trustees will be kept informed on its progress. Therefore, the Committee recommends that Resolution 100 be transmitted to the House of Delegates with the recommendation that it be adopted.

Resolution 100 was ordered transmitted to the House of Delegates with the recommendation that it be adopted.

Professional Protector Plan—Ninth District Dental Society of New York: The Committee reported as follows:

Committee A has carefully reviewed the resolution submitted by the Ninth District Dental Society of New York and the background information appended thereto requesting the Association to reaffirm its policy regarding the sponsorship of the Professional Protector Plan and to make such coverage available for all members of the Association regardless of geographic locale or constituent status. The Committee was informed by the Council on Insurance that it is making every effort to provide this coverage for the members of The Dental Society of the State of New York. Also, the Council has informed the Committee that alternatives to the Professional Protector Plan are being sought. Therefore, the Committee recommends that the following resolution be adopted by the Board of Trustees.

The Board of Trustees adopted the following resolution:

132-1976-B. **Resolved**, that the American Dental Association reaffirms its policy regarding the sponsorship of the Professional Protector Plan, and be it further

Resolved, that, to the extent possible, any constituent society wishing to do so be given the opportunity of co-endorsing the program regardless of geographic locale.

Financial Tabulation of Cost of Proposed Programs—Delegate Joseph A. Devine, Wyoming: The Committee reported as follows:

The Committee was advised that Dr. Devine stressed in a follow-up telephone call respecting his resolution that he in no manner wishes to invade or impinge on the managerial responsibilities of the Board of Trustees concerning the preparation of the annual budget for submission to and approval by the House. He merely wishes to implement a mechanism that will keep the House informed at all times of the total strain that new programs are placing within the framework of the budget, particularly on the Board's budgeted Contingent Fund which is intended to care for emergency needs. With this understanding, the Committee calls attention to the resolution adopted by the 1975 House requiring that resolutions calling "for creation of new programs, special committees or studies" be accompanied by cost estimates and the potential source of funds (*Trans.* 1975:631). The Committee sees no problem in having a running total of these estimates being flashed on the screen after each resolution is adopted but does have concern with regard to other aspects of Dr. Devine's proposal. For example, if the approval of the annual budget were held as the last order of business before the House, the Committee fears that a call for a quorum might leave the Association in the embarrassing, untenable predicament of having no approved budget for the coming year. Further, hastily formed estimates of cost, which had not undergone the benefit of agency and Board scrutiny, would become more or less fixed costs, depending on precipitate Board decisions amending the budget for House consideration and culminating in unanticipated and possible non-emergency dues increases for active members. As a consequence, the Committee recommends that the following resolution be substituted for Resolution 102.

Resolution 102 was ordered transmitted to the House of Delegates with the recommendation that it be referred to appropriate Association agencies for further study.

Amendment of "Bylaws" Regarding Treasurer: The Committee reported as follows:

> The Board of Trustees at its August 1976 session appointed Dr. Jack H. Pfister to serve as Treasurer of the Association for a one rather than three year term commencing November 19, 1976 with the thought of proposing to the House of Delegates that the office of Treasurer be strengthened by permitting the Board of Trustees to provide in its *Organization and Rules* to have the Chairman of the Committee on Finance and Investments, who is always an elected, voting member of the Board, also serve as Treasurer. However, to accomplish this objective, which incidentally will also save the Association $6,000 to $7,000 annually, an amendment to the *Bylaws* must first be enacted by the House. Therefore, the Committee proposes that the following resolution, amending the *Bylaws*, be submitted to the House for its approval.

The following resolution was ordered transmitted to the House of Delegates with the recommendation that it be adopted:

> 128. Resolved, that Chapter VIII, Appointive Officers, of the *Bylaws* be amended by the deletion of Section 20, Appointments, and the substitution therefor of the following new section:
>
> > Section 20. Appointments: Any active, life or retired member in good standing may be appointed to an appointive office by the Board of Trustees in accordance with its rules and regulations.

SPECIAL ORDER OF BUSINESS

Appearance of Dr. Louis J. Hendrickson, General Chairman, Committee on Local Arrangements, 1976 Annual Session: Dr. Louis J. Hendrickson, general chairman of the Committee on Local Arrangements for the 1976 annual session, appeared before the Board of Trustees to extend a welcome and to briefly outline the arrangements for the annual session.

REPORT OF COMMITTEE D

The Report of Committee D was read by Dr. Cappuccio, chairman. The other members of the Committee were Drs. Dixon, Gertler and Savoie.

Report of Council on Dental Laboratory Relations, Supplement 1 to Board: The Committee reported as follows:

> The Committee reviewed the Council on Dental Laboratory Relations Supplemental Report to the Board of Trustees. The Committee notes that the Council's report covers two separate matters: one is the Council's comments on implementation of assignments from the Board of Trustees on meeting the challenge of illegal dentistry; the other matter involves the application of the term "auxiliary" to commercial dental laboratories.
>
> Board Assignments on Combating Illegal Dentistry: Committee D agrees with the Council on the urgency of initiating meetings with groups outside the dental profession to acquaint them with the dangers from patronizing persons practicing dentistry illegally. The Committee, therefore, recommends that Resolution 326 be approved.

The Board of Trustees adopted the following resolution:

> 133-1976-B. **Resolved,** that the Bureau of Dental Health Education proceed immediately with its plans to meet representatives of groups outside the dental profession who represent large numbers of edentulous persons to discuss illegal dentistry and other such concerns.

The report of the Committee continued as follows:

> The Committee considered Resolution 327 which, in essence, urges all Association agencies to give priority to programs designed to combat illegal dentistry. The Committee offers an amendment to Resolution 327 changing "number one priority" for combating illegal dentistry activities to "one of the highest priorities." The Committee recommends that the second resolving clause be amended by replacing "the number one priority" with "one of the highest priorities" so that the amended Resolution 327 will read as follows.

The Board of Trustees further amended the resolution to include the phrase "commonly known as denturists" and adopted the following resolution:

> 134-1976-B. **Resolved,** that the challenges from illegal operators, commonly known as denturists, and their proponents be recognized as a serious threat to the dental health of the public and represent an impending erosion of dental practice in this country, and be it further
> **Resolved,** that one of the highest priorities of Association agencies shall be those efforts directed toward the development of programs designed to combat the illegal dentistry threat.

The report of the Committee continued as follows:

> **Position Statement on the Commercial Dental Laboratory Industry:** The Committee supports the Council's efforts to improve relations with representatives of the dental laboratory industry. The Council's proposed position statement (Resolution 328) is intended to accord recognition to the dental laboratory industry as a business entity and to emphasize its proper role in providing services to licensed dentists. The Committee concurs with Resolution 328 with one amendment and recommends that it be substituted for Resolution 47, an Illinois proposal to remove from the classification of dental auxiliaries those dental laboratory technicians who are employed in commercial dental laboratories. The Committee recommends that the following words be inserted after "dental office" in line three of the "Position Statement" within Resolution 328: "is not only an auxiliary to the dental profession but" so that the resolution as amended will read as follows:
>
> > **Resolved,** that the "Position Statement on the Commercial Dental Laboratory Industry" be approved.
>
> **Position Statement on the Commercial Dental Laboratory Industry**
>
> All personnel associated with the dentist in the delivery of health care are properly termed "auxiliary" in the sense of aiding the dentist to properly serve the public; however, the laboratory technician who performs a supportive function in an environment outside the dental office is not only an auxiliary to the dental profession but may also be properly termed a supportive or allied member of the dental health team. The

commercial dental laboratory industry, furthermore, is comprised of independent, for-profit businesses whose services are exclusively dependent upon dentists who provide the laboratory with work authorizations for the processing of prosthetic appliances.

After extensive discussion, the Board of Trustees ordered the following resolution transmitted to the House of Delegates with the recommendation that it be adopted:

127. Resolved, that the "Position Statement on the Commercial Dental Laboratory Industry" be approved.

Position Statement on the Commercial Dental Laboratory Industry

The commercial dental laboratory industry is comprised of independent, for-profit businesses whose services are exclusively dependent upon dentists who provide the laboratory with work authorizations for the processing of prosthetic or other dental appliances.

Report of Council on Judicial Procedures, Constitution and Bylaws, Supplement 1 to Board: The Committee reported as follows:

Advisory Opinions to the "Principles of Ethics": The Committee reviewed the Council on Judicial Procedures, Constitution and Bylaws Supplemental Report to the Board of Trustees. The Committee reluctantly concurs with the Council's deletion of several advisory opinions that conflict with recent court decisions.

Report of Council on Legislation, Supplement 1 to House: The Committee reported as follows:

The Committee reviewed the Council on Legislation Supplemental Report to the House of Delegates. The Committee calls attention to the final actions on all dental legislation as compiled by the Washington Office.

Clarification of Terminology in Pedodontics—California Dental Association: The Committee reported as follows:

Committee D examined the report of the Council on Judicial Procedures, Constitution and Bylaws. The Committee concurs with the recommendation of the Council that Resolution 56 be referred to the Council for report to the 1977 House of Delegates. The Council's recommendation reflects the wishes of the American Academy of Pedodontics to have an opportunity to make an official decision on the proper designation of the specialty.

Resolution 56 was ordered transmitted to the House of Delegates with the recommendation that it be referred to the Council on Judicial Procedures, Constitution and Bylaws for report to the 1977 House of Delegates.

Definition of "Denturism"—District of Columbia Dental Society: The Committee reported as follows:

The Committee reviewed Resolution 98.

Resolution 98 was ordered transmitted to the House of Delegates with the recommendation that it be approved.

Announcement of a Specialty—District of Columbia Dental Society: The Committee reported as follows:

> The Committee studied Resolution 99. Committee D concurs with the intent of Resolution 99 of the District of Columbia Dental Society which seeks (1) to permit only a dentist who limits his practice to one specialty area to announce that he is in the "exclusive" practice of a specialty, and (2) to require that a dentist who is qualified in and announces in more than one specialty area disclose to his patients and to the profession that he is a dual or multi-specialist. The Committee points out, however, that the purpose of this resolution can only be accomplished by an amendment to Section 18 of the *Principles of Ethics* and, accordingly, submits the following substitute resolution for Resolution 99 and recommends that it be transmitted to the House of Delegates.

The Board of Trustees adopted a motion to amend the Committee substitute resolution by deleting the word "exclusive." The following resolution was ordered transmitted to the House of Delegates with the recommendation that it be substituted for Resolution 99 and that the substitute resolution be adopted:

> **99B. Resolved,** that Section 18 of the American Dental Association *Principles of Ethics* be amended to delete the word "exclusive" in the first sentence thereof, so that Section 18 as amended will read as follows:
>
> > **Announcement of Limitation of Practice.** Only a dentist who limits his practice to the special areas approved by the American Dental Association for limited practice may include a statement of his limitation in announcements, cards, letterheads and directory listings (consistent with the custom of the community), provided at the time of the announcement he has met in each specialty for which he announces the existing educational requirements and standards set by the American Dental Association for members wishing to announce limitation of practice.
> >
> > In accord with the established ethical ruling that dentists should not claim or imply superiority, use of the phrases "Specialist in _____" or "Specialist on _____" in announcements, cards, letterheads or directory listings should be discouraged. The use of the phrase "Practice limited to _____" is preferable.
> >
> > A dentist who uses his eligibility to announce himself as a specialist to make the public believe that specialty services rendered in his dental office are being rendered by ethically qualified specialists when such is not the case, is engaged in unethical conduct. The burden is on the specialist to avoid any inference that general practitioners who are associated with him are ethically qualified to announce themselves as specialists.

Sharing and Coordination of Legal Expertise—Ohio Dental Association: The Committee reported as follows:

> Committee D recognizes the need for the program for sharing and coordination of legal expertise as proposed in Resolution 97 of the Ohio Dental Association. The Committee also recognizes that this action will require a supplement to the proposed 1977 budget in order to provide for additional legal services, supporting personnel and facilities. A preliminary estimate is that the minimum cost of the program will be $100,000 per year. The Committee also points out that this program will not affect the Board of Trustees' evaluation of requests from constituent and component societies for assistance in sharing portions of the cost of litigation involving such societies and concerning the interests of the profession

nationally. Decisions on the Association's participation in such litigation will be made in accordance with Guidelines adopted by the Board of Trustees at its August 1976 session. The Committee, therefore, recommends that Resolution 97 be transmitted to the House of Delegates with the approval of the Board of Trustees.

The following amended resolution was ordered transmitted to the House of Delegates with the recommendation that it be approved:

97B. Resolved, that the American Dental Association, through its legal department, develop a means by which its high level of legal expertise can be shared with constituent societies and their respective legal counsels when deemed appropriate, feasible and in the best interests of the dental profession, and be it further

Resolved, that the American Dental Association legal department establish a mechanism whereby the legal counsel of the various constituent societies may better coordinate and share expertise and information with respect to their common legal problems.

The Board of Trustees directed that, if Resolution 97B is approved by the House of Delegates, legal staff report to the March 1977 session of the Board of Trustees on the progress in implementing the program reflected in the resolution.

Amendment to Resolution 58—Fifth Trustee District: The Committee reported as follows:

Committee D considered Resolution 58S-1. Resolution 58S-1 is a substitute for Resolution 58. The original resolution was submitted by the California Dental Association. The Committee has learned that there is no procedure for annual renewal of remote area designations by the Department of Defense. The Committee therefore recommends that the phrase "annual renewal" be replaced by the word "review."

Resolution 58S-1 was ordered transmitted to the House of Delegates with the recommendation that it be substituted for Resolution 58 and the substitute resolution adopted.

Amendment to Resolution 8—Fifth Trustee District: The Committee reported as follows:

The Committee reviewed Resolution 8S-1 which is a substitute for Resolution 8. The original resolution was submitted by the Council on Federal Dental Services.

Resolution 8S-1 was ordered transmitted to the House of Delegates with the recommendation that it be substituted for Resolution 8 and that the substitute resolution be adopted.

Substitute for Resolution 41—Fifth Trustee District: The Committee reported as follows:

The Committee reviewed Resolution 41S-1. The original resolution was submitted by the Washington State Dental Association.

Resolution 41S-1 was ordered transmitted to the House of Delegates with the recommendation that it be substituted for Resolution 41 and the substitute resolution adopted.

Model State Dental Practice Act—Delegate Eugene J. Fortier, Jr., Louisiana: The Committee reported as follows:

> Committee D studied Resolution 103 transmitted by Delegate Eugene J. Fortier, Jr., Louisiana. The Committee concurs with the resolution and recommends that it be transmitted to the House of Delegates with the approval of the Board of Trustees.

The Board of Trustees adopted a motion to amend the resolution and the following amended resolution was ordered transmitted to the House of Delegates with the recommendation that it be adopted:

> 103B. Resolved, that the appropriate agency of the American Dental Association investigate the feasibility of recommending changes in state dental practice acts as they pertain to advertising and related sections of the acts, and be it further
> Resolved, that the results of this study be presented to the Board of Trustees at the earliest time for implementation and funding, if feasible.

November 4, 1976 Letter from Dr. Harry Bruce, Executive Director of the American Association of Dental Schools, on "Guidelines for Dentistry's Position in a National Health Program": The Committee reported as follows:

> The Committee studied Dr. Bruce's comments comparing the approach of the AADS *Guidelines* for a national health program with the ADA *Guidelines*. Committee D reviewed the AADS *Guidelines* during the August session of the Board of Trustees before the Committee submitted its recommendations for updating the *Guidelines*. Committee D believes that both AADS and ADA agencies, including Committee D, strove to achieve an accommodation between the two sets of *Guidelines*. Committee D is convinced that ADA and AADS have consistent policy positions on the significant issues related to national health care and dentistry's position therein. There are differences in emphases because the American Dental Association's views the *Guidelines* as directed mainly to services for beneficiaries while AADS gives substantial emphasis to resources for dental education. AADS officials will have an opportunity to present their views on the *Guidelines* to the special Reference Committee of the House of Delegates. The Committee submits no recommendations on the AADS *Guidelines*.

Recess: The Board of Trustees recessed at 12:20 PM and reconvened at 1:35 PM.

UNFINISHED BUSINESS

Review of Board Action on NHI Guidelines at August Board Session: It was noted that at the August 1976 session of the Board of Trustees, proposed revisions to the *Guidelines for Dentistry's Position in a National Health Program* were developed for submission to the 1976 House of Delegates. The Board deferred action on the proposed revisions of the *Guidelines* until the November 1976 session of the Board of Trustees. After reviewing the proposed revisions which were printed in the *Supplement to An-*

nual Reports and Resolutions, 1976, the Board adopted a motion to transmit the proposed revisions of the *Guidelines for Dentistry's Position in a National Health Program* to the House of Delegates with the recommendation that they be adopted. The negative votes of Drs. Faust and Phillips were recorded.

NEW BUSINESS

Recommended Revocation of Certain Existing Policies Respecting Third Party Dental Prepayment Programs and Related Problems: The following resolutions were ordered transmitted to the House of Delegates with the recommendation that they be approved:

118. **Resolved,** that the title of the statement, "Principles for Determining the Acceptability of Plans for the Group Purchase of Dental Care" (Revised 1957) (*Trans.* 1957:389) be amended to read "Guidelines for the Group Purchase of Dental Care," and be it further

Resolved, that the statement be amended by the deletion of the phrase, "with the advice and assistance of the dental society," in the second sentence of principle 7, to make the amended sentence read:

> Fee schedules should be developed in order that they may (1) make possible high standards of treatment in providing benefits under the plan and (2) be adjusted in accordance with changes in the economic level at reasonable intervals.

119. **Resolved,** that the "Statement of Policies on Dental Prepayment" (*Trans.* 1965:354) be amended by the deletion of the second sentence of the introductory paragraph reading as follows:

> The development and growth of dental prepayment plans, therefore, are encouraged, provided that they meet the principles and standards established by the dental profession in the interest of providing the best possible level of dental care.

and the substitution therefor of the following sentence:

> In the interest of assuring that the best level of dental care possible is being made available under dental prepayment programs, the following guidelines are offered for reference in the establishment and growth of dental prepayment plans.

and be it further

Resolved, that said statement be amended by the deletion of the section entitled "Evaluation of Dental Prepayment Plans," reading as follows:

> **Evaluation of Dental Prepayment Plans:** Constituent societies have the responsibility for evaluating dental prepayment plans which come within their jurisdiction, provided the societies' criteria are consistent with standards which have been established at the national level.

and be it further

Resolved, that said statement be amended by the deletion of the section entitled "Determination of Fees," reading as follows:

Determination of Fees: The determination of policies relating to fees and methods of remuneration should be made at the state or local level by authorized representatives of the dental profession.

and be it further

Resolved, that the said statement be amended by the deletion of the phrase, "with the advice and assistance of the dental society," in the second sentence of numbered subsection 7 of the section entitled "National Criteria for Evaluation of Dental Prepayment Plans," to make the amended second sentence in subsection 7 read:

> Fee schedules and tables of allowance should be developed in order that they may (a) assure high standards of treatment in providing benefits under the plan and (b) be subject to adjustment at reasonable intervals in accordance with changes in the economic level.

and be it further

Resolved, that the said statement under the section entitled "Payment to Dentists" be amended by deleting the second sentence reading as follows:

> The method of payment should be determined by authorized representatives of the constituent societies within policies established by those societies.

120. **Resolved,** that Resolution 38-1966-H (*Trans.* 1966:347), stating that the qualifications of the dentist participating in publicly funded health programs should be the prerogative of governing bodies of component and constituent dental societies and state dental examining boards, be amended by deleting the phrase "governing bodies of component and constituent dental societies and," to make the amended resolution read:

> **Resolved,** that the American Dental Association support the position that the determination of the qualifications of the individual dentist participating in publicly funded health programs should be the prerogative of state dental examining boards.

121. **Resolved,** that Resolution 9-1966-H (*Trans.* 1966:311), reading as follows, be rescinded:

> **Resolved,** that in future negotiations with public or private agencies in relation to dental care programs, it shall be the policy of the American Dental Association that reimbursement for professional services on the basis of usual and customary fees shall be given priority consideration.

122. **Resolved,** that Resolution 30-1968-H (*Trans.* 1968:305), urging constituent societies and dental service corporations to initiate the confidential prefiling of fees, reading as follows, be revoked:

> **Resolved,** that the constituent society or dental service corporation in each state be urged to initiate the confidential prefiling of fees to enable the accumulation and determination of reliable fee data for the development of sound private and public care programs utilizing the usual, customary and reasonable concept of reimbursement for professional services.

123. **Resolved**, that the statement on "Dental Society Review Committees" as adopted by Resolution 49-1970-H (*Trans.* 1970:485) and amended by Resolution 21-1971-H (*Trans.* 1971:485), be amended by the deletion of the word "customary" in the first sentence, to make the amended sentence read:

> The functions of review committees are to determine the relevancy of the usual and reasonable fees, of treatment procedures to the terms of the contract, and may include assessment of quality of services rendered. However, these functions shall not include setting fees, determining practice or interfering in the dentist-patient relationship.

and by the deletion of numbered principle 5, reading as follows:

> 5. The committee through the sponsoring dental society should have available formal criteria for the determination of usual, customary and reasonable fees.

124. **Resolved**, that Resolution 55-1972-H (*Trans.* 1972:673) of the 1972 House of Delegates, adopting a statement on closed panels, reading as follows, is hereby revoked:

> A closed panel practice is established when patients eligible for dental services in a public or private program can receive these services only at specified facilities by a limited number of dentists. When the services are provided in a group practice facility and are prepaid by some agency, the practice is more precisely termed "prepaid group practices."
>
> The Association has longstanding policy opposing closed panels in principle because of certain inherent restrictions, particularly on free choice of dentist and convenient location for receiving care.
>
> To protect patients' freedom to receive prepaid services from dentists of their choice, closed panel plans should be presented to consumers only as an alternative method of provision of dental benefits, along with a comparable plan which permits free choice of dentist. Under this dual choice system, the individual consumers should also have periodic options to change plans. There should be equal premium dollars available to both dental delivery systems in the dual choice framework. The closed panel option shall be financially capable to deliver the benefits called for in the contract.
>
> Existing closed panels and panels being formed should submit their programs to the constituent society for evaluation to determine whether the program is capable of delivering the scope of benefits called for by the contract and to determine that the program is in the best interest of the patients.
>
> Prepaid group practices or closed panels shall be under the direct supervision of a dentist or dentists legally licensed in the state, who shall conform to the *Principles of Ethics* of the American Dental Association and the local codes of ethics and shall maintain liaison with the constituent and component societies in the area.

and be it further

Resolved, that the following statement on closed panels be adopted:

> A closed panel practice is established when patients eligible for dental services in a public or private program can receive these services only at specified facilities by a limited number of dentists. When the services are provided in a group practice facility and are prepaid by some agency, the practice is more precisely termed "prepaid group practice."
>
> The Association has longstanding policy questioning the efficacy of closed panels in principle because of certain inherent restrictions, particularly limitations on free choice of dentist and convenient location for receiving care.
>
> To protect patients' freedom to receive prepaid services from dentists of their choice,

closed panel plans should be presented to consumers as an alternative method of provision of dental benefits, along with a comparable plan which permits free choice of dentist. Under this dual choice system, the individual consumers should also have periodic options to change plans. There should be equal premium dollars available to both dental delivery systems in the dual choice framework. The closed panel option shall be financially capable to deliver the benefits called for in the contract.

An existing closed panel and a panel being formed should make sure that its program is capable of delivering the scope of benefits called for by the contract and that the program is in the best interest of the patients.

Prepaid group practices or closed panels shall be under the direct supervision of a dentist or dentists legally licensed in the state.

125. **Resolved**, that Resolution 50-1972-H (*Trans.* 1972:664) and Resolution 33-1974-H (*Trans.* 1974:654), adopting "Guidelines on Use of Radiographs in Dental Care Programs," are hereby revoked, and be it further

Resolved, that the following "Guidelines on Use of Radiographs in Dental Care Programs" be adopted:

The Association approves the following guidelines on the use of radiographs in dental care programs:

1. The Association questions the need for any third-party's policy or attempts to require mandatory submission of radiographs in every case or on a blanket, automatic basis.

2. The use of radiographs should be only for determining the extent of liability of the program and in no case should infringe on the professional judgement of the dentist or on the dentist-patient relationship.

3. Radiographs taken by the dentist for his diagnosis are not the property of the patient but are part of the dentist's record.

4. Radiographs shall be mounted.

5. Radiographs are to be used only to obtain information which may clarify the benefits that the patient is entitled to under the terms of the contract.

6. Radiographs should be of such quality that they are properly diagnostic for clinical evaluation of the case involved.

7. Third-party agencies should not require postoperative radiographs unless a part of proper dental treatment or for peer review purposes.

8. Radiographs shall be examined only by dentists.

9. Radiographs shall be returned to the dentist within ten days.

10. No third-party agency should misuse records, either by making faulty judgements from such records or by making determinations which could not ordinarily be made without proper examination of the patient in question. Proper dental treatment is predicated on a diagnosis from many types of examination and not radiographs alone.

11. Radiographs furnished to a peer review committee or third party should not be transmitted to any other agency without written consent of the dentist.

REPORT OF COMMITTEE ON FINANCE AND INVESTMENTS

The Report of the Committee on Finance and Investments was read by Dr. Carter, chairman. The other members of the Committee were Drs. Boucek, Kerr, Shira, Shuler and Etherington, and Dr. Watson, Mr. Noone, Mr. Kleck, Mr. Wisniewski and Mr. Starkey, *ex officio*.

Review of Financial Operations for the Eight Month Period Ending August 31, 1976 and Financial Projections to December 31, 1976: The Committee reported as follows:

During the first eight months of 1976, the Association's income was $13,377,630 and its operating expenses and nonoperating disbursements were $9,604,729, resulting in an excess of $3,772,901. The excess of income over expenses and nonoperating disbursements was $281,302 more on August 31, 1976 than at August 31, 1975.

The projected income for all of 1976 is estimated to be $15,470,550, an increase of $109,600 over the approved 1976 income budget of $15,360,950. The projected expenses and nonoperating disbursements for 1976 are estimated to be $14,893,700 which is $116,300 less than the $15,010,000 approved in the 1976 budget. As a result, the anticipated excess of income over expenses and nonoperating disbursements for 1976 is predicted to be $576,850, an increase of $225,900. However, $291,547 of the predicted surplus of $576,850 was paid to the Internal Revenue Service on September 29, 1976, leaving a projected surplus balance of $285,303.

Review of Headquarters Building Operations for the Eight Months Ending August 31, 1976: The Committee reported as follows:

For the first eight months of 1976, the Headquarters Building produced income of $780,187. Expenses during this period were $1,236,416. However, if the 139,450 gross square feet were valued at $7.50 per gross square foot and then added to building income, building income would exceed expenses by $241,021.

The projected results of operations from the Headquarters Building for 1976 as compared to 1975 is summarized as follows:

	1976 Projected Results	1975 Actual	Increase Decrease*
Income from Operations	$1,161,400	$1,135,659	$25,741
Charge for ADA Space	1,045,875	1,038,750	7,125
	2,207,275	$2,174,409	$32,866
Operating Expense	1,759,100	1,707,223	51,877
Excess of Income Over Expense	$ 448,175	$ 467,186	$19,011*

Although expenditures are projected to be $51,877 greater in 1976 than in 1975, income is projected to be $32,866 greater for the same period, resulting in a net decrease in income of $19,011. Uncontrollable expenses such as very high increases in gas and electricity rates account for almost all of the $51,877 overexpenditure experienced in 1976.

Report of Treasurer—Current Status of Reserve Division of General Fund: The Committee reported as follows:

During the eight month period ended on August 31, 1976, the Reserve Division of the Association's General Fund realized interest earnings of $3,540 from sales of United States Treasury Bills, $26,783 from sales of prime commercial paper, $1,478 from a bank savings account, $29,396 on repurchase agreements and stock dividend earnings of $65,454. During this same period, the Reserve Division showed a capital gain on the sales of common stock in the amount of $18,063 and incurred portfolio investment and maintenance expenses of $17,282. In summary, the Reserve Division had a net realization of income on investments of $127,432. The estimated annual earnings for 1977 are projected to be $210,860.

The Committee noted that the securities held in the portfolio, exclusive of the $394,480 investment in the capital stock of DSPIC were shown, on August 31, 1976, as costing $4,883,862 and having a market value of $5,103,519. The Committee points out, however, the foregoing only reflects the cost of the current securities in the portfolio and does not

include prior capital gains and losses and interest and dividend income realized during Wright Investors' Service management of the portfolio for the period January 2, 1970-August 31, 1976. To measure Wright's investment performance, one must first consider the net amount that was turned over to Wright, namely $4,567,655 ($2,919,703 of which was deposited with Wright in 1975-6), and subtract that figure from the market value of the investments, namely $5,121,250 which figure excludes the Association's investment in DSPIC stock but includes cash on hand of $17,731. This approach reveals an investment return of $525,908 (after deduction of all expenses including bank charges and management fees).

Mr. Albert L. Meric, Jr., vice president of Wright Investors' Service, reported to the Committee on the outlook of the Association's portfolio and its probable success in achieving both increased value and income. The Committee was pleased to hear that Wright Investors' has projected that portfolio returns from equities over the next 12 months, 2 years and 5 years will be at a compound rate in excess of 20 percent. Of this, 13 percent will be the result of earnings growth and cash dividends with the balance coming from the upward adjustment of price earning multiples.

On September 30, 1976 the Association sold 868 shares of its investment in the capital stock of DSPIC to DSPIC for $52,080. As a result, the Association's investment in DSPIC securities was reduced to 5,706⅔ shares valued at $342,400.

Following discussion, the Board of Trustees adopted a motion directing the appropriate agency of the Association to study the performance of Wright Investors' Service, including the investment philosophy, and report to the March 1977 session of the Board of Trustees.

Resolution Authorizing Signatures on Checks: The Committee reported that as a consequence of the appointment of Dr. Jack F. Pfister as Treasurer for a one-year term commencing November 19, 1976, the list of authorized signatures on Association checks needs to be revised. The following resolution was adopted by the Board of Trustees:

135-1976-B. **Resolved,** that, effective November 19, 1976, all prior authorizations of signature to sign checks, drafts or orders for the payment of money drawn by the American Dental Association against its General Fund, Payroll, Relief Fund, Disaster Victims Emergency Loan Fund and the American Dental Association Health Foundation accounts maintained at Lake Shore National Bank, Chicago, Illinois, be and the same are hereby revoked, and be it further

Resolved, that, effective November 19, 1976, any two of the following persons be and they are hereby authorized to sign checks, drafts or orders for the payment of money drawn by the American Dental Association against its General Fund, Payroll, Relief Fund, Disaster Victims Emergency Loan Fund and the American Dental Association Health Foundation accounts maintained at Lake Shore National Bank, Chicago, Illinois:

C. Gordon Watson
Jack H. Pfister
Bernard J. Conway
John P. Noone
Leo Kleck

and be it further

Resolved, that effective November 19, 1976, all prior authorizations of facsimile signatures affixed to checks, drafts or orders for the payment of money drawn

by the American Dental Association against its General Fund, Payroll, Relief Fund, Disaster Victims Emergency Loan Fund and the American Dental Association Health Foundation accounts maintained at the Lake Shore National Bank, Chicago, Illinois, be and the same are hereby revoked, and be it further **Resolved**, that, effective November 19, 1976, the Lake Shore National Bank as a designated depository of the American Dental Association, be and it is hereby requested, authorized and directed to honor checks, drafts or other orders for the payment of money drawn by the American Dental Association against its General Fund, Payroll, Relief Fund, Disaster Victims Emergency Loan Fund and the American Dental Association Health Foundation accounts, including those drawn to the individual order of any person whose name appears thereon as a signer thereof, when bearing or purporting to bear the facsimile signatures of the following two persons:

C. Gordon Watson
Jack H. Pfister

and the Lake Shore National Bank shall be entitled to honor and charge the American Dental Association for all such checks, drafts or other orders, regardless of by whom or what means the facsimile signatures thereon may have been affixed thereto, if such facsimile signatures resemble the facsimile specimens duly certified to and filed with the Lake Shore National Bank by the Executive Director or other officer of the American Dental Association.

Status of 1976 Contingent Fund and Supplemental Appropriation Requests: The Committee reported as follows:

Contingent Fund: The Board of Trustees through its August 1976 session had appropriated $436,880 from a 1976 Contingent Fund of $445,000 (the Contingent Fund was initially $400,000 but was increased by $45,500 from unused sums recaptured from agency budgets), leaving a balance of $8,620. On October 13, 1976 two requests totaling $25,000 to assist in battling anti-fluoridation measures were submitted to the Board for vote by mail ballot. Both requests were approved, placing the Contingent Fund in deficit by $16,380. In addition, further requests for supplemental appropriations in the amount of $121,050 will be considered for funding at this session of the Board. Fortunately, several agencies recently forecast that they will not spend all the monies originally allocated to their budgets and, as a consequence, have volunteered to surrender a total of $158,200 for recapture in the Contingent Fund.

The following resolutions were adopted by the Board of Trustees:

136-1976-B. **Resolved**, that the following subtractions be made from the 1976 Budgets of the indicated Association agencies and then be added to the Contingent Fund:

Expense Section

General Committee on Local Arrangements		$ 500
Travel	$ 500	

Economic Research & Statistics, Bureau of		$ 1,000
Committee Meetings	$ 1,000	
Library Services, Bureau of		$ 9,500
Consultants	$ 550	
Printing	200	
Salaries	8,750	
Accounting		$ 2,000
Salaries	$ 2,000	
Duplicating		$ 9,000
Operating Supplies	$ 3,950	
Salaries	5,050	
Central Administrative		$ 5,300
Pensions and Annuities	$ 5,300	
Dental Education, Council on		$ 2,450
Committee Meetings	$ 2,450	
Dental Education, Council on: Division of Educational Measurements		$ 10,700
Postage & Mailing	$ 4,000	
Printing	4,400	
Testing Supplies	2,300	
Dental Laboratory Relations, Council on		$ 2,000
Conferences	$ 1,200	
Postage & Mailing	550	
Salaries	250	
Education & Hospitals, Assistant Executive Director		$ 6,000
Salaries	$ 6,000	
Hospital Dental Service, Council on		$ 1,000
Hospital Dental Services	$ 1,000	
International Relations, Council on		$ 1,350
Printing	$ 1,150	
Travel	200	
Journalism, Council on		$ 1,500
Conferences	$ 200	
Council Meetings	700	
Salaries, Overtime	100	
Travel	500	
Judicial Procedures, Constitution and Bylaws, Council on		$ 4,400
Conferences	$ 2,400	
Postage & Mailing	2,000	
Legislation, Council on		$ 1,150
Council Meetings	$ 1,150	
National Board of Dental Examiners, Council of		$ 5,400
Salaries	$ 5,400	
Scientific Session, Council on		$ 4,500
Salaries	$ 1,500	
Special Projects	3,000	
Board of Trustees		$35,000
Special Projects	$35,000	
Headquarters Building		$ 20,000
Real Estate Taxes	$20,000	

Editorial Office		$ 2,000
Salaries	$ 2,000	
Journal of Dental Research		$ 2,000
Sales Promotion	$ 2,000	
Journal of Endodontics		$ 1,000
Special Services	$ 1,000	
Treasurer		$ 450
Travel	$ 450	
Washington Office		$ 30,000
Dues, Books & Subscriptions	$ 250	
Postage & Mailing	500	
Printing	250	
Rent	1,250	
Salaries	16,500	
Special Services	300	
Supplies & Stationery	1,250	
Telephone & Telegraph	4,500	
Travel	200	
Travel, Unscheduled	5,000	
Total		$158,200

137-1976-B. Resolved, that the following appropriations be made from the Contingent Fund and allocated to the line items in the budgets in accordance with the terms of the supplemental appropriation requests:

Expense Section

Annual Session		$ 900
Committee Meetings	$ 900	
Dental Society Services, Bureau of, Continuing Education Registry		$ 3,300
Postage and Mailing	$ 1,500	
Supplies and Stationery	1,000	
Telephone and Telegraph	800	
Personnel		$ 1,750
Personnel Procurement	$ 1,750	
Purchasing		$ 1,450
Printing	$ 1,450	
Sales and Advertising		$ 2,400
Exhibit Expense	$ 2,400	
Executive Director		$ 5,000
Salaries	$ 5,000	
President		$ 5,000
Salaries	$ 5,000	
President-Elect		$ 7,000
Salaries	$ 4,000	
Travel	3,000	

Dental Abstracts		$ 2,050
Postage and Mailing	$ 1,050	
Printing	1,000	
Editorial Office — *ADA News*		$ 10,550
Postage and Mailing	$ 5,450	
Printing	4,850	
Supplies and Stationery	250	
Journal of the American Dental Association		$ 31,250
Postage and Mailing	$ 8,400	
Printing	22,850	
Journal of Oral Surgery		$ 7,400
Postage and Mailing	$ 400	
Printing	7,000	
Oral Research Abstracts and *Advances (Update)* series		$ 19,200
Printing	$16,000	
Sales Promotion	3,200	
Total		$ 97,250

Reimbursement to Trustees for Travel Within Their District to Other Than Annual Meeting of Constituent Societies: The Committee reported as follows:

> The Committee took note of the study conducted by the Comptroller which indicates that of the $14,000 budgeted for this expenditure in 1976, $7,492.88 has been spent as of October 20, 1976, with a remaining balance of $6,507.12. Of special significance is the fact that travel costs incurred by trustees and not reimbursed by the Association amounts to $7,395 and the estimated costs of meetings not attended because of budget restrictions is $3,480. The Committee is concerned that in some instances inequities may exist where trustees are paying out-of-pocket for travel expenses while on Association business. Therefore, the Committee recommends that this matter be referred to a committee of the Board for study with recommendations and amendment of the *Organization and Rules of the Board of Trustees* should such inequities be proved to exist.

It was suggested that the Committee on Finance and Investments restudy the travel of trustees and report back to the Board of Trustees as soon as possible.

Amendments to 1977 Annual Budget of Income, Expense (Excluding Depreciation) and Nonoperating Disbursements: The Committee reported as follows:

> After the proposed 1977 Budget was submitted by the Board of Trustees, the Association's Editor was advised that the American Association of Dental Research, a division of the International Association of Dental Research, was terminating the agreement appointing and engaging the ADA as the publisher of the *Journal of Dental Research,* effective January 1, 1977. As a consequence of this termination, modifications need to be made in the proposed 1977 Budget. As a result, the Committee recommends that the Revised 1977 Budget—Summary in Table VI be included in a Board of Trustees' report and transmitted to the House of Delegates.

The Board of Trustees adopted the following resolution:

> 138-1976-B. Resolved, that the proposed 1977 Budget be revised by reducing Income to $16,364,750, Total Expenses and Nonoperating Disbursements to $16,348,000, and Excess of Income Over Expenses and Nonoperating Disburse-

ments to $16,750, and be it further

Resolved, that the foregoing changes in the proposed 1977 Budget be transmitted to the House of Delegates.

Request by Alaska Dental Society to Keep $15,000 Grant Available for Balance of 1976 and in 1977: The Committee reported as follows:

In early spring 1976, the Board of Trustees by mail ballot approved a grant of $15,000 to the Alaska Dental Society to assist it "in resolving legislative and other difficulties confronting the society." The Alaska Dental Society, as it was requested to do, spent its own monies first and was successful, without calling on any of the $15,000 grant monies, in defeating proposed legislation which would have made it mandatory for Alaska's board of dental examiners to issue a one year temporary permit, without examination, to an applicant who "desires to practice dentistry in the state for an Alaska nonprofit corporation. . . ." As indicated by Dr. William Marlay, president of the Alaska Dental Society, the battle will be renewed in 1977. As a result, the Alaska Dental Society is requesting the Association to renew its commitment for 1977.

The Committee was advised by the President-elect, Dr. Shuler, that he had given the Alaska Dental Society specific recommendations regarding submission of a detailed budget which would satisfy one of the criteria for grant assistance to constituent societies. As of this date, the Committee noted that no such budget has been submitted. As a result, the Committee is unable to accurately determine to what extent this grant is necessary. Therefore, the Committee refers the following resolution to the Board of Trustees without recommendation.

The following resolution was adopted by the Board of Trustees:

139-1976-B. Resolved, that the $15,000 appropriated from the 1976 Contingent Fund to assist the Alaska Dental Society in resolving legislative and other difficulties confronting the Society continue to be made available to the Society for the balance of 1976 and also in 1977, contingent upon the submission of a budget.

Request by Illinois State Dental Society for Advertising of Constituent Society Annual Sessions at Cost in "The Journal of the American Dental Association": The Committee reported as follows:

The Committee carefully considered the resolution submitted by the Illinois Dental Society which would authorize the Editor of *The Journal of the American Dental Association* to offer constituent societies, on a once-a-year basis, the purchase of advertising space at cost for the purpose of advertising the constituent society's annual session. The Committee notes that the Association's cost for printing such an advertisement is approximately one-third of the rate charged. The Committee concurs with the intent of the resolution submitted by the Illinois State Dental Society; however, it is of the opinion that such authorization is the responsibility of the Executive Director of the Association. Therefore, the Committee recommends that the Illinois State Dental Society resolution be amended by substituting the following resolution which complies with the intent of the Illinois State Dental Society resolution.

The following resolution was adopted by the Board of Trustees:

140-1976-B. Resolved, that the Executive Director of the Association be authorized to offer to the constituent societies, on a once-a-year basis, the purchase of advertising space in *The Journal of the American Dental Association,* at cost, for the purpose of advertising the constituent society's annual session.

The Board also adopted a motion requesting appropriate Association staff to study the possibility of offering the same advertising opportunity to allied organizations and report back to the March 1977 session of the Board of Trustees.

Request for Short-Term Loan to American Dental Association Disaster Victims Emergency Loan Fund: The Committee reported as follows:

> After making four $10,000 loans to Idaho dentists who sustained heavy losses as a result of the 1976 Teton Dam flooding, the Council on Relief found that it could not make similar loans to two other Idaho dentists who also sustained heavy damages from the same flood simply because the Association's Disaster Victims Emergency Loan Fund has a current balance of only $3,353.
>
> The Association could make a loan of $20,000 to the Disaster Victims Emergency Loan Fund to permit the Council on Relief, in turn, to issue two $10,000 loans to the two needy Idaho dentists who sustained considerable losses from the Teton Dam flooding. The loan from the Association could be made from available monies in the Operating Division of the General Fund with the understanding that the loan would be repaid on or before March 1, 1977 from monies realized from the Council on Relief's campaign for contributions to the Disaster Fund.

The Board of Trustees adopted the following resolution:

> 141-1976-B. Resolved, that a $20,000 loan be made to the American Dental Association Disaster Victims Emergency Loan Fund from available monies in the Operating Division of the General Fund, with the stipulation that such non-interest bearing loan be repaid on or before March 1, 1977.

Request by New Jersey Dental Association for a Conference on Constituent Society Executives, Presidents and Legal Counsels: The Committee reported as follows:

> The Committee carefully reviewed the resolution submitted by the New Jersey Dental Association requesting that the Association plan a conference for constituent society executives, presidents and legal counsels, specifically designed to address the many legal and legislative issues currently facing the profession. The Committee concurs that such a conference would be extremely valuable, especially in light of the current legal climate affecting associations.
>
> Since the early scheduling of a conference such as suggested by the New Jersey Dental Association could present not only a budgetary problem for the American Dental Association but also constituent societies, the suggestion is made that such a conference could be scheduled by adding a day to the Annual Management Conference that is held in June, limiting the attendance to the executives and legal counsels of the constituent societies. The additional costs should be borne by the constituent societies.

The following resolution was adopted by the Board of Trustees:

> 142-1976-B. Resolved, that the Annual Management Conference scheduled for June 1977 be extended by one day for the purpose of addressing the many legal and legislative issues facing the dental profession, and be it further
> Resolved, that the executives and legal counsels of the constituent societies be invited to attend the added one-day session at the expense of the constituent societies.

Recent Tax Increases: The Committee reported as follows:

After the August 1976 session of the Board of Trustees, the ceiling on earnings subject to Social Security tax was increased effective January 1, 1977 from $15,300 to $16,500, thus boosting the maximum Social Security tax which the Association must pay for employees earning $16,500 or more from $895.05 to $965.25.

In addition, President Ford, on October 21, 1976, signed a bill into law that will increase the federal unemployment tax on employers from the current rate of $21 per employee to $29.40 in 1977 and $42 in 1978. This makes a 40 percent increase in such tax for 1977 and a further increase in 1978 of 100 percent over the 1976 figure.

A supplemental appropriation request to cover the increased Social Security and federal unemployment taxes will need to be presented for consideration at either the January or March 1977 session of the Board of Trustees.

Active Member Dues of Faculty Members: The Committee reported as follows:

On October 11, 1976, Dr. Charles Perlman, Chairman of Medicine/Roentgenology, Dental Branch, Health Science Center at Houston, University of Texas, wrote to President Robert B. Shira requesting that consideration be given to charging dental school faculty members who do not have a private practice a lesser rate of dues for active membership. Dr. Perlman cites the fact that currently faculty members must pay ever-increasing component and constituent society dues, unlike the federal dental service member, as well as full ADA dues. Dr. Perlman is particularly concerned over the prospect of a sizeable increase in ADA dues, commencing in 1978. He believes that the burden of three tier membership dues ". . . can cause a possible hardship on the category of full-time faculty without practice, and the ADA might lose interested members."

The Committee, while recognizing that paying "three tier membership dues" may on occasion cause a hardship, is not sympathetic to Dr. Perlman's request. The Committee is of the opinion that dental educators reap the benefits of Association activities and should be called upon to participate on the same basis as all other active members in the Association's expenses.

If a decision is made that full-time dental school faculty members who do not engage in private practice should be charged a lesser rate of dues than other active members, such decision will need to be translated into an amendment of the *Bylaws* and introduced into the House for consideration the following year since it would effect the dues of some active members.

The Board of Trustees directed that a letter be transmitted to Dr. Perlman indicating the Board's unfavorable consideration of the request.

Reconsideration of Grant to Women's Auxiliary to the American Dental Association: The Committee reported as follows:

The Committee carefully reviewed the resolution submitted by the Executive Council of the Illinois State Dental Society urging the Board of Trustees to reconsider their action amending the 1977 Budget to include a grant of $7,000 to the Women's Auxiliary to the American Dental Association. The Committee points out that this grant was made for one year only with the advice to the Women's Auxiliary that further grant requests will have to be considered separately and that the Women's Auxiliary be encouraged to raise its dues in an effort to become self-supporting. This grant request was thoroughly discussed by the Board of Trustees prior to approval in August 1976. No new information has been presented to the Committee which would suggest that the Board should reconsider its decision. The Committee, therefore, recommends that the resolution submitted by the Executive Council of the Illinois State Dental Society be rejected. The Committee further recommends that the Executive Director provide the Illinois State Dental Society with all the relevant details of this grant to the Women's Auxiliary to the American Dental Association.

The Board of Trustees concurred with the recommendations of the Committee.

Grant Request to Support Fluoridation for Greater Boston: The Committee reported as follows:

> On November 3, 1976, Dr. James Dunning, chairman of the Fluoridation Committee of the Massachusetts Dental Society, requested by telegram that the Board of Trustees, through the Committee on Finance and Investments, make a grant of $15,000 to the Massachusetts Citizens Committee for Dental Health to assist its educational campaign for fluoridation of the waters of Greater Boston. Dr. Dunning states that the water works now under construction in Boston will serve a population of 2 million with fluoridated water in 33 communities "but faces accelerated opposition." He indicates that funds for the campaign are "desired on or before January 1, 1977."
>
> Dr. Dunning has been advised of the criteria adopted by the Board of Trustees for its guidance in awarding grants, and details which respond to the criteria will be furnished by the Massachusetts Dental Society as soon as possible.

Request from Illinois State Dental Society for Reconsideration of Decision Not to Fund the Dental Editors' Seminar: The Committee reported as follows:

> At the request of Trustee I. Lawrence Kerr, chairman of Committee A of the Board of Trustees and a member of the Committee on Finance and Investments, the Committee reviewed the resolution and background statement submitted by the Illinois State Dental Society asking the House of Delegates to urge the Board of Trustees to reconsider its decision not to fund the 14th Annual Dental Editors' Seminar in 1977.
>
> The Committee carefully considered this resolution and recognizes the value of the seminar. Nevertheless, the Committee noted that a considerable number of programs of the Association, as presented by various councils and bureaus, had to be either delayed or cancelled as a result of the financial constraints placed upon the Association. Therefore, the Committee advises that it stands by its original recommendation that the Dental Editors' Seminar not be funded in 1977 but instead considered for funding in 1978.

The Board of Trustees concurred with the recommendation of the Committee.

SPECIAL ORDER OF BUSINESS

Appearance of Dr. Jan Erik Ahlberg, Executive Director, Fédération Dentaire Internationale: Dr. Jan Erik Ahlberg, executive director of the Fédération Dentaire Internationale, appeared before the Board of Trustees as a special order of business.

NEW BUSINESS

Amendment to Relief Fund "Rules": The following resolution was adopted by the Board of Trustees:

> 143-1976-B. Resolved, that the Board of Trustees approves amendment by substitution of Chapter III, Paragraph B of the Relief Fund *Rules* to read as follows:
>
> > B. Distribution of Contributions. Three-quarters (¾) of the relief fund sum collected from members of a constituent society in the annual relief fund-disaster fund cam-

paign will be returned to the relief fund of such constituent society; provided, however, that after July 1965, such refunds may be made only to constituent society relief funds that have been established as charitable organizations having purposes consistent with the purpose of the American Dental Association Relief Fund and that have been accorded tax-exempt status under the Internal Revenue Code.

For the current fiscal year ending June 30, a constituent society will be paid a bonus of one-quarter (¼) of the total amount contributed to the relief fund by members of a constituent society in the annual relief fund-disaster fund campaign, provided that the constituent society (1) attains the annual relief fund quota assigned to it for the year by the Council on Relief, and (2) pays out in grants during the year, shared on an equal basis with the American Dental Association Relief Fund, a sum greater than three-fourths of the society's assigned relief fund annual quota.

Consideration of Annual Session Site for 1982: The following resolution was adopted by the Board of Trustees:

144-1976-B. Resolved, that the Bureau of Convention Services be instructed to secure necessary contracts covering the 1982 annual session from Las Vegas, Los Angeles and, if possible, San Francisco for consideration at the Spring 1977 session of the Board of Trustees, and be it further

Resolved, that if the necessary contracts are received covering the convention hall and hotels from the Atlanta Convention Bureau, the site for the 1984 annual session would be Atlanta.

Report of Commission on Accreditation Meeting with NADL: The Board of Trustees reviewed the recent background material regarding NADL negotiations with the Commission on Accreditation concerning potential participation in the Commission's accreditation activities. The Board also reviewed the proposal letter forwarded by the Commission on Accreditation to the NADL which outlined the items of agreement. The Board discussed the NADL position statement regarding this matter as well as the Commission's advisory opinion and concluded that the Commission's approach was realistic and in keeping with the criteria for recognition as an accrediting agency as established by both the Council on Postsecondary Accreditation and the U.S. Office of Education. The Board of Trustees was informed that this matter is still under consideration by the Executive Committee of the NADL and would be decided in February and reported to the March 1977 session of the Board of Trustees.

Request of Council on Hospital Dental Service for Appointment of American Hospital Association Consultant: The following resolution was adopted by the Board of Trustees:

145-1976-B. Resolved, that Mr. William Kreyces, a member of the American Hospital Association Council on Professional Services, be appointed as a consultant to the Council on Hospital Dental Service for the term ending with the 1977 annual session.

Amendment of "Bylaws" Regarding Time of Caucus for Selecting Trustees: The following resolution was adopted by the Board of Trustees:

146-1976-B. Resolved, that Chapter VI, Section 40, first paragraph of the *Bylaws* be amended (1) to strike the opening phrase after the title "Nomination,"

namely: "At each annual session of the House of Delegates," and (2) to capitalize the next word after the stricken phrase, namely: "The," so that the revised first paragraph of Chapter VI, Section 40 will read as follows:

> Section 40. Nomination: The delegates from the constituent societies of the trustee district in which the term of the trustee is to terminate shall hold a caucus to select a nominee or nominees for the office of trustee. Such caucus shall be called by the trustee whose term is about to expire, or by his designee. The notice of time and place of such caucus shall be reported to the Secretary of the House.

and be it further

Resolved, that Chapter VI, Section 40, second paragraph of the *Bylaws* be amended by the addition of the phrase, "An action taken at a duly constituted caucus of the trustee district to nominate or select a trustee may be reconsidered at a later caucus during the appropriate annual session." so that the revised second paragraph of Chapter VI, Section 40 will read as follows:

> At the caucus the delegates shall nominate one (1) or two (2) candidates for the office of trustee, whose name or names shall be presented to the House of Delegates in accordance with the following rules. An action taken at a duly constituted caucus of the trustee district to nominate or select a trustee may be reconsidered at a later caucus during the appropriate annual session.

Substitute for Resolution 66: The Board of Trustees reviewed Resolution 66 of the House Standing Committee on Rules and Order and ordered that the following substitute resolution be transmitted to the Standing Committee on Rules and Order for its consideration:

66B. Resolved, that the *Manual of the House of Delegates* be amended by substituting the word "Sunday" for the word "Wednesday" in the first paragraph in the section entitled "Nomination Procedures" under the section "Rules of the House of Delegates" and by striking the second paragraph of that section and substituting therefor the following words and phrases as the second paragraph: "The nomination of members of the Board of Trustees will be the first order of business on Wednesday. The details of the nomination procedures are set forth in Chapter VI, Section 40 of the *Bylaws*" and by striking the third paragraph of that section and substituting the following words and phrases therefor, "The nominations for members to councils by the Board of Trustees shall be made at the Sunday afternoon meeting. The nomination of council members is governed by the provisions of Chapter IX, Section 20 of the *Bylaws*" and by adding the following paragraph to that section, "Additional nominations for officers, trustees and council members may be made at the Wednesday morning meeting" to make that section now read as follows:

> **Nomination Procedures:** Nominations of President-elect, two Vice Presidents and the Speaker of the House of Delegates are made at the Sunday afternoon meeting. Nominating speeches for these officers shall not exceed four minutes in length. Seconding speeches are not permitted except that two (2) members of the House of Delegates will be permitted to indicate their second from the floor.
>
> The nomination of members of the Board of Trustees will be the first order of business on Wednesday. The details of the nomination procedure are set forth in Chapter VI, Section 40 of the *Bylaws*.

The nominations for membership to councils by the Board of Trustees shall be made at the Sunday afternoon meeting. The nomination of council members is governed by the provisions of Chapter IX, Section 20 of the *Bylaws*.

Additional nominations for officers, trustees and council members may be made at the Wednesday morning meeting.

Tribute to Dr. Floyd A. Peyton: The following resolution was adopted by the Board of Trustees:

147-1976-B. Resolved, that the officers and trustees of the American Dental Association salute Dr. Floyd A. Peyton for his long and distinguished services to the health of the public and for his meritorious contribution to the profession during almost 40 years of materials research, and be it further

Resolved, that an appropriate certificate be authorized commending Dr. Peyton for his outstanding services to the dental profession.

Recess: The Board of Trustees recessed at 6:20 PM.

EXECUTIVE MEETING

FRIDAY, NOVEMBER 12, 1976

Call to Order: An Executive Meeting of the Board of Trustees was convened at 9:00 AM, Friday, November 12, 1976, President Robert B. Shira presiding.

Roll Call: Those present were the President, President-elect, First Vice-President, Second Vice-President, Speaker of the House of Delegates, Executive Director, Treasurer, all members of the Board of Trustees, the assistant to the Executive Director, the assistant executive director for scientific affairs, the associate house counsel and the official reporter.

Various Association matters were discussed.

Adjournment: The Executive Meeting adjourned at 10:15 AM.

Call to Order: The meeting of the Board of Trustees was called to order at 10:20 AM by President Shira.

Roll Call: The officers, members of the Board of Trustees and members of staff were present as previously recorded.

SPECIAL ORDER OF BUSINESS

Presentations to Retiring Officers and Trustees: Gifts were presented to the retiring officers, members of the Board of Trustees and their wives as a special order of business.

REPORTS OF BOARD OF TRUSTEES TO HOUSE OF DELEGATES

Report 4 of Board to House—Further Recommendations on Reports and Resolutions: Report 4 of the Board of Trustees to the House of Delegates was read by Dr. Pfister, chairman of the Committee on Reports of the Board of Trustees to the House of Delegates. The other members of the Committee were Drs. Cappuccio, Carter, Kerr, Phillips, Shira, Shuler, and Bowyer and Watson, *ex officio*. Various amendments were made during the reading of the report. Report 4 was approved, as amended, and ordered transmitted to the House of Delegates.

Report 5 of Board to House—Illegal Dentistry: Report 5 of the Board of Trustees to the House of Delegates was read by Dr. Pfister and amended by the Board of Trustees. Report 5 was approved, as amended, and ordered transmitted to the House of Delegates.

Report 6 of Board to House—Consumer Directories of Practicing Dentists: Report 6 of the Board of Trustees to the House of Delegates was approved and ordered transmitted to the House of Delegates.

Report 7 of Board to House—Report of Committee on Advance Planning: Report 7 of the Board of Trustees to the House of Delegates was approved and ordered transmitted to the House of Delegates.

Report 8 of Board to House—The Public Education Program: Report 8 of the Board of Trustees to the House of Delegates was approved and ordered transmitted to the House of Delegates.

Report 9 of Board to House—Recommended Revocation of Certain Existing Policies Respecting Third Party Dental Prepayment Programs and Related Matters: Report 9 of the Board of Trustees to the House of Delegates was approved and ordered transmitted to the House of Delegates.

Adjournment: The session of the Board of Trustees adjourned at 11:30 AM.

LAS VEGAS HILTON HOTEL, LAS VEGAS
NOVEMBER 18, 1976

Call to Order: The first session of the new Board of Trustees was called to order by President Shuler in the Las Vegas Hilton Hotel, Las Vegas, Nevada, at 4:00 PM, Thursday, November 18, 1976.

Roll Call: The following officers were present: Frank F. Shuler, president; Frank P. Bowyer, president-elect; Ralph R. Lopez, first vice-president; James E. Rubin, second vice-president; Burton H. Press, speaker of the House of Delegates; C. Gordon Watson, executive director; Jack H. Pfister, treasurer; Herbert C. Butts, editor.

The following members of the Board of Trustees were present: Donald E. Bentley, George P. Boucek, Weston D. Brown, Joseph P. Cappuccio, Kenneth M. Clemens, Floyd E. Dewhirst, Robert B. Dixon, John M. Faust, Coleman Gertler, Robert H. Griffiths, Joseph H. Hagan, John J. Houlihan, I. Lawrence Kerr and Eugene A. Savoie.

Staff members present were: Eric M. Bishop, assistant executive director, dental health; Hal M. Christensen, assistant executive director, Washington Office; John M. Coady, assistant executive director, education and hospitals; Bernard J. Conway, assistant executive director, legislation and legal affairs; Peter C. Goulding, assistant executive director, communications; John P. Noone, assistant executive director, business affairs and house counsel; Richard W. Tiecke, assistant executive director, scientific affairs; Walter E. Wisniewski, associate house counsel; Leo Kleck, comptroller; Howard I. Wells, assistant to the Executive Director; Susan W. Brock, administrative assistant; Terri B. Rapp, administrative assistant.

Also present were the retiring officers and trustees.

Introduction of New Officers and Trustees: The retiring officers and trustees introduced their successors and brief comments were made by each. In accordance with the *Rules of the Board of Trustees,* the retiring officers and trustees were invited to attend the remainder of the session.

REPORT OF COMMITTEE ON RULES AND ORDER

The Report of the Committee on Rules and Order was read by the Executive Director. The other members of the Committee were Drs. Shuler, chairman, Dixon, Griffiths and Houlihan, and Dr. Bowyer, observer.

Approval of Agenda: A resolution was adopted approving the agenda submitted by the Committee on Rules and Order as the official order of business for the current session of the Board of Trustees.

Nomination of Chairman and Member of Committee on Finance and Investments: The Committee nominated Dr. George P. Boucek as Chairman of the Committee on Finance and Investments and Dr. John J. Houlihan for the term ending in 1979, the personnel of the Committee to be constituted as follows:

Boucek, George P., 1977, trustee, chairman
Kerr, I. Lawrence, 1978, trustee
Houlihan, John J., 1979, trustee
Shuler, Frank F., president
Bowyer, Frank P., president-elect
Pfister, Jack H., treasurer
Watson, C. Gordon, executive director, *ex officio*
Noone, John P., assistant executive director (business affairs-house counsel), *ex officio*
Kleck, Leo S., comptroller, *ex officio*
Wisniewski, Walter E., associate house counsel, *ex officio*
Starkey, Warren L., accounting manager, *ex officio*

A resolution was adopted approving the nominations to the Committee on Finance and Investments as submitted.

Nominations to Reference Committee of Board of Trustees: The Committee presented a resolution to suspend the *Rules of the Board of Trustees* to allow the newly elected First Vice-President to serve on Board Reference Committee C and the newly elected Second Vice-President to serve on Board Reference Committee B until the 1977 annual session and the resolution was adopted.

The Committee presented the following nominations to the reference committees of the Board of Trustees:

Committee A
Cappuccio, Joseph P., chairman
Bentley, Donald E.
Griffiths, Robert H.
Savoie, Eugene A.

Committee B
Dewhirst, Floyd E., chairman
Dixon, Robert B.
Hagan, Joseph H.
Rubin, James E.

Committee C
Faust, John M., chairman
Brown, Weston D.
Houlihan, John J.
Lopez, Ralph R.

Committee D
Kerr, I. Lawrence, chairman
Boucek, George P.
Clemens, Kenneth M.
Gertler, Coleman

A resolution was adopted approving the nominations to the reference committees of the Board of Trustees as submitted.

Appointment of Committee on Reports to House of Delegates: In accordance with the *Rules of the Board of Trustees*, the Committee on Rules and Order announced that the personnel of the Committee on Reports of the Board of Trustees to the House of Delegates for the next year would consist of the following, and nominated Dr. John M. Faust as chairman:

Faust, John M., chairman of Committee C, chairman
Cappuccio, Joseph P., chairman of Committee A
Dewhirst, Floyd E., chairman of Committee B
Kerr, I. Lawrence, chairman of Committee D
Boucek, George P., chairman of Committee on Finance and Investments
Shuler, Frank F., president
Bowyer, Frank P., president-elect
Press, Burton H., speaker, House of Delegates, *ex officio*
Watson, C. Gordon, executive director, *ex officio*

A resolution was adopted approving the nomination of the Chairman of the Committee on Reports to the House of Delegates as submitted.

Appointment of Member to Committee on Salary and Tenure: In accordance with the *Rules of the Board of Trustees*, the Committee reported that it nominated Dr. Eugene A. Savoie to the Committee on Salary and Tenure for the term ending in 1978, the personnel of the Committee to be as follows:

Shuler, Frank F., president, chairman
Bowyer, Frank P., president-elect
Boucek, George P., chairman of Committee on Finance and Investments
Dewhirst, Floyd E., 1977, trustee
Savoie, Eugene A., 1978, trustee

A resolution was adopted approving the nomination to the Committee on Salary and Tenure as submitted.

Committee on Council Review: The Committee announced that, under the *Rules of the Board of Trustees,* the personnel of the Committee on Council Review would be as follows:

Bowyer, Frank P., president-elect, chairman
Shuler, Frank F., president
Cappuccio, Joseph P., chairman of Committee A
Dewhirst, Floyd E., chairman of Committee B
Faust, John M., chairman of Committee C
Kerr, I. Lawrence, chairman of Committee D
Watson, C. Gordon, executive director, *ex officio*

Appointment of Delegate to Annual Session of Fédération Dentaire Internationale: In accordance with the *Rules of the Board of Trustees,* the Committee announced that the delegates to the 1977 annual session of the Fédération Dentaire Internationale would be as follows, and nominated Dr. Frank F. Shuler to serve as a delegate for the term expiring in 1979:

Dewhirst, Floyd E., 1977
Houlihan, John J., 1978
Shuler, Frank F., 1979

A resolution was adopted approving the nomination to the delegation to the 1977 annual session of the Fédération Dentaire Internationale.

Amendment to "Organization and Rules of the Board of Trustees"—Special Committee on Inter-Agency Affairs: The following resolution was adopted by the Board of Trustees:

148-1976-H. Resolved, that the *Organization and Rules of the Board of Trustees* be amended by the addition of the Committee on Inter-Agency Affairs under the section entitled "Standing, Reference and Special Committees," the addition to read as follows:

> Committee on Inter-Agency Affairs: shall consist of the President, President-elect, the chairmen of the four reference committees of the Board of Trustees, the chairman of the Committee on Finance and Investments, and the Executive Director. The President shall serve as chairman.
>
> Meetings: shall be subject to the call of the chairman or any three of its members.

Duties: to maintain liaison on matters of mutual interest with health related organizations.

According to the resolution adopted above, the members of the Committee on Inter-Agency Affairs will be as follows:

Shuler, Frank F., president, chairman
Bowyer, Frank P., president-elect
Watson, C. Gordon, executive director
Cappuccio, Joseph P., chairman of Committee A
Dewhirst, Floyd E., chairman of Committee B
Faust, John M., chairman of Committee C
Kerr, I. Lawrence, chairman of Committee D
Boucek, George P., chairman of Committee on Finance and Investments

Amendment to "Organization and Rules of the Board of Trustees"—Committee on Advance Planning: The following resolution was adopted by the Board of Trustees:

149-1976-B. Resolved, that the *Organization and Rules of the Board of Trustees* be amended to include the Speaker of the House of Delegates as an *ex officio* member of the Committee on Advance Planning.

The Committee, in accordance with the *Rules of the Board of Trustees*, nominated Dr. Weston D. Brown and Dr. I. Lawrence Kerr to the Committee on Advance Planning for terms ending in 1978, the personnel of the Committee to be as follows:

Bowyer, Frank P., president-elect, chairman
Shuler, Frank F., president
Boucek, George P., 1977
Faust, John M., 1977
Brown, Weston D., 1978
Kerr, I. Lawrence, 1978
Press, Burton H., speaker, House of Delegates, *ex officio*
Watson, C. Gordon, executive director, *ex officio*

A resolution was adopted approving the nominations to the Committee on Advance Planning as submitted.

Special Committee to HEW: The following resolution was adopted by the Board of Trustees:

150-1976-B. Resolved, that the Board of Trustees' Special Committee to HEW be composed of four trustees, each with a two-year term, and the Executive Director as an *ex officio* member.

The Committee on Rules and Order presented the following nominations to the Special Committee to HEW and a resolution was adopted approving the nominations as submitted:

Griffiths, Robert H., 1977, chairman
Cappuccio, Joseph P., 1977
Brown, Weston D., 1978
Dixon, Robert B., 1978
Watson, C. Gordon, executive director, *ex officio*

Appointments to PEP Advisory Committee: The Committee on Rules and Order presented the following nominations to the PEP Advisory Committee and a resolution was adopted approving the nominations as submitted:

Savoie, Eugene A., Arizona, chairman
Brown, Weston D., Washington
Carter, Charles D., Kentucky
Gertler, Coleman, Wisconsin
Klein, Sanford E., New York
Linder, John E., Georgia
Schiefer, William E., California

Appointments to Ad Hoc Committee for the Delivery of Quality Prosthetic Care for the Financially Disadvantaged: The following were nominated to serve on the Ad Hoc Committee for the Delivery of Quality Prosthetic Care for the Financially Disadvantaged by Dr. Robert H. Griffiths, chairman, with the concurrence of Dr. Robert B. Shira and Dr. Frank F. Shuler:

Griffiths, Robert H., Illinois, chairman
Colvin, Charles J., Georgia
Elliott, Robert W., Jr., Maryland
Gronlund, Hal E., Illinois
Huber, Arthur, Oregon
Lytle, Robert B., Washington, D.C.
Maberry, Robert T., Texas
Pollard, Henry, Maine
Shirley, Dale E., Arizona

President Shuler stated that an invitation to submit a nomination to the Ad Hoc Committee had been extended to the National Dental Association.

A resolution was adopted approving the nominations to the Ad Hoc Committee for the Delivery of Quality Prosthetic Care for the Financially Disadvantaged as submitted.

Amendment to "Organization and Rules of the Board of Trustees"—Mail Ballots: The following resolution was adopted by the Board of Trustees:

151-1976-B. Resolved, that the first paragraph under "Mail Ballots" in the *Rules of the Board of Trustees* be amended by the addition of the following sentence:

> Requests for financial assistance shall be considered by the Board of Trustees at its next regular or special session following receipt of such request instead of by mail ballot.

to make the section read as follows:

> Mail Ballots: Mail ballots shall be submitted to the members of the Board of Trustees in the form of a resolution, which shall be accompanied by evidence of the emergent need for action and by sufficient information to permit an intelligent vote. Requests for financial assistance shall be considered by the Board of Trustees at its next regular or special session following receipt of such request instead of by mail ballot. Mail votes may be initiated by the Executive Director or by any member of the Board of Trustees.

1977 Schedule of the Board of Trustees: The Committee noted that the Board of Trustees had selected the following dates for the 1977 sessions of the Board:

> Winter Session: January 6-8, 1977 with the Committee on Rules and Order, Committee on Finance and Investments and Committee on Inter-Agency Affairs meeting on January 5.
>
> Spring Session: March 23-26, 1977 with the Committee on Rules and Order, Committee on Finance and Investments and Committee on Inter-Agency Affairs meeting on March 22.
>
> Summer Session: August 14-20, 1977 with the Committee on Rules and Order and Committee on Inter-Agency Affairs meeting on August 13 and the Committee on Finance and Investments meeting on July 20-23.
>
> Annual Session: October 4-7, 1977 with the Committee on Rules and Order, Committee on Finance and Investments and Committee on Inter-Agency Affairs meeting on October 3.

A motion was adopted by the Board of Trustees requesting the Committee on Rules and Order to study the feasibility of advancing the dates of the Summer Session of the Board of Trustees and the dates of the summer meeting of the Committee on Finance and Investments by one week and report to the Board of Trustees at its session in January 1977.

REFERRALS FROM THE HOUSE OF DELEGATES

Conference to Review Aspects of Illegal Practice of Dentistry: The 1976 House of Delegates adopted a resolution (Resolution 151H) requesting "that a conference be sponsored by the ADA to review all aspects of the illegal practice of dentistry regarding the profession's concern for the protection of the public." A motion was adopted by the Board of Trustees to combine the conference with the legal enforcement workshop planned for early 1977.

Dental Editors' Seminar: The 1976 House of Delegates adopted the following resolution (Resolution 93H):

> Resolved, that the House of Delegates urges that the Board of Trustees recon-

sider its elimination of any allocation of monies in the 1977 budget to support the holding of the Council on Journalism's 14th annual Dental Editors Seminar and, while so doing, consider appropriating sufficient monies from the 1977 Contingent Fund to permit scheduling and conducting such a Seminar in 1977.

The Board of Trustees adopted a motion to reinstate the Dental Editors' Seminar in 1977 and requested the Committee on Finance and Investments to present cost estimates at the January 1977 session of the Board of Trustees.

Disciplinary Actions Involving Advertising: The 1976 House of Delegates referred the following resolution (Resolution 15RC) to the Board of Trustees with the request that the Board immediately alert all constituent and component societies to the need for unusual restraint in initiating disciplinary actions under Section 12 of the American Dental Association *Principles of Ethics* and corresponding sections of the ethical codes of constituent and component dental societies:

Resolved, that constituent and component societies apply for six months, subject to extension by the Board of Trustees, a moratorium to disciplinary actions against dentists for ethical violations involving advertising with the exception of advertising that is designed to solicit patients, and be it further
Resolved, that the same moratorium apply to disciplinary actions against direct members of this Association, and be it further
Resolved, that for the purpose of Resolution 15(a)RC the term "solicit" means the attempt to obtain patients by persuasion or influence and includes but is not limited to a statement or claim which:

1) contains a misrepresentation of fact;
2) is likely to mislead or deceive because in context it makes only a partial disclosure of relevant facts;
3) contains a patient's laudatory statements about a dentist;
4) is intended or is likely to create false or unjustified expectations of favorable results;
5) implies unusual competence, other than as permitted under "Announcement of Limitation of Practice";
6) relates to dental fees other than a standard consultation fee or a range of fees for specific types of procedures without fully disclosing all variables and other relevant factors;
7) is intended or is likely to imply or to guarantee atypical results;
8) is intended or is likely to appeal primarily to a lay person's fears or similar emotions;
9) contains other representations or implications that in reasonable probability will cause an ordinary, prudent person to misunderstand or be deceived.

The Board of Trustees adopted a motion to alert the presidents and executive secretaries of constituent societies and the presidents, secretaries and executive secretaries of component societies (where addresses were available) by certified mail with return receipt requested of the need for exercising extreme caution before initiating disci-

plinary proceedings against members who engage in a form of advertising currently not prohibited under a given state's dental practice act.

NEW BUSINESS

Appointment of Council Chairmen: The Committee on Council Review, composed of Dr. Shuler, chairman, Drs. Shira, Cappuccio, Kerr, Pfister, Phillips, and Dr. Watson, *ex officio*, reported that it met on November 12 and presented a list of recommendations for chairmen of the councils of the Association.

Dr. Clemens nominated Dr. David B. McClure, Indiana, to serve as chairman of the Council on Judicial Procedures, Constitution and Bylaws and the nomination was seconded by Dr. Dixon. The Committee on Council Review nominated Dr. Raymond J. LaFond, Nevada. After a written ballot, Dr. LaFond was declared elected.

The following were appointed as chairmen of the councils for terms ending with the 1977 annual session:

Dental Care Programs, Council on: Dr. Emil W. Lentchner, New York
Dental Education, Council on: Dr. Edward F. Furstman, California
Dental Health, Council on: Dr. Robert I. Kaplan, New Jersey
Dental Laboratory Relations, Council on: Dr. Daniel L. Flad, Pennsylvania
Dental Materials and Devices, Council on: Dr. Robert V. Vining, Nebraska
Dental Research, Council on: Dr. John L. Manning, Illinois
Dental Therapeutics, Council on: Dr. Sebastian G. Ciancio, New York
Federal Dental Services, Council on: Dr. Milton Siskin, Tennessee
Hospital Dental Service, Council on: Dr. Leon Eisenbud, New York
Insurance, Council on: Dr. Leon J. English, Wisconsin
International Relations, Council on: Dr. Jacob H. Oxman, New Jersey
Journalism, Council on: Dr. Franklin M. Kenward, Florida
Judicial Procedures, Constitution and Bylaws, Council on: Dr. Raymond J. LaFond, Nevada
Legislation, Council on: Dr. William E. Allen, California
National Board of Dental Examiners, Council of: Dr. Marvin E. Revzin, Missouri
Relief, Council on: Dr. Anthony A. Caputi, Rhode Island
Scientific Session, Council on: Dr. Leon E. Oursland, California

Appointment of Commission on Accreditation of Dental and Dental Auxiliary Educational Programs Appeal Board Chairman: The Board of Trustees adopted a resolution approving the appointment of Dr. Joseph R. Beard as chairman of the Commission on Accreditation of Dental and Dental Auxiliary Educational Programs Appeal Board for a one-year term ending with the 1977 annual session.

Appointment of ADA Representatives to Board of Directors of American Dental Political Action Committee (ADPAC): A resolution was adopted appointing the following members of the Board of Trustees to the Board of Directors of the American Dental Political Action Committee (ADPAC) for terms ending with the 1977 annual session:

Brown, Weston D.
Dixon, Robert B.
Houlihan, John J.
Kerr, I. Lawrence
Savoie, Eugene A.

Appointment of Chairman of American Dental Political Action Committee (ADPAC): The Board of Trustees appointed Dr. William M. Creason, Michigan, as chairman of the American Dental Political Action Committee (ADPAC) for a term ending with the 1977 annual session.

Appointment of National Treasurer for Fédération Dentaire Internationale (USA): The Board of Trustees adopted a resolution appointing Dr. L. M. Kennedy, Texas, as the National Treasurer for the United States of the Fédération Dentaire Internationale for a term ending with the 1977 annual session.

Appointment of ADA Member to AMA Council on Legislation: A resolution was adopted appointing Dr. Wilfred A. Springer, New York, a member of the ADA Council on Legislation, as the Association's representative on the American Medical Association Council on Legislation for the term ending with the 1977 annual session.

Appointment of ADA Member to AMA Commission on the Cost of Medical Care: The Board of Trustees adopted a resolution appointing Dr. Robert H. Griffiths, Illinois, as the Association's representative on the American Medical Association Commission on the Cost of Medical Care for a term ending with the 1977 annual session.

Appointment of ADA Member to Commission on Medical Liability: The Board of Trustees adopted a motion appointing Dr. Lyle O. Bishop, California, as the Association's representative to the Commission on Medical Liability.

Adjournment: The session of the Board of Trustees adjourned at 5:40 PM.

House Minutes

November 14-18, 1976

SUNDAY, NOVEMBER 14, 1976

Call to Order: The first meeting of the 117th annual session of the House of Delegates of the American Dental Association was called to order at 2:00 p.m., Sunday, November 14, 1976 in the Las Vegas Convention Center, Las Vegas, Nevada, by the Speaker of the House of Delegates, Dr. Frank P. Bowyer.

Invocation: The invocation was offered by Bishop Stanton E. Schmutz, Church of Jesus Christ of Latter Day Saints, Las Vegas.

Introduction of Officers: The Speaker introduced the officers of the American Dental Association who were seated on the platform.

Introduction of Distinguished Guests: The Speaker introduced Dr. Maynard K. Hine, president of the Fédération Dentaire Internationale, and Dr. Jan Erik Ahlberg, executive director of the Fédération Dentaire Internationale. Drs. Hine and Ahlberg briefly addressed the House of Delegates.

Introduction of Past Presidents: The Speaker introduced the past presidents of the Association who were seated in the House of Delegates.

Introduction of Chairman of American Dental Political Action Committee: The Speaker introduced Dr. William M. Creason, Michigan, chairman of the American Dental Political Action Committee (ADPAC). Dr. Creason briefly addressed the members of the House of Delegates.

Report of Standing Committee on Credentials: Dr. William H. McKenna, Massachusetts, chairman of the Standing Committee on Credentials, reported a quorum present. The other members of the Committee were Drs. Edward C. Austin, North Carolina; Henry C. Garabedian, California; Louis Kramer, New York; Joseph J. Murphy, Montana; Robert M. Unger, consultant, Illinois.

REPORT OF STANDING COMMITTEE ON RULES AND ORDER

The Report of the Standing Committee on Rules and Order was presented by Dr. W. L. Lockett, Tennessee, acting chairman. The other members of the Committee were Drs. Leon J. English, Wisconsin; O. R. Nutter, North Dakota; Mark A. Price, Louisiana. Dr. Leo Taft, New York, who was appointed by President Shira to serve as chairman of the Committee was unable to attend the annual session of the House of Delegates due to an illness in his family.

Approval of Minutes of 1975 Session of House of Delegates: (Standing Committee on Rules and Order Resolution 62) On motion by Dr. Lockett, and seconded, the following resolution was adopted by the House of Delegates:

> 62H-1976. Resolved, that the minutes of the 1975 session of the House of Delegates, as published in *Transactions, 1975*, pages 620-748, be approved.

Adoption of Agenda for Current Session: (Standing Committee on Rules and Order Resolution 63) On motion by Dr. Lockett, and seconded, the following resolution was adopted by the House of Delegates:

> 63H-1976. Resolved, that the agenda on pages 7-16 of the *Supplement to Annual Reports and Resolutions, 1976* be adopted as the official order of business for this session.

Amendments to "Manual of the House of Delegates": (Standing Committee on Rules and Order Resolutions 64, 65, 66 and 66S-1) On motion by Dr. Lockett, and seconded, the following resolution (Resolution 64) was adopted by the House of Delegates:

> 64H-1976. Resolved, that the *Manual of the House of Delegates* be amended by the addition of the following section under the section entitled "Resolutions on the Appropriation of Funds" under "Rules of the House of Delegates":
>
> > Resolutions on Creation of New Programs: Any resolutions submitted to the House of Delegates which call for creation of new programs, special committees or studies must be accompanied by estimates of the financial impact on the Association and the potential source of funds. The Association will assist in determining the cost estimates of such new programs.

On motion by Dr. Lockett, and seconded, the following resolution (Resolution 65) was adopted by the House of Delegates:

> 65H-1976. Resolved, that the following paragraph of the section on "Conduct of Hearings" of the *Manual of the House of Delegates* be amended by the addition of the sentences which are in italics:
>
> > All members of the American Dental Association have the right to attend reference committee hearings and participate in the discussion, whether or not they are members of the House of Delegates. Non-members of the Association may participate in the discussion at hearings only at the invitation of a majority of the reference committee. *Participants should be aware that members of news media may attend committee hearings.*

At the start of the reference committee hearing, each chairman shall read the foregoing paragraph and ask any non-members who are present to identify themselves. The committee can then make its decision on whether the non-members may participate. In general, non-members should be permitted to take part so long as they do not interfere with the orderly conduct of the hearings.

The following resolution (Resolution 66) was presented by the Committee for adoption by the House of Delegates:

66. Resolved, that the *Manual of the House of Delegates* be amended by substituting the word "Sunday" for the word "Wednesday" wherever it appears in the section entitled "Nomination Procedures" under the section "Rules of the House of Delegates" and by deleting the phrase ", the nominations of the Board of Trustees having been presented at the Sunday meeting." in the third paragraph in the section.

Prior to the meeting of the House of Delegates the Committee reconsidered Resolution 66. Dr. Lockett moved to substitute the following resolution (Resolution 66S-1) for Resolution 66, and the motion was seconded:

66H-1976. Resolved, that the *Manual of the House of Delegates* be amended by substituting the word "Sunday" for the word "Wednesday" in the first paragraph in the section entitled "Nomination Procedures" under the section "Rules of the House of Delegates" and by striking the second paragraph of that section and substituting therefor the following words and phrases as the second paragraph: "The nomination of members of the Board of Trustees will be the first order of business on Wednesday. The details of the nomination procedures are set forth in Chapter VI, Section 40 of the *Bylaws*" and by striking the third paragraph of that section and substituting the following words and phrases therefor, "The nominations for membership to councils by the Board of Trustees shall be made at the Sunday afternoon meeting. The nomination of council members is governed by the provisions of Chapter IX, Section 20 of the *Bylaws*" and by adding the following paragraph to that section, "Additional nominations for officers, trustees and council members may be made at the Wednesday morning meeting" to make that section now read as follows:

Nomination Procedures: Nominations of President-elect, two Vice Presidents and the Speaker of the House of Delegates are made at the Sunday afternoon meeting. Nominating speeches for these officers shall not exceed four minutes in length. Seconding speeches are not permitted except that two (2) members of the House of Delegates will be permitted to indicate their second from the floor.

The nomination of members of the Board of Trustees will be the first order of business on Wednesday. The details of the nomination procedure are set forth in Chapter VI, Section 40 of the *Bylaws*.

The nominations for membership to councils by the Board of Trustees shall be made at the Sunday afternoon meeting. The nomination of council members is governed by the provisions of Chapter IX, Section 20 of the *Bylaws*.

Additional nominations for officers, trustees and council members may be made at the Wednesday morning meeting.

On vote, the motion to substitute was adopted.

Dr. Lockett moved the adoption of the substitute resolution and the motion was seconded.

On vote, the substitute resolution (Resolution 66H-1976) was adopted.

Referral of Reports and Resolutions: (Standing Committee on Rules and Order Resolution 67) On motion by Dr. Lockett, and seconded, the following resolution was adopted by the House of Delegates:

> 67H-1976. Resolved, that the preliminary and supplemental lists of referrals submitted by the Speaker of the House of Delegates be approved.

Presentation of Reference Committee Reports: (Standing Committee on Rules and Order Resolution 68) On motion by Dr. Lockett, and seconded, the following resolution was adopted by the House of Delegates:

> 68H-1976. Resolved, that background material contained in the reports of reference committees not be read by the chairmen, unless the chairmen and members of the committee feel that it is necessary and important to do so.

Installation of Officers and Trustees in House of Delegates—Special Order of Business: (Standing Committee on Rules and Order Resolution 69) On motion by Dr. Lockett, and seconded, the following resolution was adopted by the House of Delegates:

> 69H-1976. Resolved, that a special order of business be established for 11:30 a.m., Thursday, November 18, in the House of Delegates for the installation of the newly elected officers and trustees.

REPORT OF PRESIDENT

President Shira addressed the members of the House of Delegates (see p. 11 of this volume) and was given a standing ovation. The Report was referred to the Reference Committee on President's Address and Miscellaneous Matters.

REPORTS OF BOARD OF TRUSTEES TO HOUSE OF DELEGATES

Report 1 of Board to House—Association Affairs and Resolutions: Dr. Jack H. Pfister, chairman of the Committee of the Board of Trustees on Reports to the House of Delegates, read Report 1 of the Board to the House. (For the complete text of Report 1, see p. 461 of this volume.) The other members of the Committee were Drs. Cappuccio, Carter, Kerr, Phillips, Shira and Shuler, and Bowyer and Watson, *ex officio*.

Election of Honorary Members: (Board of Trustees Resolution 70) On motion by Dr. Robert T. Maberry, Texas, and seconded by Dr. W. M. Kaldem, Arkansas, the following resolution presented by the Board of Trustees was adopted:

> 70H-1976. Resolved, that in accordance with Chapter I, Section 20D, of the *Bylaws*, the following be elected to honorary membership:

Dr. Donald E. G. D. Derrick
Mr. George A. Roose
Lieutenant General George E. Schafer, Surgeon General, USAF
Professor Marjorie L. Swartz
Dr. William B. Walsh

The certificates of honorary membership were presented by President Shira. Professor Marjorie L. Swartz and Dr. William B. Walsh were unable to be present to receive their certificates.

Introduction of Recipient of Distinguished Service Award: Dr. Pfister read the section of Board Report 1 entitled "Distinguished Service Award" in which the Board of Trustees announced that the recipient of the 1976 Award was Dr. Percy T. Phillips. The Speaker announced that the presentation of the Award was made at the Opening Ceremony. President Shira introduced Dr. Phillips.

Nominations to Councils: (Board of Trustees Resolution 71) Action on Resolution 71 was deferred until the time of the elections at the Wednesday meeting.

Dr. Pfister extended the Board of Trustees' appreciation to the council members who complete their terms with this annual session. Dr. Richard A. Shick, Michigan, stated that the name of Dr. James A. Catchings, Michigan, Council on Dental Health, had been omitted and asked that it be placed in the record.

Nominations to Commission on Accreditation of Dental and Dental Auxiliary Educational Programs and Commission Appeal Board: (Board of Trustees Resolutions 72 and 73) Action on Resolutions 72 and 73 was deferred until the time of elections at the Wednesday meeting.

Nominations to Commission on Licensure: (Board of Trustees Resolution 74) Action on Resolution 74 was deferred until such time as the House of Delegates acts on Board of Trustees Resolution 77 which was referred to the Reference Committee on Dental Licensure and Related Matters.

Report 2 of Board to House—Recommendations on Reports and Resolutions: Report 2 of the Board to the House, which commented on the reports of councils and the resolutions from the constituent societies, was not read, but was referred to the various reference committees for consideration. (For the complete text of Report 2, see p. 471 of this volume.) The Speaker announced that Resolution 41 of the Washington State Dental Association had been referred to the Reference Committee on Legislative Matters instead of the Reference Committee on Budget and Administrative Matters. The Speaker also announced that Texas Dental Association Resolution 53 had been withdrawn.

Report 3 of Board to House—Financial Affairs and Recommended Budget for Fiscal Year 1977: Report 3 of the Board to the House was referred to the Reference Committee on Budget and Administrative Matters. (For the complete text of Report 3, see p. 504 of this volume.)

Report 4 of Board to House—Further Recommendations on Reports and Resolutions: Report 4 of the Board to the House was not read, but the appropriate referrals were made to the various reference committees. (For the complete text of Report 4, see p. 513 of this volume.)

Report 5 of Board to House—Illegal Dentistry: Report 5 of the Board to the House was not read, but was referred to the Reference Committee on Legislative and Related Matters. (For the complete text of Report 5, see p. 535 of this volume.)

Report 6 of Board to House—Consumer Directories of Practicing Dentists: Report 6 of the Board to the House was not read, but was referred to the Reference Committee on President's Address and Miscellaneous Matters. (For the complete text of Report 6, see p. 544 of this volume.)

Report 7 of Board to House—Report of Committee on Advance Planning: Report 7 of the Board to the House was not read, but was referred to the Reference Committee on Budget and Administrative Matters. (For the complete text of Report 7, see p. 547 of this volume.)

Report 8 of Board to House—The Public Education Program: Report 8 of the Board to the House was not read, but was referred to the Reference Committee on President's Address and Miscellaneous Matters. (For the complete text of Report 8, see p. 594 of this volume.)

Report 9 of Board to House—Recommended Revocation of Certain Existing Policies Respecting Third Party Dental Prepayment Programs and Related Matters: Report 9 of the Board to the House was not read, but was referred to the Reference Committee on Dental Care Programs and Health. (For the complete text of Report 9, see p. 599 of this volume.)

The Speaker announced that Resolution 117 from Delegate Harry W. F. Dressel, Jr., Maryland, had been referred to the Reference Committee on Auxiliary Utilization instead of the Reference Committee on Dental Education and Related Matters.

ELECTION OF OFFICERS AND TRUSTEES

President-Elect: Dr. Frank P. Bowyer, Tennessee, was nominated for the office of President-elect by Dr. Charles D. Carter, Kentucky, trustee of the Sixth District. The nomination was moved by Dr. L. Willard Parker, Tennessee, and seconded by Dr. Duane M. Hunt, Nebraska, and Dr. Bernard S. Snyder, Ohio. Nominations were closed at the November 17 meeting of the House of Delegates and Dr. Bowyer was declared elected President-elect.

First Vice-President: Dr. Ralph R. Lopez, New Mexico, was nominated for the office of First Vice-President by Dr. David E. Simms, New Mexico. The nomination was seconded by Dr. Clarence D. Honig, California, and Dr. J. P. Chancey, Jr., Arkansas. Nominations were closed at the November 17 meeting of the House of Delegates and Dr. Lopez was declared elected First Vice-President.

Second Vice-President: Dr. James E. Rubin, Connecticut, was nominated for the office of Second Vice-President by Dr. Lawrence Scinto, Connecticut. The nomination was seconded by Dr. S. N. Bhaskar, Army, and Dr. Edward U. Austin, North Carolina. Nominations were closed at the November 17 meeting of the House of Delegates and Dr. Rubin was declared elected Second Vice-President.

Trustee of District 1: The Secretary of the House of Delegates announced that the caucus of the First District unanimously nominated Dr. John J. Houlihan, New Hampshire, for the office of Trustee and the Speaker declared Dr. Houlihan elected.

Trustee of District 6: The Secretary of the House of Delegates announced that the caucus of the Sixth District unanimously nominated Dr. Joseph H. Hagan, Missouri, for the office of Trustee and the Speaker declared Dr. Hagan elected.

Trustee of District 7: The Secretary of the House of Delegates announced that the caucus of the Seventh District nominated Dr. Kenneth M. Clemens, Ohio, for the office of Trustee and the Speaker declared Dr. Clemens elected.

Trustee of District 9: The Secretary of the House of Delegates announced that the caucus of the Ninth District unanimously nominated Dr. Coleman Gertler, Wisconsin, for the office of Trustee for one year to fulfill the unexpired term of Dr. Frank F. Shuler. The Speaker declared Dr. Gertler elected.

Trustee of District 10: The Secretary of the House of Delegates announced that the caucus of the Tenth District unanimously nominated Dr. Donald E. Bentley, Minnesota, for the office of Trustee and the Speaker declared Dr. Bentley elected.

Trustee of District 14: The Secretary of the House of Delegates announced that the caucus of the Fourteenth District unanimously nominated Dr. Eugene A. Savoie, Arizona, for the office of Trustee and the Speaker declared Dr. Savoie elected.

Speaker of the House of Delegates: Dr. Edward F. Leone, Wisconsin, was nominated for the office of Speaker of the House of Delegates by Dr. Norbert M. Sabin, Wisconsin. The nomination was seconded by Dr. G. William Wegmann, Florida, and Dr. Ernest H. Besch, Texas. Dr. Burton H. Press was nominated for the office of Speaker of the House of Delegates by Dr. Robert L. Taylor, California. The nomination was seconded by Dr. John L. Bomba, Pennsylvania, and Dr. Marshall M. Fortenberry, Mississippi. The names of Dr. Leone and Dr. Press were placed on the voting machines and, at the November 18 meeting, Dr. Press was declared elected Speaker of the House of Delegates by a vote of 244 to 171.

UNFINISHED BUSINESS

The Speaker announced that the resolutions referred back to the 1976 House of Delegates were listed on the Supplemental List of Referrals.

NEW BUSINESS

The Speaker called for items of new business and there were none.

Recess: The House of Delegates recessed at 4:45 p.m.

WEDNESDAY, NOVEMBER 17, 1976

Call to Order: The second meeting of the House of Delegates was called to order at 8:10 a.m. by the Speaker of the House of Delegates, Dr. Frank P. Bowyer.

Invocation: The invocation was offered by Reverend Karl Spatz, Christ Church Episcopal, Las Vegas.

Introduction of Dr. Lloyd J. Phillips, President, American Fund for Dental Health, and Trustee, Seventh District: The Speaker introduced Dr. Lloyd J. Phillips, president of the American Fund for Dental Health, and trustee of the Seventh District. Dr. Phillips announced that the W. K. Kellogg Foundation has committed $2.5 million over four years to a national program for dental quality assurance and that the American Fund for Dental Health will coordinate and administer the program. Dr. Phillips stated that the AFDH will assemble a nine member advisory committee which will be chaired by Dr. Maynard K. Hine, past president of the American Dental Association. Included in the advisory committee will be representatives from the American Dental Association, dental researchers, dental practitioners, dental educators and the public. Through the advisory committee, the AFDH will evaluate proposals and recommend projects to be funded as well as disseminate the program results. The objectives of the program include the investigation of methods to improve the quality of dental care; the development of a workable and valid definition of the quality of dental care which will be acceptable to dental practitioners, consumers and third party payers; the development of vital methods to assess the quality of dental care; the development of more cost effective methods for peer reveiw; and the development of curriculums designed for students and practitioners on how to evaluate the quality of dental care.

Introduction of Winners of Student Clinic Program: The winners of the Student Clinic Program were introduced by Dr. Lyle A. Brecht, chairman of the Council on Scientific Session.

Report of Committee on Credentials: Dr. William H. McKenna, Massachusetts, chairman of the Standing Committee on Credentials, reported a quorum present.

ELECTION OF COUNCIL MEMBERS

The Speaker called attention to the nominations of the Board of Trustees for membership on the various councils of the Association as they appeared on Page 160 of

the *Supplement to Annual Reports and Resolutions, 1976* (p. 467 of this volume). The Speaker called for additional nominations and there were none. The Speaker declared the following resolution adopted:

71H-1976. Resolved, that the nominees for membership on the councils of the Association, submitted by the Board of Trustees in accordance with Chapter VI, Section 90H of the *Bylaws*, be elected.

ELECTION OF MEMBERS TO COMMISSION ON ACCREDITATION OF DENTAL AND DENTAL AUXILIARY EDUCATIONAL PROGRAMS AND COMMISSION APPEAL BOARD

The Speaker called attention to the nominations of the Board of Trustees for membership on the Commission on Accreditation of Dental and Dental Auxiliary Educational Programs and Commission Appeal Board as they appeared on Page 161 of the *Supplement to Annual Reports and Resolutions, 1976* (p. 469 of this volume).

There were no additional nominations from the floor. The Speaker declared the following resolutions adopted:

72H-1976. Resolved, that the nominees for membership on the Commission on Accreditation of Dental and Dental Auxiliary Educational Programs submitted by the Board of Trustees in accordance with Article IV, Section 2 of the *Bylaws of the Commission on Accreditation of Dental and Dental Auxiliary Educational Programs* be elected.

73H-1976. Resolved, that the nominees for membership on the Appeal Board of the Commission on Accreditation of Dental and Dental Auxiliary Educational Programs submitted by the Board of Trustees in accordance with Article V, Section 2 of the *Bylaws of the Commission on Accreditation of Dental and Dental Auxiliary Educational Programs* be elected.

NEW BUSINESS

Use of Motion "Postpone Indefinitely": (Fifth Trustee District Resolution 179) Dr. Robert J. Cole, Florida, moved the adoption of the following resolution and the motion was seconded by Dr. Bernard S. Snyder, Ohio.

179H-1976. Resolved, that when a resolution is brought before the House of Delegates with a motion to postpone indefinitely, the resolution may be debated, amended and all other subsidiary motions may be applied against it, in order of precedence.

Dr. Ernest H. Besch, Texas, spoke in favor of the resolution.

On vote, the resolution (Resolution 179H-1976) was adopted.

REPORT OF REFERENCE COMMITTEE ON BUDGET AND ADMINISTRATIVE MATTERS

The Report of the Reference Committee on Budget and Administrative Matters was read by Dr. Joseph A. Devine, Wyoming, chairman. The other members of the Committee were Drs. Ben H. Benson, Oklahoma; Roger J. Burke, Minnesota; Eugene S. Czarnecki, Pennsylvania; Edwin A. Troutt, Illinois.

Reconsideration of Funding for Dental Editors' Seminar: (Illinois State Dental Society Resolution 93) The Committee reported as follows:

> The Committee reviewed Resolution 93 (p. 370) submitted by the Illinois State Dental Society and agrees with Illinois that the Dental Editors' Seminar, which will only cost the Association $18,000, is of inestimable value. Therefore, the Committee recommends that Resolution 93 be adopted.

Dr. Devine moved the adoption of the following resolution (Resolution 93) and the motion was seconded.

> 93H-1976. Resolved, that the House of Delegates urges that the Board of Trustees reconsider its elimination of any allocation of monies in the 1977 Budget to support the holding of the Council on Journalism's 14th Annual Dental Editors' Seminar and, while so doing, consider appropriating sufficient monies from the 1977 Contingent Fund to permit scheduling and conducting such Seminar in 1977.

Dr. Grant A. MacLean, Illinois, and Dr. Anthony F. Posteraro, New York, spoke in favor of the resolution.

Dr. Jack M. Saroyan, California, spoke in favor of the resolution, stating ". . . To give you a little background concerning the Dental Editors' Seminar, it has been going on for 13 years. So far, it has trained for this Association 325 editors. Now what is this Dental Editors' Seminar all about? It is a week long course. It is a mini-course in dental journalism put on by the University's School of Journalism particularly for training dental editors. They know what our problems are and they come prepared to give us the information we need to better improve communications with our membership. . . . This workshop places squarely before the dental editors the concerns of our profession so that they may be debated and each journal, newsletter and bulletin be a forum of discussion. It shows the editor how to improve readability, improve his format, and make his journal more attractive so you people and your constituents will pick it up and read it. I know the Board of Trustees has its concern about priorities in expenditures. I know because we have placed before the delegation for the last couple of years one of our highest priorities, and that is spokesmen training. The spokesmen training course, under test, has been allocated the largest funds this Association has ever given to any special project. What we have, however, in the Dental Editors' Seminar and workshop is the first spokesmen training program for those people who speak directly not only to you, the profession, but who speak for the profession. . . . I urge your support in passage of this because to do otherwise would be pennywise and dollar foolish."

On vote, the resolution (Resolution 93H-1976) was adopted.

Financial Tabulation of Cost of Proposed Programs: (Delegate Joseph A. Devine Resolution 102) The Committee reported as follows:

> The Committee has carefully reviewed Resolution 102 (p. 422) submitted by delegate Joseph A. Devine. The Committee is of the opinion that the House of Delegates should be aware of the costs of new programs it implements and the total effect such costs have on the budget. The Committee is of the further opinion that the effect on the budget of such new programs cannot be effectively communicated to the House unless a cumulative total is projected to the House.
>
> The Committee believes that a mechanism should be developed whereby the House, after determining the total increases to the expense section of the budget, may provide for those funds during the same session of the House. One means to accomplish this is by declaring a special assessment. Such assessment would have the salutary effect of allowing for the implementation of special programs of an emergency nature without affecting the current provision in the *Bylaws* which requires that a dues increase not be acted on at the session it is proposed.
>
> The Committee is of the opinion that because of logistic difficulties involved in requiring the approval of the budget as the last order of business at the last meeting of the House that Resolution 102 be amended by deleting the last two resolving clauses and substituting therefor the following additional resolving clause:
>
> > Resolved, that the Board of Trustees develop a mechanism whereby the House of Delegates may appropriate the necessary monies to fund the programs adopted at the session and report back to the 1977 House of Delegates.
>
> to make that resolution read as follows:
>
> > 102RC. Resolved, that the Board of Trustees in cooperation with the Secretary and the Speaker of the House of Delegates develop the mechanism to project on the screen a financial tabulation of the cost of each program as it is deliberated by the House of Delegates, so that at the end of each session the projection would show the House of Delegates how its deliberations affected the proposed budget to that point, and be it further
> >
> > Resolved, that the Board of Trustees develop a mechanism whereby the House of Delegates may appropriate the necessary monies to fund the programs adopted at the session and report back to the 1977 House of Delegates.

Dr. Devine moved the adoption of the amendment and the motion was seconded. On vote, the amendment was adopted.

Dr. Robert M. Unger, Illinois, spoke in favor of the resolution.

Dr. Devine moved the adoption of the amended resolution and the motion was seconded. On vote, the following amended resolution (Resolution 102RC) was adopted:

> 102H-1976. Resolved, that the Board of Trustees in cooperation with the Secretary and the Speaker of the House of Delegates develop the mechanism to project on the screen a financial tabulation of the cost of each program as it is deliberated by the House of Delegates, so that at the end of each session the projection would show the House of Delegates how its deliberations affected the proposed budget to that point, and be it further
>
> Resolved, that the Board of Trustees develop a mechanism whereby the House of Delegates may appropriate the necessary monies to fund the programs adopted at the session and report back to the 1977 House of Delegates.

Approval of 1977 Annual Budget of Income and Expense: (Board of Trustees Resolution 87) The Committee reported as follows:

> The Committee reviewed the proposed 1977 Budget, which has been submitted by the Board of Trustees, and notes that the budget is now about $1.75 million less than it was when initially prepared and submitted by the Association's agencies in May. The achieving of this balanced budget in the face of such stiff odds is a real tribute to the unstinting efforts and business acumen of the Board of Trustees and its Committee on Finance and Investments. The Committee finds the proposed budget to be fiscally sound and takes pleasure in recommending Resolution 87 for approval.

Dr. Devine moved the adoption of Resolution 87 and the motion was seconded. Dr. Jack W. Gottschalk, Ohio, stated "I am concerned about the fiscal organization using depreciation to live on. Look at the situation in that second resolving clause. It calls for an equipment depreciation of $286,000 and furniture and equipment of $166,000. If you are on a cash flow basis, you are using this money. Where does it show up in income? I rise to ask where it is shown, and in what particular account this is kept. For the future of this organization to be fiscally responsible, you should take the depreciation if you are going to include it in expense . . . and use it in the future to depreciate those items and replace them when they do come due."

On vote, the following resolution (Resolution 87) was adopted:

> 87H-1976. Resolved, that the 1977 Annual Budget of Income, Expense (excluding depreciation) and Nonoperative Disbursements be approved, and be it further
>
> Resolved, that building and building furniture and equipment depreciation in the amount of $286,000 and depreciation on other furniture and equipment of the American Dental Association in the amount of $166,000 be approved.

The Speaker requested that Dr. Devine yield to Dr. Thomas J. Hicks, Jr., chairman of the Reference Committee on President's Address and Miscellaneous Matters, in order that Dr. Hicks could present a resolution pertinent to the budget. Dr. Devine yielded.

Dues Raise in 1977: The Reference Committee on President's Address and Miscellaneous Matters reported as follows:

> There was virtual unanimity in the Committee hearing in support of Dr. Shira's call for an immediate and unanimous vote on a dues raise. A few delegates suggested that it might be wise to seek an "instant raise" of $25 or $50 and to ask for the remainder of the $75 in the 1977 House of Delegates. But the vast majority of those who spoke to the issue strongly supported Dr. Shira's call for passage of Resolution 88 (p. 513) by unanimous vote of this House of Delegates.
>
> There was repeated stress placed on the dangers facing the profession and the need for funds to meet those dangers. Illegal dentistry was cited over and over. The need for an expanded Public Education Program, the necessity of facing the challenges of the Federal Trade Commission and other governmental agencies, the myriad of lawsuits facing the Association—all were cited in support of immediate passage of Resolution 88.
>
> The Committee fully recognizes the difficulty of getting 417 individual dentists to agree unanimously on anything, including the time of day. The Committee will only pass on to the delegates the statement made by President Shira in the Reference Committee hearing:

> Have you got the guts to do what you know you should do? Your profession is on the line.

Therefore, the Committee urges unanimous passage of the following resolution, which is Resolution 88 amended so as to have the dues raise take effect on January 1, 1977.

88RC. Resolved, that Chapter I, Section 50A of the *Bylaws* be amended by the deletion of the words and figures "one hundred dollars ($100.00)" and insertion in lieu therefor of the words and figures "one hundred seventy-five dollars ($175.00)" to make the amended section read as follows:

> A. Active Members. The dues of active members shall be one hundred seventy-five dollars ($175.00) due January 1 of each year.

and be it further
Resolved, that increased active members dues become effective January 1, 1977.

Dr. Hicks moved the adoption of the amendment and the motion was seconded. The motion failed to pass.

Dr. Hicks moved to reconsider the issue to present the same amendment substituting a $25 dues raise in lieu of a $75 dues raise. The motion to reconsider failed to pass.

The Speaker called on Dr. Devine to proceed with the Report of the Reference Committee on Budget and Administrative Matters.

Dues Increase from $100 to $175: (Board of Trustees Resolution 88) The Committee reported as follows:

> Since Resolution 88 (p. 513) submitted by the Board of Trustees proposes a *Bylaws* amendment effecting a change in the dues of active members from $100 to $175 annually, the Committee requests that the Speaker of the House declare Resolution 88 to be referred to the 1977 House of Delegates for action.

The Speaker referred the following resolution to the 1977 House of Delegates for action:

88. Resolved, that Chapter I, Section 50A of the *Bylaws* be amended by the deletion of the words and figures "one hundred dollars ($100.00)" and insertion in lieu therefor of the words and figures "one hundred seventy-five dollars ($175.00)" to make the amended section read as follows:

> A. Active Member. The dues of active members shall be one hundred seventy-five dollars ($175.00) due January 1 of each year.

and be it further
Resolved, that increased active members dues become effective January 1, 1978.

Amendment of "Bylaws" on Dues of Members Elected After October 1: (Odontological Society of Western Pennsylvania Resolution 79 to 1975 House of Delegates) The Committee reported as follows:

The Committee has reviewed Resolution 79-1975 (*Trans.* 1975:629) proposing a *Bylaws* amendment changing the dues obligation for active members joining after October 1. Since this resolution, if adopted, would change the dues of a segment of active members, the Speaker referred the resolution to this House of Delegates for action. The Committee joins the Board in recommending the adoption of this resolution since it will encourage, through payment of one-quarter instead of one-half the rate of dues, prospective members, particularly those coming out of military service, to join even in the last quarter of the year instead of choosing to delay joining until the beginning of the following year. The Committee presents the following resolution, the language of which has been approved by the Standing Committee on Constitution and Bylaws.

Dr. Devine moved the adoption of the resolution and the motion was seconded.

Dr. F. Eugene Ewing, Pennsylvania, spoke in favor of the motion, stating ". . . I personally feel that we need all the options that are available to recruit young men into organized dentistry. . . . The majority of these are people who have just been discharged from the service, young men who would like to become involved in organized dentistry, but primarily those who have young families who would like to be covered under our insurance programs. I feel that this is something that we must do. . . ."

On vote, the following resolution was adopted by a two-thirds vote:

79(1975)H-1976. Resolved, that Chapter I, Membership, Section 50, Dues and Reinstatements, Subsection H, Members Elected After July 1, be amended by adding the words "and October 1" to the subsection heading and by inserting after the words "current year's dues" in line 310* the words and punctuation "; and who are elected after October 1, shall pay one-quarter (¼) of the current year's dues:" so that the subsection will read:

> **H. Members Elected After July 1 and October 1.** Active members elected to active membership in this Association for the first time, and who are elected after July 1, shall pay one-half (½) the current year's dues; and who are elected after October 1, shall pay one-quarter (¼) of the current year's dues; except that a student member, upon his classification as an active member by a constituent society shall pay no further dues for the remainder of the calendar year in which he was entitled to the benefits of student membership.

Report of Council on Insurance: The Committee reported as follows:

The Committee has reviewed the Report of the Council on Insurance (p. 151) and takes note of the new Survivors Income Benefit program initiated by the Council. The Committee commends the Council on its continued diligence in administering to the insurance needs of the membership.

Insurance Programs for ADA Members: (Michigan Dental Association Resolution 112) The Committee reported as follows:

The Committee has carefully reviewed Resolution 112 (p. 376) submitted by the Michigan Dental Association and joins the Board of Trustees in expressing concern over the issues raised. The Committee, however, concurs with the Board that these matters require further study by the Council on Insurance. Therefore, the Committee recommends that Resolution 112 be referred to the Council on Insurance for study and report back to the 1977 House of Delegates.

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*Editorially corrected from reference to "line 303" to reference to "line 310" as a consequence of the revised edition of January 1, 1976, of the *Constitution and Bylaws*.

Dr. Devine moved to refer Resolution 112 to the Council on Insurance for study and report back to the 1977 House of Delegates and the motion was seconded.

On vote, the following resolution (Resolution 112) was referred to the Council on Insurance for study and report back to the 1977 House of Delegates.

> 112. **Resolved,** that the American Dental Association Council on Insurance and the Poe Agency distribute the experience statistics by state, relative to the Professional Protector Plan, 90 days prior to the renewal dates of the program for analysis and discussion with that constituent society, prior to a rate increase, and be it further
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> **Resolved,** that the American Dental Association Council on Insurance forward all information pertaining to proposed changes in coverage to constituent societies that endorse ADA insurance programs for their input prior to definitive action on such changes.

Formation of Self-Insured Malpractice Program: (New Jersey Dental Association Resolution 100) The Committee reported as follows:

> The Committee has carefully reviewed Resolution 100 (p. 378) submitted by the New Jersey Dental Association. While Resolution 100 asks that this matter be referred to the proper agency for study, the Committee is of the opinion that even such a study could prove costly since undoubtedly it would require the services of an actuary as well as considerable staff time. The Committee is of the opinion that the formation of a self-insured malpractice program would not be feasible and therefore believes that it would be an unnecessary expenditure of funds to conduct such study. The Committee recommends, therefore, that Resolution 100 be postponed indefinitely.

Dr. Devine moved to postpone indefinitely the following resolution (Resolution 100) and the motion was seconded:

> 100. **Resolved,** that the American Dental Association meet the crisis of rising malpractice insurance premiums that are occurring throughout the nation with the formation of a self-insured malpractice program, and be it further
>
> **Resolved,** that the self-insured malpractice program shall be the result of a thorough actuarial investigation, and be it further
>
> **Resolved,** that said self-insured program shall be financed on a pro-rated basis throughout the nation, and be it further
>
> **Resolved,** that this matter be referred to the proper agency for study and report back to the 1977 House of Delegates.

Dr. Herbert N. D. Cahan, New Jersey, spoke in opposition to indefinite postponement, stating ". . . We respectfully request this feasibility study because there is a growing increase in premiums on malpractice insurance in several areas of the country. In some areas of the country it is even difficult, outside of the personal protective plan which the ADA has, to receive malpractice insurance. Realizing that there would be a request for an estimate for this type of project, I did contact an organization in Connecticut that has done this for several national organizations in other areas and inquired of the cost. . . ." Dr. Cahan read a letter dated November 2, 1976 from Harry R. Richards of Portermain, Richards & Davis, Inc. which outlined a feasibility study and quoted an approximate cost of $10,000.

Dr. Carlton H. Williams, California, moved to amend Resolution 100 by substituting the word "study" for the word "meet" in the first resolving clause, by substituting the words "view to forming" for the words "formation of" in the first resolving clause, and by deleting the word "malpractice" and substituting the word "proposal" for the word "program" in the second resolving clause. The motion was seconded.

Dr. Herbert N. D. Cahan, New Jersey, stated that the New Jersey delegation would accept the amendments presented by Dr. Williams.

The Speaker stated that the amendments would be considered editorial changes since they were accepted by the New Jersey delegation.

Dr. Jacob H. Oxman, New Jersey, spoke in opposition to indefinite postponement.

On vote, the motion to postpone indefinitely was defeated.

Dr. Carlton H. Williams, California, moved the adoption of Resolution 100 with editorial changes and the motion was seconded by Dr. Dudley S. Moore, California.

On vote, the following resolution (Resolution 100 as editorially changed) was adopted:

> 100H-1976. **Resolved**, that the American Dental Association study the crisis of rising malpractice insurance premiums that are occurring throughout the nation with the view to forming a self-insured malpractice program, and be it further
> **Resolved**, that the self-insured proposal shall be the result of a thorough actuarial investigation, and be it further
> **Resolved**, that said self-insured program shall be financed on a pro-rated basis throughout the nation, and be it further
> **Resolved**, that this matter be referred to the proper agency for study and report back to the 1977 House of Delegates.

Engagement of Actuary for ADA Insurance Programs: (Oregon Dental Association Resolution 37; Fifth Trustee District Resolution 37S-1) The Committee reported as follows:

> Since the Fifth Trustee District substitute resolution for Resolution 37 (p. 406) and Oregon Resolution 37 (p. 384) are identical with the exception of the additional phrase "and assist constituent societies in the evaluation of state-sponsored programs" being added to the end of Oregon Resolution 37, the Committee considered both resolutions together. The Committee concurs with the Board of Trustees (p. 494) that evaluation of members' insurance programs is an ongoing process of the Council on Insurance and that on those occasions where services of an actuary are called for such services can be contracted for that specific purpose. The Committee is of the opinion that the retention of an actuary on a continuous basis would be an unnecessary expenditure of Association funds.
>
> The Committee is further of the opinion that presently the constituent societies may retain the services of consultants and/or actuaries to review their insurance programs. Since additional personnel and space would have to be allocated to the Council on Insurance to assist constituent societies in the evaluation of state-sponsored programs and such staff would have to be available for all societies requesting such service, the Committee is of the opinion that such a program is not feasible. The estimated cost for the implementation of such a program may be as much as $130,000.
>
> Since the Committee considered Resolution 37 and Resolution 37S-1 together, the Committee recommends that Resolution 37S-1 be substituted for Resolution 37.

Dr. Devine moved the substitution of the following resolution (Resolution 37S-1) for Resolution 37, and the motion was seconded:

37S-1. **Resolved,** that the American Dental Association be directed to engage an independent actuary who is a Fellow of the Society of Actuaries, or a firm of independent actuaries, at least one of whose members is a Fellow of the Society of Actuaries, to review experience of the sponsored life, disability and health programs, and, in addition, to engage an independent actuary who is a Fellow of the Casualty Actuarial Society, or a firm of independent actuaries, at least one of whose members is a Fellow of the Casualty Actuarial Society, to review experience of the sponsored liability programs and assist constituent societies in the evaluation of state-sponsored programs.

Dr. James J. Bell, Oregon, moved to amend Resolution 37S-1 by deleting the words "and assist constituent societies in the evaluation of state-sponsored programs." The motion was seconded by Dr. Vernon R. Manny, Oregon.

On vote, the amendment proposed by Dr. Bell was adopted.

On vote, Resolution 37S-1 as amended was substituted for Resolution 37.

Dr. James J. Bell, Oregon, moved to refer Resolution 37S-1 as amended to the Board of Trustees for further study and report back to the 1977 House of Delegates. The motion was severally seconded.

On vote, the following resolution (Resolution 37S-1 as amended) was referred to the Board of Trustees for study and report back to the 1977 House of Delegates:

37S-1. **Resolved,** that the American Dental Association be directed to engage an independent actuary who is a Fellow of the Society of Actuaries, or a firm of independent actuaries, at least one of whose members is a Fellow of the Society of Actuaries, to review experience of the sponsored life, disability and health programs, and, in addition, to engage an independent actuary who is a Fellow of the Casualty Actuarial Society, or a firm of independent actuaries, at least one of whose members is a Fellow of the Casualty Actuarial Society, to review experience of the sponsored liability programs.

Package Insurance Plans: (Fifth Trustee District Resolution 158) The Committee reported as follows:

The Committee reviewed Resolution 158 (p. 402) submitted by the Fifth Trustee District requesting the Association to encourage insurance companies to create package plans which include malpractice insurance. The Committee points out that the Association currently co-endorses with the constituent societies the Professional Protector Plan which is a package policy. Further, the Association has no control over insurance companies and has no knowledge of the method to be employed in implementing the intent of this resolution. Therefore, the Committee recommends that Resolution 158 be postponed indefinitely.

Dr. Devine moved that the following resolution (Resolution 158) be postponed indefinitely, and the motion was seconded:

158. **Resolved,** that the American Dental Association encourage insurance companies to create package plans which include malpractice insurance which package plans would be available to independent agents in order to ensure competitive rate structures and avoid the evolution of a monopolistic situation in the area of malpractice insurance.

On vote, Resolution 158 was postponed indefinitely.

Reconsideration of 1974 Wisconsin Resolution 43 Regarding Modification of Membership Card: (Wisconsin Dental Association Resolution 42; Board of Trustees Resolution 42B) The Committee reported as follows:

> The Committee has carefully reviewed Resolution 42 (p. 389) and Board of Trustees substitute Resolution 42B (p. 497) requesting that the Board of Trustees study the feasibility of issuing each active, life and retired member a plastic membership card and, if practicable, arrange for the issuance of such card commencing in 1978. The Committee is of the opinion that because of recent amendments to the Internal Revenue Code which, under certain circumstances, no longer considers income from trade shows unrelated business income subject to taxation, the Board should reconsider the feasibility of plastic membership cards. The Committee notes that Board of Trustees substitute Resolution 42B is presented merely for the purpose of correcting parliamentary errors in Wisconsin Resolution 42 and recommends that Resolution 42B be substituted for Resolution 42 and that Resolution 42B be adopted.

Dr. Devine moved to substitute Resolution 42B for Resolution 42 and the motion was seconded. On vote, the motion to substitute was adopted.

Dr. Devine moved the adoption of the substitute resolution (Resolution 42B) and the motion was seconded. On vote, the following resolution (Resolution 42B) was adopted:

> 42H-1976. **Resolved,** that the Board of Trustees study the feasibility of issuing each active, life and retired member a plastic membership card and, if practicable, arrange for the issuance of such cards commencing in 1978.

Numbering of Pages in "Supplement": (Fourth Trustee District Resolution 150) The Committee reported as follows:

> The Committee has reviewed Resolution 150 (p. 395) submitted by the Fourth Trustee District requesting that the pages of the *Supplement* be numbered in sequence to the pages of the *Annual Reports and Resolutions*. The Committee concurs with the intent of this resolution; however, is of the opinion that the number of the first and last page should be identified on the covers of these publications. Therefore, the Committee recommends that Resolution 150 be amended by the addition of the following words and phrases at the end of the sentence, "and that the first and last page should be identified on the cover of these publications" to make the resolution read as follows:
>
> > 150RC. **Resolved,** that the pages of the *Supplement to Annual Reports and Resolutions* should be numbered in sequence to the pages of the *Annual Reports and Resolutions* and that the first and last page be identified on the cover of these publications.

Dr. Devine moved the adoption of the amendment to Resolution 150 and the motion was seconded. On vote, the amendment was adopted.

Dr. Devine moved the adoption of the amended resolution and the motion was seconded. On vote, the following resolution (Resolution 150 as amended) was adopted:

> 150H-1976. **Resolved,** that the pages of the *Supplement to Annual Reports and Resolutions* should be numbered in sequence to the pages of the *Annual Reports and Resolutions* and that the first and last pages be identified on the cover of these publications.

Grant Space in Headquarters Building: (Eighth Trustee District Resolution 138) The Committee reported as follows: (For final disposition see p. 822.)

> The Committee has carefully reviewed Resolution 138 (p. 411) submitted by the Eighth Trustee District urging the Board of Trustees to refuse granting free space and sharing free services to any organization not subject to the policies of this Association nor responsible to the Board of Trustees. The Committee is of the opinion that this matter comes within the purview of the management power and duties of the Board of Trustees as outlined in Sections 80 and 90 of Chapter VI, Board of Trustees of the *Bylaws* and that the House of Delegates must rely on the wisdom of the Board of Trustees in the faithful exercise of these powers and duties. Therefore, the Committee recommends that Resolution 138 be postponed indefinitely.

Dr. Devine moved to postpone indefinitely Resolution 138 and the motion was seconded.

Dr. Fred E. Cory, Illinois, spoke in opposition to indefinite postponement, stating ". . . We in Illinois agree that the *Bylaws* of the Association place the responsibility for management of the fiscal affairs within the purview of the Board of Trustees. This resolution, however, does not relate to management but rather to policy. . . . This body, the House of Delegates, is the supreme legislative body responsible for establishing policy. . . . Shall we grant free space and the free use of clerical personnel to organizations who have their own policies, governing bodies and bylaws? . . . What this resolution directs itself to is that the Board shall charge something for the utilization of space and staff for the association; otherwise, we can expect requests from many associations for free space and personnel. . . . All dental related organizations now occupying space in the ADA building pay hard dollars for their space. They are charged a lesser rate than non-dental related organizations. . . . It is vital to this House and to this Association that we make a statement, that we establish policy in this area before we commit a serious error. . . . The question has been raised that nothing is free in the ADA. It has all been budgeted. The answer to that, of course, is that it is true as far as it goes. To the organization which gets free space and free services, as well as the free use of personnel, it is free; but it is not free to the members of the ADA. They must pay for this with increased dues and it is only free to the receiving organization. Emotionally, this has been discussed by some as relating to the Women's Auxiliary. It does not. . . . It is, however, an attempt to develop a positive policy under which our Board of Trustees may be guided. Should the Board of Trustees wish to grant the Women's Auxiliary space and services at a very nominal fee, we in Illinois would be their strongest supporter. . . ."

Dr. Israel Shulman, District of Columbia, questioned the Executive Director of the Association as to how many organizations, if any, are currently granted free space and services and if the Women's Auxiliary is subject to the policies of the American Dental Association or responsible to the Board of Trustees.

Dr. Watson stated that there are no organizations receiving free space or services in the ADA building. In answer to Dr. Shulman's second question, Mr. John P. Noone, assistant executive director for business affairs and house counsel, quoted from Chapter XVIII, Section 20 of the *Bylaws* that "no provision in the constitution and bylaws of the Auxiliary shall be in conflict with the *Constitution and Bylaws* of this Association."

Dr. William R. Alstadt, Arkansas, past president of the Association, stated "I rise to support the statements made by the member of the Illinois delegation. As long as it is clearly understood that we are going to provide some space or some secretarial help,

it has been estimated that the total fee would be approximately $200 a year. . . . There are no more loyal supporters of the entire dental profession than our wives. . . . I want to be assured by the Board of Trustees and this House of Delegates that we provide for them. . . . I want to be certain that WAADA can be given some assistance. . . . They are our best supporters and I think we had better take cognizance of that. . . ."

Dr. Eugene J. Truono, Delaware, requested the names of other agencies or representative groups who would be affected by the resolution. Dr. Watson replied that the Women's Auxiliary to the American Dental Association is the only organization which has requested free space.

Dr. Fred E. Cory, Illinois, stated "It really makes no difference who is affected at this time. We do not want the resolution to affect anyone at this time but merely want to establish policy where there is no policy. . . ."

Dr. Carlton H. Williams, California, stated ". . . When this House of Delegates starts to tell the Board of Trustees, who is the managing body of this Association, what to do, I think you have to realize that we have had policy because we have charged the Board of Trustees with being our managing agency. . . . You are telling the Board of Trustees how to manage its affairs. . . ."

On vote, the following resolution (Resolution 138) was postponed indefinitely:

> 138. **Resolved**, that the House of Delegates urge the Board of Trustees to refuse granting free space and sharing free services to any organization not subject to the policies of this Association nor responsible to the Board of Trustees.

Provisions for Advance Copies of "Reports" and "Supplement": (Tenth Trustee District Resolution 134) The Committee reported as follows:

> The Committee has reviewed Resolution 134 (p. 414) submitted by the Tenth Trustee District requesting that the Association provide an opportunity for the general membership to place orders for copies of the *Annual Reports and Resolutions* and the *Supplement to Annual Reports and Resolutions* in advance of the annual session. The Committee concurs that it would be of great value for the delegates to be provided with input from the membership on issues to be deliberated upon by the Houes of Delegates. Those members desirous of providing such input would be better advised of the issues by having copies of the above publications in advance of the annual session. However, to avoid confusion in the intent of Resolution 134, the Committee recommends an editorial amendment to this resolution by deleting the word "advance" in the second line of the resolution and by adding the words and phrase ", prior to the annual session" after the word "resolutions" in the third line of the resolution to make that resolution read as follows:
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> > 134RC. **Resolved**, that the American Dental Association provide an opportunity for the general membership to place orders for copies of the *Annual Reports and Resolutions*, prior to the annual session, at a cost equal to the printing and mailing costs for these documents.

Dr. Devine moved the adoption of the amendment to Resolution 134 and the motion was seconded. On vote, the amendment was adopted.

Dr. Devine moved the adoption of the amended resolution and the motion was seconded. On vote, the following resolution (Resolution 134 as amended) was adopted:

134H-1976. Resolved, that the American Dental Association provide an opportunity for the general membership to place orders for copies of the *Annual Reports and Resolutions,* prior to the annual session, at a cost equal to the printing and mailing costs for these documents.

Offices of Immediate Past President and Vice-Presidents: (Board of Trustees Resolutions 78, 79 and 80) The Committee reported as follows:

> Since the Committee understood that there was sentiment for amending the *Constitution* by unanimous vote at this session of the House of Delegates to make the Immediate Past President a voting member of the Board of Trustees, eliminate the office of Second Vice-President and change the office of First Vice-President to simply Vice-President, the Committee permitted testimony on proposed constitutional changes that normally must lay over for one year after being received by the House before action can be taken. The Committee was particularly grateful to the Past Presidents who addressed themselves to the proposal concerning the Immediate Past President. The testimony of members, including some who were wearing delegate badges, cogently attested to the fact that these three proposed constitutional changes would not carry unanimously. As a consequence, this will leave the *Constitution and Bylaws* unchanged with respect to these three positions until the 1977 House. Therefore, the Committee requests, since no motion is required, that the Speaker of the House declare Resolutions 78, 79 and 80 to be referred to the 1977 House of Delegates for action.

The Speaker declared the following resolutions referred to the 1977 House of Delegates:

78. Resolved, that the office of Immediate Past President be created and that the Immediate Past President be given a vote on the Board of Trustees.

79. Resolved, that the office of Second Vice-President be eliminated.

80. Resolved, that the office of First Vice-President be changed to Vice-President and that the Vice-President serve for a term of one year with a vote.

Officers and Trustees Not to Serve as Council Members or Voting Members of the House of Delegates: (Board of Trustees Resolution 81) The Committee reported as follows:

> The Committee has reviewed Resolution 81 submitted by the Board of Trustees (p. 485) recommending that officers and trustees not serve as Council members or voting members of of the House of Delegates. The Committee concurs with the Board and is of the opinion that the adoption of this resolution would allow for active participation in Association affairs by a greater number of members. Since Resolution 81 requires an amendment to the *Bylaws,* this resolution has been submitted to the Standing Committee on Constitution and Bylaws for language approval. At the suggestion of the Standing Committee on Constitution and Bylaws, the Committee, for editorial purposes, presents the following substitute resolution, the language of which has been prepared by the Standing Committee on Constitution and Bylaws.

Dr. Devine moved to substitute Resolution 81RC for Resolution 81 and the motion was seconded. On vote, the motion to substitute was adopted.

Dr. Devine moved the adoption of the substitute resolution (Resolution 81RC) and the motion was seconded. On vote, the following substitute resolution (Resolution 81RC) was adopted:

81H-1976. Resolved, that Chapter V, Section 10 of the *Bylaws* be amended by deleting the third and fourth sentences as follows:

> The elective and appointive officers and past presidents of this Association shall be *ex officio* members of the House of Delegates without the power to vote unless designated as delegates. The trustees shall not serve as delegates, but shall be *ex officio* members of the House of Delegates without the power to vote.

and substituting therefor the following:

> The elective and appointive officers and the trustees of this Association shall be *ex officio* members of the House of Delegates without the power to vote. They shall not serve as delegates. Past Presidents of this Association shall be *ex officio* members of the House of Delegates without the power to vote unless designated as delegates.

to make the amended section read:

> Section 10. Composition: The House of Delegates shall be limited to four hundred seventeen (417) voting members. It shall be composed of the officially certified delegates of each constituent society and one (1) officially certified delegate from each federal dental service. The elective and appointive officers and the trustees of this Association shall be *ex officio* members of the House of Delegates without the power to vote. They shall not serve as delegates. Past Presidents of this Association shall be *ex officio* members of the House of Delegates without the power to vote unless designated as delegates.

and be it further
Resolved, that Chapter IX, Section 20(A) of the *Bylaws* be amended by addition of the following sentence after the second sentence:

> The elective and appointive officers and the trustees of the Association shall not serve as members of councils.

to make the amended subsection read:

> A. All councils, except as otherwise provided for in these *Bylaws*, shall be composed of the five (5) members. Nominations for all councils shall be made by the Board of Trustees. The elective and appointive officers and the trustees of this Association shall not serve as members of councils. Additional nominations may be made by the House of Delegates unless otherwise provided for in these *Bylaws*. Members of councils shall be elected by the House of Delegates in accordance with Chapter V, Section 140.

Amendment of "Bylaws" on Composition of House of Delegates: (Board of Trustees Resolution 82) The Committee reported as follows:

> The Committee reviewed Resolution 82 (p. 500) submitted by the Board of Trustees which recommends that the *Bylaws* be amended to grant the representative of the American Student Dental Association the privilege to vote in the House of Delegates of the American Dental Association. Since the future of dentistry rests in the hands of these 14,952 members of ASDA, the Committee urges that the House display its confidence in this group from which the American Dental Association's future leaders will emerge. Since Resolution 82 requires an amendment to the *Bylaws* this resolution has been submitted to the Standing Committee on Constitution and Bylaws for language approval. At the suggestion of the Standing Committee on Constitution and Bylaws the Committee, for editorial purposes, presents the following substitute resolution, the language of which has been prepared by the

Standing Committee on Constitution and Bylaws with the recommendation that it be approved.

82RC. Resolved, that Chapter V, House of Delegates of the *Bylaws* be amended as follows:

1. Amend the first sentence of Section 10 by substituting the number "four hundred eighteen (418)" for the number "four hundred seventeen (417)" to make the amended sentence read as follows:

> The House of Delegates shall be limited to four hundred eighteen (418) voting members.

2. Delete the second sentence of Section 10 and substitute therefor the following:

> It shall be composed of the officially certified delegates of each constituent society, one (1) officially certified delegate from each federal dental service and one (1) student member of the American Dental Association who is an officially certified delegate from the American Student Dental Association.

3. Delete the first sentence of Section 20 and substitute therefor the following:

> The Secretary of each constituent society, the ranking administrative officer of each federal dental service, and the secretary of the American Student Dental Association shall file with the Executive Director of this Association, at least sixty (60) days prior to the first day of the annual session of the House of Delegates, the names of the delegates and alternate delegates designated by his society, service or association.

Dr. Devine moved that Resolution 82RC be substituted for Resolution 82 and the motion was seconded. On vote, the motion was adopted.

Dr. Devine moved the adoption of the substitute resolution (Resolution 82RC) and the motion was seconded.

Dr. Paul Zackon, New Jersey, spoke in opposition to the motion, stating ". . . It sounds like I am speaking against motherhood, but I have to object to it on the basis that it would be a token vote. Dental students have not been exposed to all the problems of practice and certainly not the interpersonal reactions which are needed to make a meaningful decision on subjects such as governmental harassment over the forms and whatever else the future has in store for it. We are told the students are the dentists of tomorrow. . . . When they do so become, we will be happy to have them sit as voting members of the House of Delegates, coming up in the usual manner. . . . I must emphasize that we are making a mistake by giving a vote to them now. As far as giving them input, they will have considerable input by being invited to speak at the reference committee meetings. I think we should make more effort to have them come out and speak at the meetings of the reference committees."

Dr. Carlos J. Noya, Puerto Rico, stated "I want to speak in favor of the vote for the young delegate, the student delegate, because I have great faith in the youth of America and of Puerto Rico. I feel that we have been denying these youths their votes long enough, and they deserve their votes. I keep in touch with young people and I learn a great deal from young people. I feel that this House could get and should get that same opportunity. I think they will do a good job, and I urge the delegates to vote in favor of the vote for the students."

Dr. W. L. Lockett, Tennessee, spoke in favor of the motion, stating ". . . I think it is

of the utmost importance that the graduating dentists become members of the American Dental Association. I think we will encourage them to do so if we allow them full privileges in this House. I have been in the House as an alternate or as a delegate for 19 years, and I can remember only one time where one vote made a difference, and that was in this city in an election for President. I may be wrong, but I would ask you to search your minds as to what harm it is going to do to give them a vote, and weigh that against what good it can be for the entire profession of dentistry. I urge you with all my ability to let the student delegates vote, please."

Dr. Harold E. Young, California, and Dr. Jules N. Lewin, New Jersey, spoke in favor of the motion. Dr. P. W. Evans, Kentucky, spoke in opposition to the motion.

On vote, the motion failed to pass the necessary two-thirds majority vote. Resolution 82RC, substituted for Resolution 82, was not adopted.

Rescinding 1972 House Resolution 24-1972-H on Publication of Business Referred to Council by House: (Board of Trustees Resolution 83) The Committee reported as follows:

> Since the Committee concurs with the Board of Trustees and the Executive Director that the prohibition against publication of business referred by the House to agencies of the Association for report to a future meeting of the House is unduly restrictive because such a policy prevents the general membership from being informed concerning important issues under consideration by the House (p. 501), the Committee recommends the adoption of the following resolution.

Dr. Devine moved the adoption of Resolution 83 and the motion was seconded. On vote, the following resolution was adopted:

> **83H-1976. Resolved,** that Resolution 24-1972-H, adopted by the 1972 House of Delegates (*Trans.* 1972:620), be rescinded, and be it further
> **Resolved,** that all business referred to councils or other agencies of the ADA by the House of Delegates, with explicit instructions to be returned to a future meeting of the House, be submitted back to the House before implementation and that publication outside the officers, Board of Trustees, delegates and alternate delegates of the Association and officers of constituent societies be left to the discretion of the Board of Trustees.

Recommendation Regarding Office of Treasurer: (Board of Trustees Resolution 128) The Committee reported as follows:

> The Board of Trustees at its August 1976 session appointed Dr. Jack H. Pfister to serve as Treasurer of the Association for a one rather than three year term commencing November 19, 1976, with the thought of proposing to the House of Delegates that the office of Treasurer be strengthened by permitting the Board to provide in its *Organization and Rules* to have the Chairman of the Committee on Finance and Investments, who is always an elected, voting member of the Board, also serve as Treasurer. However, to accomplish this object, which incidentally also will save the Association $6,000 to $7,000 annually, an amendment to the *Bylaws* must first be approved. Therefore, the Committee recommends that Resolution 128, the language of which has been approved by the Standing Committee on Constitution and Bylaws, be adopted.

Dr. Devine moved the adoption of Resolution 128 and the motion was seconded. On vote, the following resolution was adopted:

128H-1976. Resolved, that Chapter VIII, Appointive Officers, of the *Bylaws* be amended by the deletion of Section 20, Appointments, and the substitution therefor of the following new section:

> Section 20. Appointments: Any active, life or retired member in good standing may be appointed to an appointive office by the Board of Trustees in accordance with its rules and regulations.

Report of Committee on Advance Planning: (Board of Trustees Resolution 116) The Committee reported as follows:

> The Committee has carefully reviewed Resolution 116 presented by the Board of Trustees recommending that the *Proposal of the Committee on Advance Planning on Structure of American Dental Association* be approved. The Committee takes notice of the extensive study of the structure of the Association made by the Committee on Advance Planning and is impressed with the obvious thoroughness and care taken in developing the *Proposal*. The Committee further notes that many areas of comment contained in the *Proposal* are administrative in nature and therefore may be implemented by the Board without House of Delegates' approval. The Committee commends the Board for including these areas in its submission to the House which provides the House with a proper overview of the entire structure of the Association. Such an overview will enable the House to more accurately determine its wishes on those matters which come under its auspices. Due to the importance of the *Proposal*, the Committee entertained and heard considerable testimony regarding certain provisions of the *Proposal*. The Committee is of the opinion that because of the significance of the *Proposal* and the effect it has on several councils, bureaus and agencies requiring *Bylaws* amendments, the House would be best served in its deliberations regarding these *Bylaws* changes by referring the *Proposal* to the Board for report back to the 1977 House of Delegates. The Committee is quick to point out that such recommendation is in no way intended to reflect adversely on the *Proposal*. Indeed, the Committee, in principle, approves the concept. However, such referral will offer the membership an opportunity to digest the voluminous material contained in the *Proposal* for input to the delegates. The House, then, will be better able to consider this matter. Further, the Committee recommends that because of the many issues presented a separate House Reference Committee be established to consider this *Proposal*. Therefore, the Committee recommends the adoption of the following substitute resolution for Resolution 116.
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> > 116RC. Resolved, that the *Proposal of the Committee on Advance Planning on Structure of American Dental Association Agencies* be referred to the Board of Trustees for report back to the 1977 House of Delegates, and be it further
> > Resolved, that a separate reference committee of the House be established to consider this *Proposal*.

Dr. Devine moved that Resolution 116RC be substituted for Resolution 116 and the motion was seconded.

Dr. Mark A. Price, Louisiana, moved to postpone definitely Resolution 116RC until such time as a resolution from the Twelfth Trustee District is before the House for consideration. The motion was seconded by Dr. W. M. Kaldem, Arkansas.

On vote, the motion to postpone definitely was adopted.

Later in the session Dr. Devine's motion that Resolution 116RC be substituted for Resolution 116 was adopted.

Dr. Devine moved the adoption of Resolution 116RC and the motion was seconded.

On vote, the following resolution (Resolution 116RC) was adopted:

116H-1976. Resolved, that the *Proposal of the Committee on Advance Plan-*

ning on Structure of American Dental Association Agencies be referred to the Board of Trustees for report back to the 1977 House of Delegates, and be it further

Resolved, that a separate reference committee of the House be established to consider this *Proposal.*

Dr. Mark A. Price presented the following resolution (Resolution 183) from the Twelfth Trustee District and moved its adoption, and the motion was seconded by Dr. Fred J. Ackel, Florida: (For final disposition see p. 830.)

183. **Resolved,** that Chapter VIII, Appointive Officers, Section 40(C), Duties, Editor, of the *Bylaws* be amended by adding after the first sentence the sentence, "The Editor shall engage all editorial employees and shall supervise and coordinate all administrative, budgetary, and editorial activities within the Editorial Department," so that the substitution will read as follows:

> **Editor.** The Editor shall be Editor-in-Chief of all journals of the Association and shall exercise full editorial control over such publications, subject only to policies established by the Board of Trustees and by these *Bylaws.* The Editor shall engage all editorial employees and shall supervise and coordinate all administrative, budgetary, and editorial activities within the Editorial Department. He shall perform other duties prescribed by the Board of Trustees and these *Bylaws.*

Dr. Ackel moved to amend Resolution 183 by deleting the words "and coordinate all administrative, budgetary, and" and the motion was seconded by Dr. Price. The Speaker ruled that the amendment would be accepted as an editorial change to the resolution.

Dr. Ackel stated "This resolution concerns only a small number of the personnel of the Division of Publications, about 10 or so of the 30 employees. They are employees who are the professionals in the field of publications, such as editor, manuscript editor and associate editor; clerical help and others are not affected. Therefore, as you can see, the bottom line of this resolution is simply allowing the Editor of the ADA to employ his own professional editorial assistants. This resolution will assure freedom of the press under the broad umbrella of the ADA policy."

Dr. Charles E. Foster, Utah, stated "We are genuinely complimentary of the present Editor and the policy he has instigated in our publications. In our opinion, in the history of the ADA we have not had the quality of these publications as long as I can remember. It is our opinion, however, that we have our Association managed properly, and all of the employees of the ADA should be under one administrative policy. There cannot be the segmenting that would occur within the staff, that would happen if this resolution is passed. There should be only one ultimate administrative head of any organization regarding the policy of its employees. We feel that if you have two separate policies, you have no policy at all. We also feel that since we, as delegates, have just received the report of the Committee on Advance Planning and that the Board of Trustees received it not too much earlier, this resolution should be referred back to the Board for study to consider all of the ramifications of the complete administration of its employees in our Association."

Dr. Alex J. McKechnie, Jr., Pennsylvania, seconded the motion to refer.

Dr. Mark A. Price, Louisiana, moved to amend the motion to refer so that the Board

of Trustees would be directed to report back to the 1977 House of Delegates. Dr. Foster stated that the amendment was acceptable to him and the Speaker ruled the amendment as an editorial change to the motion.

Dr. Bruce A. Keyworth, Minnesota, spoke in favor of the motion to refer.

Dr. I. Lawrence Kerr, trustee of District 2, stated ". . . The Board of Trustees has felt, from its very beginning of discussion relating to the position of Editor and the rest of the Association, that there are these three important points. First of all, the trustees are fully in accord with the policy where the Editor is given total editorial freedom. There has never been, to my knowledge, any attempt whatsoever to interfere with the editorial processes as laid down by the Editor or those with whom he works. Secondly, we have within the past year developed a job description spelling out very clearly the responsibilities of the Editor and the people about him, as well as the rest of the people in the Association, for the best possible administration to assist him in the conduct of his department. We believe this kind of relationship is similar to that of an editor and his publisher. Thirdly, let me assure the House of Delegates upon receiving this for referral that we can fully understand those circumstances which brought this concern to your attention and we would preserve the right of the Editor to say what he says, when he says it, and how he says it. At the same time, we tell the House that we want the best possible administration so that this Association can go on to meet the challenges of the future."

President Robert B. Shira stated ". . . When you elect your trustees and officers you place faith and trust in them that they are going to supervise your affairs in the proper manner. To refer this for further study is just delaying a decision that needs to be made. If you would pass this, or if it is passed in its current state, then every other department head would want to employ the people within his staff. The Executive Director does not go out and employ these people himself. He employs upon the recommendation of the people who are responsible for certain activities of the Association. In my office as Chairman of the Committee on Salary and Tenure, we reviewed the job descriptions of the Executive Director and the Editor. We were very careful to explain to them the delineation of duties. Both of them agreed to the job descriptions as they were prepared and presented to the Board and approved by the Board. So I think it is wrong to refer this. I think you should settle it right now, defeat it, and put the trust that you should back in the hands of your Board of Trustees and officers."

Dr. Charles J. Defever, Michigan, chairman of the Council on Journalism, stated ". . . I am certainly a strong believer in freedom of the press. Upon initial reading of this proposed *Bylaws* revision, and from an editor's viewpoint, the resolution did sound interesting. Upon very close scrutiny, however, this resolution is unsound in the control aspects, and from a management viewpoint it is poor. Therefore, I would urge you to reject it."

Dr. Richard A. Shick, Michigan, called for the question and the motion was seconded. The motion to vote immediately was passed.

On vote, the motion to refer was defeated.

Dr. W. Kelley Carr, Indiana, moved to adopt Resolution 183 and the motion was seconded by Dr. Eugene J. Fortier, Jr., Louisiana.

Dr. Carr stated ". . . I have been in this arena a long time and yesterday we alluded to the manpower situation, and we can remember when we fought against the creation of 44 new dental schools in early 1960, which was the ADA policy and at that time the assurance that we received was for bricks and mortar only, and there would

be no problem of federal control over education. It is true that General Shira and every other educator in this room realizes that there is a great deal of control over education as a result of where the funds go. I see this as an effort by the Twelfth District probably to ensure the fact that the Editor of our *Journal* has indeed a free hand to conduct it exactly as he feels he should be responsible for conducting it. That may not be the attempt, but that is the way I see it. If that is the way it is, I think it is well worth the support of this House."

Dr. Fred J. Ackel, Florida, stated ". . . Unless the Editor has complete freedom in the selection of his staff, he cannot function within the realm of the free press which is necessary in order for him to put out this publication. Presently these employees are hired as provided in the *Bylaws* by the Executive Director. I have all the confidence in the world in the Executive Director, but I do not know of his knowledge in the field of publications. This is the reason that we want merely to have these ten employees taken out of that particular place in the overall administration of the office and allow the Editor to employ these ten or so employees. . . . Nothing else is changed whatsoever. All the other employees of the ADA come under the scrutiny of ADA policy. I believe it has been implied that it would create something much different, that these individuals would not be accountable to anyone. They are accountable to the same people as the other employees of the Association and in particular the Board of Trustees who, overall, have to hire the Editor."

Dr. Bruce A. Keyworth, Minnesota, moved to postpone indefinitely Resolution 183 and the motion was seconded by Dr. John W. Parler, South Carolina.

Dr. L. M. Kennedy, Texas, past president of the Association, urged indefinite postponement, stating ". . . I have great friendship and admiration for the Editor, but I think President Shira, Trustee Kerr and the gentleman from Utah, as well as others, have enunciated the principle very effectively. We do have a managing body that is perfectly capable of taking these things as their responsibility and, to me, with a $16.5 million operation, this type of thing would be fragmenting and extremely hazardous. . . ."

Dr. Joseph G. DiStasio, Massachusetts, called for the question and the motion was seconded. The motion to vote immediately was passed.

On vote, Resolution 183 was postponed indefinitely.

Committee on Advance Planning: (California Dental Association Resolution 106) The Committee reported as follows:

> The Committee reviewed Resolution 106 (p. 363) submitted by the California Dental Association requesting that the Board of Trustees of the Association report to the House of Delegates the proceedings of its Committee on Advance Planning. Since the Board has already presented this report to the House in Board Report 7, this resolution becomes moot. Therefore, the Committee recommends that it be postponed indefinitely.

The Speaker announced that Resolution 106 had been withdrawn by the California Dental Association.

REPORT OF REFERENCE COMMITTEE ON AUXILIARY UTILIZATION

The Report of the Reference Committee on Auxiliary Utilization was read by Dr. J.

Vernon Scott, California, chairman. The other members of the Committee were Drs. Robert M. Perrin, Vermont; Ignatius N. Quartararo, New York; Richard A. Shick, Michigan; Stanley Sutnick, Florida.

Statement on Expanded Function Dental Auxiliary Utilization and Education: (Council on Dental Education Resolution 24; Board of Trustees Resolution 24B; Wisconsin Dental Association Resolution 43; Fourth Trustee District Resolution 149; Fifth Trustee District Resolution 24S-2; Tenth Trustee District Resolution 24S-3; Delegate Eugene J. Fortier, Jr., Resolution 24S-1) The Committee reported as follows: (For final disposition see p. 836.)

During the Reference Committee hearing there was extensive discussion of the proposed "American Dental Association Statement on Expanded Function Dental Auxiliary Utilization and Education" (p. 234). In the discussion, comments also were addressed to the Board of Trustees amended Resolution 24B (p. 480) and the following resolutions which also call for amendment of the proposed statement: Resolution 24S-1 submitted by Delegate Eugene J. Fortier, Jr., Louisiana (p. 426), Resolution 24S-2 of the Fifth Trustee District (p. 403), Resolution 24S-3 of the Tenth Trustee District (p. 415) and Resolution 149 of the Fourth Trustee District (p. 392). In the context of the discussion on the resolutions, reference also was made to the Wisconsin Dental Association Resolution 43 (p. 390) which would require that the Council on Dental Education develop another conference on expanded functions, and the "Minority Report to the Proceedings, Workshop on Dental Auxiliary Expanded Functions" (p. 239).

The Committee deliberated the resolutions at length. In considering Resolution 43 to convene another workshop on expanded functions, the Committee agreed with opinions expressed during the hearing and with the Board that the comprehensive and thorough report provided by the Council on Dental Education presents the background required for the House to take action on the "Statement on Expanded Function Dental Auxiliary Utilization and Education." The Committee noted that the workshop was only one source of information for the Advisory Committee and Council in developing a report in response to the 1975 House of Delegates' directives.

The Advisory Committee and Council made a thorough study of all available information which bears directly on the subject of expanded function dental auxiliary utilization and education. In the Committee's view, preparation for and conduct of another workshop would seriously retard the Association's progress in this critical area and would be wasteful of resources needed to address other aspects of auxiliary utilization and education that the profession must address if it is to retain ultimate responsibility for the delivery of care by all personnel. It is essential that the Association provide additional assistance to states which have legal provisions for delegation of expanded functions and to educational institutions. Specifically, there is immediate need to direct attention to developing resource information for education and training in expanded functions for use by states in educational institutions. For these reasons the Committee believes another workshop on expanded functions should not be convened at this time.

In considering statements made during the hearing in support of adoption or amendment of the "Statement on Expanded Function Dental Auxiliary Utilization and Education," the Committee noted that, in general, the resolutions call for two major changes. One would delete condensing and carving amalgam restorations, placing and contouring silicate cement and composite resin restorations in individual teeth and administering local anesthetic agents from the lists of functions. The other would delete the entire sections on functions which could be delegated and educational requirements. The Committee believes the Advisory Committee and Council should be commended for the extent of the study, comprehensive report and statement. The Committee notes that the House directed that the Council prepare a statement on functions which should be delegated and define those functions that may require formal education for consideration at this session. The Council's decision to identify functions which *could* be delegated rather than functions which *should* be delegated to assure that the statement would not be construed as a mandate was sound. However, the Committee had concern about adopting a statement which includes lists of functions which cannot be all inclusive.

The Committee particularly had serious reservations about including a list of functions that

should not be delegated to dental assistants or dental hygienists. Although the list is qualified by the statement that it is not all inclusive, it could be interpreted as a definition of dentistry and would not present a comprehensive or accurate description of dentistry. The Committee considered adding functions to the list of those that should not be delegated but found it virtually impossible to develop a list that would include all procedures or functions. Thus, the Committee came to the conclusion that it would be inadvisable for the Association to include in the statement reference to functions which should not be delegated. This led the Committee to the conclusion that it also would be inappropriate to include the sections of the statement titled "Expanded Functions Which Could be Delegated to Dental Assistants and/or Dental Hygienists." Without that section the statement titled "Educational Requirements for Expanded Functions Which Could be Delegated to Dental Assistants and/or Dental Hygienists" would not be meaningful. Therefore, the Committee recommends that the "American Dental Association Statement on Expanded Function Dental Auxiliary Utilization and Education" be amended by deletion of lines 75 through 216.

Dr. Scott moved the adoption of the amendment and the motion was seconded.

Dr. Brodie G. Secrest, Jr., Ohio, moved to amend the amendment by deleting lines 75 and 76 and lines 104 through 216 and the motion was seconded.

Dr. Anthony F. Posteraro, New York, stated "What has happened now is that we have brought before us immediately the basic question which the reference committee struggled with, and that question has provided us, over the last day or two, with a good deal of conversation. . . . The question is whether or not it is necessary or desirable to include a thou shalt not list in the thinking of the House as we go through the report. The reference committee looked at this question and decided that it really was not only a thou shalt not list; really what was happening was that we were saying there is dentistry and auxiliaries should not be doing dentistry. We all agree on that. . . . The reference committee developed a consistent philosophy. It is early in the game now to say that this amendment has value. . . . There is no need now to have a thou shalt not list. As the report develops, you will understand that the reference committee is asking the states to manage their own problems. It is not necessary to accept this amendment and I ask you to vote against it."

Dr. William Falla, Massachusetts, spoke in favor of the amendment, stating ". . . I feel it is important to the American Dental Association to be on record as having some policy regarding the expansion of auxiliary personnel. If these recommendations of the reference committee are followed, when we leave here today we will have no policy whatsoever regarding the auxiliary personnel. The only thing we will have done is to restate the law which provides that the final decision is to be made by the State Board of Dental Examiners. That is not a policy. . . . We all know that regardless of what decisions we make here, the final decisions will still rest with the states. What concerns me is that we are talking now about national health programs, federally-funded and federally-sponsored programs such as HMOs which contain in their enabling legislation provisions that override the Dental Practice Act. I feel that we would be in a weak position in negotiating with the coming national health programs, which President-elect Carter has already gone on record as proposing, if we have no policies even on the simplest items which we feel are necessary to preserve the practice of dentistry. The list of seven items which have been added . . . are presently not allowed in any state. We would not be stepping on any state's toes by adopting these seven items. These seven items, however, address themselves to the problem of cutting a tooth structure, denturism, and a few of the other problems that face us today. I hope that we will adopt something so that at least when we leave this House we will have something with which we can go back to our own states and fight denturism and fight the filling of teeth by auxiliaries. . . ."

Dr. Jack R. Beattie, Florida, and Dr. J. L. Clines, Kentucky, spoke in favor of the amendment and speaking in opposition to the amendment were Dr. J. David Gaynor, California; Dr. Eugene J. Fortier, Jr., Louisiana; and Dr. Weston D. Brown, Washington, trustee of District 11.

Dr. Ashur G. Chavoor, District of Columbia, spoke in support of the amendment, stating "To those who say we should not define what is dentistry I ask, who, if not the American Dental Association, should define what is dentistry? The criticism of the list of seven items is that it is not complete and it is not valid. In fact it is not complete, but it is flexible. It is amendable. We have time to do that in the future or today if we so desire. The main thrust of the argument is that the state boards should be free to do what they want to do. The problem is, for instance, that the military is not governed by state boards. They rely solely on policy made by the American Dental Association and now they are left without policy lists because the policy has been abolished, and it is only by establishing these items that you can have policy. Furthermore, the reference committee states that it understands that everything, having done away with the list, abrogates its responsibility. In fact, it does abrogate its responsibility. But almost worse is that the responsibility is put on the Council on Dental Education, and the Council on Dental Education would have no policy to refer to, but would make its own policy."

Dr. Bruce A. Keyworth, Minnesota, spoke against the amendment, stating "In defining the duties of auxiliaries . . . they do not do it with a negative list. It has been indicated by the attorneys for the Board and other people that a negative list is not enforceable. . . . It is much more practical to retain lists of things that can be delegated and put a caveat at the end to the effect that anything that isn't listed is prohibited, rather than trying to define an entire list of negatives and, by inference, include things that you do not list."

Dr. Lawrence Pearson, Connecticut, spoke in favor of the amendment.

Dr. Brodie G. Secrest, Jr., Ohio, stated ". . . In Ohio the attorneys for the Ohio Dental Association and the Attorney General of the State of Ohio have jointly helped us establish a list of thou shalt nots as the best means of protecting the rules that we wish to enforce in Ohio. We have a list of thou shalts, but we have an even more thorough list of thou shalt nots."

Dr. Robert A. Probst, Pennsylvania, spoke in support of the amendment, stating ". . . I would like to remind this House that it was in this city . . . where we were given a directive to return to our respective states and change our Dental Practice Acts to enable expanded use of auxiliary personnel. Now it has been almost 11 years and the reason we are still discussing this is because we haven't drawn a line somewhere on what constitutes the practice of dentistry, and it can only be done by dentists. . . ."

Dr. Lawrence Scinto, Connecticut, called for the question and the motion was seconded. The motion to vote immediately was passed.

Dr. Anthony F. Posteraro, New York, requested a division of the House. On vote, the amendment offered by Dr. Brodie G. Secrest, Jr., Ohio, was adopted by a majority vote.

Dr. Richard A. Shick, Michigan, moved to further amend by deleting the word "prosthodontic" from line 96, item 7, and the motion was seconded by Dr. Ashur G. Chavoor, District of Columbia.

On vote, the amendment moved by Dr. Shick was adopted.

Dr. Eugene J. Fortier, Jr., Louisiana, moved to further amend by adding the following items, and the motion was seconded:

8. Intraoral restorative procedures.
9. Administering of local anesthetics.

Dr. Jacob H. Oxman, New Jersey, moved that the question be divided on items 8 and 9. On vote, the motion was defeated.

Speaking in opposition to the amendment proposed by Dr. Fortier were Dr. Jacob H. Oxman, New Jersey; Dr. J. David Gaynor, California; Dr. George W. Wood, Washington; Dr. Robert M. Perrin, Vermont.

Dr. Jacob H. Oxman, New Jersey, requested that the amendment be changed to include "general anesthesia" in item 9. The addition was accepted by Dr. Fortier.

Dr. Thomas W. Slack, Colorado, stated ". . . Many of those who have spoken have stood and talked as if what we are doing here is going to be the laws of somebody's land. I would hasten to point out to this House of Delegates that you are not a lawmaking body. You are a policymaking body. You will not interfere with the laws of any state. Therefore, why make a list at all? Let the states do what the states are going to do no matter what you do anyway."

Dr. Eugene J. Fortier, Jr., Louisiana, called for the question and the motion was seconded. The motion to vote immediately was passed.

On vote, the amendment moved by Dr. Fortier was adopted.

Dr. Anthony F. Posteraro, New York, moved to further amend by adding the words "or restorations" following the word "impressions" in item 4, and the motion was seconded.

Dr. Paul G. Hartman, Jr., Pennsylvania, spoke in opposition to the amendment.

On vote, the amendment proposed by Dr. Posteraro was defeated.

Dr. Arthur C. McFeaters, Pennsylvania, moved to further amend by adding the following item, and the motion was seconded by Dr. John L. Bomba, Pennsylvania:

10. Insertion or condensation of root canal filling materials.

Dr. Marshall M. Fortenberry, Mississippi, spoke in opposition to the amendment.

On vote, the amendment moved by Dr. McFeaters was defeated.

Dr. Harold S. Harada, California, moved to further amend by adding the words "or dispensing" after the word "prescribing" in item 3, and the motion was seconded by Dr. Theodore L. Jerrold, New York.

On vote, the amendment moved by Dr. Harada was defeated.

Dr. Jack R. Beattie, Florida, moved to reconsider item 7 and reinsert the word "prosthodontic" and the motion was seconded.

Dr. W. Kelley Carr, Indiana, and Dr. William Falla, Massachusetts, spoke in favor of the motion to reconsider.

Dr. Richard A. Shick, Michigan, spoke in opposition to the motion to reinsert the word "prosthodontic" in item 7 and Dr. Lyman E. Wagers, Kentucky, spoke in favor of the motion.

Dr. W. Kelley Carr, Indiana, called for the question and the motion was seconded. The motion to vote immediately was passed.

On vote, the motion to reinsert the word "prosthodontic" was defeated.

Dr. Scott continued with the report of the Reference Committee as follows:

> In considering the philosophy and principles section of the "Statement," the Committee noted that emphasis is given to the fact that the individual state or jurisdiction makes the final decisions on which functions may be delegated to dental assistants and/or dental hygienists, and the qualifications for the performance of those functions. Demands for dental care vary within regions and within states; and individual states have accommodated demands for dental care, when they exceed the capacity of the profession in the jurisdiction to provide care, through legal provisions for delegation of expanded functions. The Committee believes that the Association would be severely criticized by its constituents and outside groups if it took a position which would deny the rights of states to respond to demands for dental care when those demands occur. The Committee is aware that if the Association does not adopt a statement that includes identification of functions which would not be delegated to dental assistants and/or dental hygienists, and functions which could be delegated to these auxiliaries, and recommendations on educational requirements for performance of those functions, it could abrogate its responsibility to provide guidance to educational institutions and states. Therefore, the Committee reiterates a recommendation in the Special Report that the Council on Dental Education develop resource information for education and training in expanded functions for use by states and educational institutions where need exists.
>
> In its discussion of the section of the "Statement" titled "Philosophy on and Principles for Utilization and Education of Dental Auxiliaries," the Committee concurred with the Board that it is a clear and concise statement and represents the position the Association has established through adoption of policies over the past several years. Further, it is the Committee's opinion that the statement of philosophy presents a positive posture for the Association which can serve as a basis for Association activities, and testimony on this important subject. The principles reiterate positively the Association's position on delegation of functions to dental assistants and dental hygienists; and further supports the policies that individual states and ultimately the dentist make final decisions on delegation of functions, that delegation should be in compliance with legal provisions in the jurisdiction and that supervision by the dentist should be specified in provisions for delegation of functions. The Committee agrees with the Board of Trustees' recommended amendments of the philosophy and principles. Additionally, the Committee agrees with the Fifth Trustee District that one further amendment of the substitute sentence for lines 13 through 18 is necessary to more accurately reflect the factual information on the effect of utilizing expanded function auxiliaries. It has not been demonstrated conclusively that assigning expanded functions will increase availability of services at a reasonable cost. Therefore, the Committee is recommending that "should" be substituted for "will" prior to "increase," and that "continuing" be inserted before "reasonable" in the substitute sentence for lines 13 through 18. The amended substitute sentence to read:
>
> > The purpose of delegating expanded functions to dental auxiliaries is to improve the productivity of the dentist by assigning those functions which should increase the availability of services at a continuing reasonable cost with assurances of quality control.

Dr. Scott moved the adoption of the amendment and the motion was seconded.

Dr. Richard W. Shick, Michigan, moved to further amend by removing the words "improve the" and inserting therefor the words "increase the potential for." The motion was seconded by Dr. Mark A. Price, Louisiana.

On vote, the amendment moved by Dr. Shick was defeated.

On vote, the amendment moved by Dr. Scott was adopted.

Dr. Scott continued with the report of the Reference Committee as follows:

> The Committee recommends that the following resolution be substituted for Resolutions 24, 24B, 43, 149, 24S-2, 24S-3 and 24S-1.

24RC. Resolved, that the American Dental Association Statement on Expanded Function Dental Auxiliary Utilization and Education as amended be adopted.

Dr. Scott moved the adoption of the amendment and the motion was seconded. On vote, the motion was adopted.

Dr. Scott moved that Resolution 24RC be substituted for Resolutions 24, 24B, 43, 149, 24S-1, 24S-2, and 24S-3 and that the amended substitute resolution be adopted, and the motion was seconded.

On vote, the following resolution (Resolution 24RC) was adopted:

24H-1976. Resolved, that the American Dental Association Statement on Expanded Function Dental Auxiliary Utilization and Education as amended be adopted.

Complete Utilization of Dentists in Treatment of Patients: (District of Columbia Dental Society Resolution 33; Board of Trustees Resolution 33B) The Committee reported as follows:

The Committee considered Resolution 33 (p. 367) and the Board amendment to the resolution (p. 488). The Committee agrees with the Board amendment for clarification of the intent of the resolution and recommends that Resolution 33B be adopted.

Dr. Scott moved the adoption of the amendment and the motion was seconded. On vote, the amendment was adopted.

Dr. Scott moved the adoption of the amended resolution (Resolution 33B) and the motion was seconded.

On vote, the following resolution (Resolution 33B) was adopted:

33H-1976. Resolved, that the American Dental Association urges and endorses the fullest utilization of dentists, before delegation of expanded functions to auxiliaries in the treatment of patients.

Recess: The House of Delegates recessed at 12:05 p.m.

Call to Order: The third meeting of the House of Delegates was called to order at 1:20 p.m. by the Speaker of the House of Delegates.

Dr. Scott resumed the reading of the Report of the Reference Committee on Auxiliary Utilization.

Termination of TEAM Programs: (The Dental Society of the State of New York Resolution 36; Board of Trustees Resolutions 36aB and 36bB; Fifth Trustee District Resolutions 36(aB)S-1 and 36(bB)S-1) The Committee reported as follows:

The Committee considered Resolution 36 (p. 380), the Board of Trustees substitute Resolution 36aB (p. 494) and the Board of Trustees substitute Resolution 36bB (p. 494) as well as the Fifth Trustee District substitute Resolution 36(aB)S-1 (p. 405) and the Fifth Trustee District substitute Resolution 36(bB)S-1 (p. 406).

The Committee considered carefully all of the ramifications associated with establishing an Association policy which would preclude federal funding for support of programs designed to provide instruction to students in the management of multiple auxiliary personnel. The

Committee wishes to reiterate the Board's comment included in the Board Report 2 (p. 493) which specified that TEAM programs are oriented exclusively to the training of dental students in the effective management of expanded function auxiliaries. Further, the Committee wishes to point out that the number of auxiliaries trained to perform expanded functions is limited to the needs of the individual program and not designed to train auxiliaries for the workforce. The Committee is supportive of the TEAM program concept, but is concerned with the conflict that has developed between educational institutions, organized dentistry and state boards of dentistry. Basically, the Committee relates the conflict to progams which permit auxiliaries to perform functions illegal in the state.

The Reference Committee believes it is in the best interest of the federal government in its responsibility for expending public funds to foster the concept of management of expanded function auxiliaries in full cooperation with the profession to insure that the graduate dentist can take full advantage of this educational experience in private practice.

Since the Committee believes dental education programs have an obligation to provide quality education and since the clear direction of the profession is toward the greater utilization of auxiliaries, it is considered important that the federal government work in concert with the profession in providing a TEAM experience acceptable to all.

For these reasons, the Reference Committee recommends adoption of the following substitute resolution for Resolutions 36, 36aB, 36bB, 36(aB)S-1, and 36(bB)S-1.

> 36RC. Resolved, that the American Dental Association strongly urges those federal agencies responsible for management of TEAM program grant funds to cooperate with individual educational institutions, state dental societies and state boards of dentistry in the development of acceptable TEAM program guidelines.

Dr. Scott moved that Resolution 36RC be substituted for Resolutions 36, 36aB, 36bB, 36(aB)S-1 and 36(bB)S-1 and the motion was seconded. On vote, the motion was adopted.

Dr. Scott moved the adoption of the substitute resolution and the motion was seconded.

On vote, the following resolution (Resolution 36RC) was adopted:

> 36H-1976. Resolved, that the American Dental Association strongly urges those federal agencies responsible for management of TEAM program grant funds to cooperate with individual educational institutions, state dental societies and state boards of dentistry in the development of acceptable TEAM program guidelines.

Continued Development of Criteria for Curriculum and Development of an Accreditation Mechanism for Expanded Functions Dental Auxiliary Education Program: (Ohio Dental Association Resolution 96) The Committee reported as follows:

> The Committee considered Resolution 96 (p. 382) in conjunction with its deliberations on the *Special Report on Dental Auxiliary Utilization and Education* (p. 208). As indicated previously the Committee agrees that the Council's guidelines for expanded functions education should be revised. However, the Committee concurs with the Board (p. 520) that adoption of Resolution 96, as worded, could create a new category of auxiliary as it calls for development of educational standards for an expanded function dental auxiliary program and that the matter requires further study before decisions can be made. Therefore, the Committee recommends that Resolution 96 be referred to the Council on Dental Education for study with the directive that a complete report be submitted to the 1978 House of Delegates.

The Speaker announced that Resolution 96 had been withdrawn by the Ohio Dental Association.

Policy on Functions of Dental Auxiliaries; Reinstatement of 1975 Resolution 861: (Washington State Dental Association Resolution 40; Wisconsin State Dental Association Resolution 107) The Committee reported as follows: (For final disposition see p. 839.)

The Committee considered Resolution 40 (p. 388) submitted by the Washington State Dental Association and Resolution 107 (p. 391) submitted by the Wisconsin Dental Association together since both of these resolutions refer to Resolution 861 (*Trans.* 1975:699) adopted by the 1975 House of Delegates.

On the basis of the extensive discussion regarding the *Special Report on Dental Auxiliary Utilization and Education* (p. 208), it became clear that the common principle involved in all of the discussion regarding auxiliary utilization was the need to provide the profession with general guidelines on the limits of delegatable functions, but to preserve the integrity of individual licensing jurisdictions to regulate the practice of dentistry within states. The Committee, in support of its position regarding that principle, modified the "Statement on Dental Auxiliary Education and Utilization" to eliminate the serial listing of functions that could be delegated. In recommending that action, the Committee believes that it is preferable to adopt Association policy in broad principles rather than providing a serial listing of functions that may or may not be delegated to dental auxiliaries. The Committee believes Association policy should offer guidance to states and should not be directive. It also believes that the listed principles in the "Statement on Dental Auxiliary Education and Utilization" as amended provide ample guidance to the individual states and licensing jurisdictions regarding utilization of auxiliaries.

In the general discussion of Resolution 40 it was brought to the Committee's attention that the last resolving clause which requires the Board of Trustees to take action to effect the intent and purpose of the resolution through appropriate legislative efforts has caused a great deal of difficulty since it has been interpreted as requiring the Board of Trustees to intervene in state policy. Therefore, the Committee recommends that Resolution 40RC be substituted for Resolution 40 and Resolution 107.

40RC. **Resolved**, that Resolution 40-1974-H, as revised by the adoption of Resolution 861 by the 1975 House of Delegates, be amended by the deletion of the following resolving clauses:

> **Resolved**, that the American Dental Association oppose the preparation of teeth, the placement, carving and contouring of dental restorations, and the injection of local anesthetics by dental auxiliaries, and be it further
> **Resolved**, that the Board of Trustees take action to effect the intent and purpose of this resolution through appropriate legislative efforts.

to make the amended resolution read:

> **Resolved**, that in the training, education, and utilization of dental auxiliaries for the purpose of assisting the dentist in providing high quality dental care through expanded functions, it shall be the policy of the American Dental Association that expanded functions shall be performed under the direct supervision of the dentist and that auxiliaries shall perform only those functions as defined in state dental practice acts for which they have had appropriate education and training, and be it further
> **Resolved**, that final decisions related to dental practice and utilization of dental auxiliaries rest with the state society and the state board of dentistry, and be it further
> **Resolved**, that the American Dental Association opposes any program, or funding of such program, of training, education, or utilization of dental auxiliaries that is not in accord with these policies.

The Speaker ruled to divide the question on the two resolving clauses.

Dr. Scott moved to delete the first resolving clause and the motion was seconded.

Dr. Douglas C. Wendt, Virginia, spoke in opposition to deleting the first resolving clause. Dr. Weston D. Brown, Washington, trustee of District 11, spoke in favor of deleting the first resolving clause.

On vote, the motion to delete the first resolving clause was adopted.

Dr. Scott moved to delete the second resolving clause and the motion was seconded.

Dr. Weston D. Brown, Washington, trustee of District 11, spoke in favor of deleting the second resolving clause.

Dr. Ashur G. Chavoor, District of Columbia, moved to amend the second resolving clause by inserting the words "through appropriate American Dental Association agencies" after the words "Board of Trustees" and the motion was seconded by Dr. James P. Kerrigan, District of Columbia.

Dr. Eugene J. Fortier, Jr., Louisiana, spoke in favor of retaining the second resolving clause with the amendment proposed by Dr. Chavoor.

On vote, the amendment moved by Dr. Chavoor was adopted.

On vote, the motion to delete the second resolving clause was adopted.

The following resolution (Resolution 40RC) was adopted:

> 40H-1976. Resolved, that Resolution 40-1974-H, as revised by the adoption of Resolution 861 by the 1975 House of Delegates, be amended by the deletion of the following resolving clauses:
>
> > Resolved, that the American Dental Association oppose the preparation of teeth, the placement, carving and contouring of dental restorations, and the injection of local anesthetics by dental auxiliaries, and be it further
> > Resolved, that the Board of Trustees take action to effect the intent and purpose of this resolution through appropriate legislative efforts.
>
> to make the amended resolution read:
>
> > Resolved, that in the training, education, and utilization of dental auxiliaries for the purpose of assisting the dentist in providing high quality dental care through expanded functions, it shall be the policy of the American Dental Association that expanded functions shall be performed under the direct supervision of the dentist and that auxiliaries shall perform only those functions as defined in state dental practice acts for which they have had appropriate education and training, and be it further
> > Resolved, that final decisions related to dental practice and utilization of dental auxiliaries rest with the state society and the state board of dentistry, and be it further
> > Resolved, that the American Dental Association opposes any program, or funding of such program, of training, education, or utilization of dental auxiliaries that is not in accord with these policies.

Terminology Used to Describe Duties Performed in the Mouth by Dental Auxiliaries; Classification System for Traditional and Non-Traditional Duties; Single Standard of Performance for Intraoral Duties: (Delegate Harry W. F. Dressel, Jr., Resolutions 104, 105 and 117) The Committee reported as follows:

The Committee considered Resolution 104 (p. 425) and Resolution 105 (p. 423) submitted by Delegate Harry W. F. Dressel, Jr., Maryland, and heard other testimony in support of change of the term "expanded functions." The Committee concurs with the Board (p. 525) that the term "expanded functions" has a specific connotation to legislators and consumers as well as members of the dental profession and that a change in terminology at this time may be inappropriate. Also, the Committee agrees that classifying functions as "traditional" and "non-traditional" might not be feasible and could complicate discussion of and documents on delegation of functions.

The Committee also heard discussion of Resolution 117 (p. 424) submitted by Delegate Dressel.

The Committee believes that, in its preparation of educational guidelines for expanded function education, the Council on Dental Education will need to review the concerns addressed in the three resolutions submitted by Delegate Dressel. Therefore, the Committee recommends that Resolutions 104, 105 and 117 be referred to the Council on Dental Education.

Dr. Scott moved that the following resolution (Resolution 104) be referred to the Council on Dental Education, and the motion was seconded:

104. **Resolved,** that whenever reference is made to those procedures which involve the use of the hands or instruments in the mouth by a dental auxiliary, the term "intraoral duties" shall be used rather than the term "extended duties" or "expanded duties."

On vote, Resolution 104 was referred to the Council on Dental Education.

Dr. Scott moved that the following resolution (Resolution 105) be referred to the Council on Dental Education, and the motion was seconded:

105. **Resolved,** that those duties which have been legally performed by the dental assistant or dental hygienist in the majority of states prior to 1970 shall be classified as "traditional duties" for the respective auxiliary having performed them, and all other duties legally allowed since that date shall be classified as "non-traditional duties" for the respective auxiliary performing them, and be it further

Resolved, that this classification shall continue until 1980 when a reclassification or update of "traditional" and "non-traditional" duties shall be made in the same manner as previously, based on the duties allowed by the majority of states at that time, and be it further

Resolved, that the Council on Dental Education shall be charged with the prompt preparation of said classification for dental assistants and dental hygienists and its publication and distribution to the membership of the American Dental Association and to dental organizations concerned.

On vote, Resolution 105 was referred to the Council on Dental Education.

Dr. Scott moved that the following resolution (Resolution 117) be referred to the Council on Dental Education, and the motion was seconded:

117. **Resolved,** that in order to assure quality patient care, the education, clinical competence and examination of any auxiliary performing a state regulated intraoral function shall be based on achieving a single standard of performance.

On vote, Resolution 117 was referred to the Council on Dental Education.

REPORT OF THE REFERENCE COMMITTEE ON DENTAL CARE PROGRAMS AND HEALTH

The Report of the Reference Committee on Dental Care Programs and Health was read by Dr. John L. Bomba, Pennsylvania, chairman. The other members of the Committee were Drs. Joseph H. Hagan, Missouri; Norbert M. Sabin, Wisconsin; William G. Schmidt, Indiana; Donald R. Yent, California.

Report of Council on Dental Care Programs: The Committee reported as follows:

> The Committee reviewed with interest the report of the Council (p. 22) and commends it for its fine work on issues of vital importance to the Association and the dental profession.

Report of Council on Dental Care Programs, Supplemental Report 1: (Council on Dental Care Programs Resolution 44; Board of Trustees Resolution 44B) The Committee reported as follows: (For final disposition see p. 842.)

> Reimbursement Mechanisms: In reviewing Supplemental Report 1 of the Council on Dental Care Programs (p. 28), Resolution 44 (p. 32) and Resolution 44B (p. 472), the Committee was mindful of the fact that any reimbursement mechanism can be subject to abuse and that honest and competent administration is of the utmost importance. While the Committee is persuaded that both the table of allowance approach and the usual, customary and reasonable fee approach have value, it believes that the analysis provided in Supplemental Report 1 and the experience of the Committee members are congruent in identifying the mechanism of the usual, customary and reasonable fee as preferable. It gives the individual dentist the most direct way of maintaining his own value judgement with respect to fees and also is the method best suited to swift adjustment in a volatile economy.
>
> The Committee, thus, would concur generally with the sentiments expressed in both Resolution 44 and Resolution 44B. However, the Committee believes that the literal emphasis placed on proper administration in the wording of Resolution 44 makes it the more pertinent of the two.
>
> Accordingly, the Committee recommends that Resolution 44B be postponed.

Dr. Bomba moved to postpone indefinitely the following resolution (Resolution 44B) and the motion was seconded:

> 44B. Resolved, that the *Standards for Dental Prepayment Programs* (revised November 1974—*Trans.* 1974:639) be amended by substituting the following standard for Standard 12.
>
> > 12. The usual, customary and reasonable fee reimbursement method is preferred but other methods, such as a table of allowance, are acceptable.

Note: Standard 12 was incorrectly identified as Standard 21 on pages 84, 88 and 165 of the *Supplement to Annual Reports and Resolutions, 1976* and on page 32 of this volume.

On vote, Resolution 44B was postponed indefinitely.

Dr. Bomba moved the adoption of Resolution 44 and the motion was seconded.

Dr. Charles G. Lewis, Texas, moved to amend Resolution 44 by inserting the words

"or usual and customary and reasonable fees" after the word "allowance" and the motion was seconded by Dr. Ernest H. Besch, Texas.

Dr. Grant A. MacLean, Illinois, spoke in favor of the amendment.

Dr. Sidney B. Francis, California, stated "I speak as a member of the Council on Dental Care Programs. We were asked a year ago to do a study on reimbursement—and a very extensive study was done and reported to you—and to come out with a recommendation. It was our recommendation, based on the findings for both the profession and those involved in third party care, that the usual, customary and reasonable fee schedule was preferable. This particular amendment actually would change that around. . . ."

Dr. W. Kelley Carr, Indiana, stated ". . . I myself do not care whether you put table of allowance first or second, but I do think the key phrase . . . is 'with proper administration,' not the fact of the UCR or not the fact of the table of allowance."

Dr. Gordon D. Marx, California, stated "I would certainly agree . . . that a proper administration is the key issue. . . . I think, however, one thing this body should keep in mind is that we have a policy that UCR is preferable, and it's preferable not so much in a self-serving way, but it is preferable inasmuch as it provides our patients a better mechanism to have greater benefit in their third party program. . . ."

Dr. Robert Murray, Michigan, stated "I would like to call attention to the very fine report that the Council presented, Supplemental Report 1, on reevaluating this problem. There were two points in there—the table approach that may protect the carrier and purchaser from that reverse experience which is done by transferring the risk to the patient being one, and second, let's keep in mind that the 1975 survey of dentists demonstrated that our dentists and our members by a very high percentage preferred the UCR method of reimbursement."

Dr. Israel Shulman, District of Columbia, stated "I would only submit that the UCR is compiled by one carrier and many times differs from the UCR utilized by another carrier without regard to the percentile used and, regrettably, this does lead to various complaints concerning various procedures."

Dr. Lawrence Scinto, Connecticut, stated "It appears to me that the intent of the resolution is a fine one. You are, however, speaking to issues over which we have no control. There is no method for evaluating what is proper administration. Until those guidelines have been brought down, we are speaking to a rather self-serving resolution. Whether you have a table of allowances or usual, reasonable and customary as a method of reimbursement for dental services provided, the subject of the proper administration is really in the purview of the administrator and not in the providers of services."

On vote, the amendment moved by Dr. Lewis was defeated.

On vote, the following resolution (Resolution 44) was adopted:

> 44H-1976. Resolved, that the *Standards for Dental Prepayment Programs* (revised November 1974—*Trans.* 1974:639) be amended by substituting the following standard for Standard 12:
>
> > 12. The properly administered usual, customary and reasonable fee reimbursement method is preferred. However, with proper administration, various methods of reimbursement, such as a table of allowance, are acceptable.

Report of Council on Dental Care Programs, Supplemental Report 2: (Indiana Dental Association Resolution 110; Board of Trustees Resolutions 75, 110aB and 110bB; Fifth Trustee District Resolution 110(bB)S-1; Reference Committee Resolution 177) The Committee reported as follows:

Delta Dental Plans: In reviewing the Supplemental Report 2 of the Council on Dental Care Programs (p. 32), directed by the 1975 House of Delegates (*Trans.* 1975:664), the Committee was impressed with the report and the obvious intent of the Council to meet fully the mandate of the House.

During its hearing, the Committee received a substantial number of comments about the report and comments on the intent of Resolution 110 of the Indiana Dental Association (p. 372) which asks the House of Delegates to reject the report.

The Committee is not persuaded that the report, useful in such great degree, should be rejected. The Committee is, however, deeply concerned about the intense depth of feeling that remains with respect to the relationship between the American Dental Association and the Delta Dental Plans Association. The Committee considers these feelings to be sincere and believes that attention must be given to them.

It is clear, for example, that a significant concern exists that the format of the report is not such as to permit reflection of the critical comments about both Delta itself and the relationship between it and the Association. There was no attention in the report to the propriety of the Association's substantial stock holding in the Delta affiliate, the Dental Service Plans Insurance Company (DSPIC). There was no comment by the Council regarding the repayment by Delta Dental Plans of the loans received from the Association. Additionally, sentiments were expressed regarding the ability not only of constituent societies, but of individual dentists to have their views fully reflected in the deliberations of the state dental service corporations.

In the Committee's view, the report cannot necessarily be faulted for not being all encompassing since the terms of the directive of the 1975 House of Delegates were focused and specific.

But the Committee cannot in conscience allow the opportunity to pass to urge the Association and this House of Delegates to continue to make all efforts to work toward enhanced unity of the profession by taking definite steps to provide a forum where these unresolved concerns can be closely addressed.

It is with these convictions that the Committee is recommending disposition of the various related resolutions assigned to it.

With respect to Resolution 75 of the Board of Trustees (p. 473), the Committee recommends that it be approved with an amendment deleting the words "public and" from it. The Committee believes that the nature of the report and of the related considerations refer to Delta and the profession and that deletion of this phrase will make that fact clearer than it would otherwise be. The amended resolution would then read:

> 75RC. Resolved, that Delta Dental Plans be urged to expand and improve its program of professional relations, the intent of which should be the establishment of thorough and consistent communications between the Delta plan and the members of the profession.

Dr. Bomba moved the adoption of the amendment and the motion was seconded. On vote, the amendment was adopted.

Dr. Bomba moved the adoption of the amended resolution (Resolution 75RC) and the motion was seconded.

On vote, the following resolution (Resolution 75RC) was adopted:

> 75H-1976. Resolved, that Delta Dental Plans be urged to expand and improve its program of professional relations, the intent of which should be the establishment of thorough and consistent communications between the Delta plan and the members of the profession.

The report of the Reference Committee continued as follows:

> With respect to Resolution 110, the Committee is in agreement with the Board of Trustees (p. 517) that it is better dealt with by being divided since it clearly deals with two separate matters.
>
> In accordance with the comments already made, the Committee would recommend that Resolution 110aB be postponed indefinitely.

Dr. Bomba moved to postpone indefinitely Resolution 110aB and the motion was seconded.

On vote, the following resolution (Resolution 110aB) was postponed indefinitely:

> 110aB. **Resolved**, that the Council on Dental Care Programs Supplemental Report 2 not be accepted.

The report of the Reference Committee continued as follows:

> With respect to the second and third resolving clauses of Resolution 110, the Committee concurs with the Board of Trustees that its substitute Resolution 110bB (p. 518) better expresses the action expected as well as taking note of the fact that activity is already under way. Accordingly, the Committee recommends that Resolution 110bB be substituted for the second and third resolving clauses of Resolution 110 and that the substitute resolution be approved.

Dr. Bomba moved the adoption of the substitute resolution (Resolution 110bB) and the motion was seconded.

Dr. Jack R. Beattie, Florida, moved to amend Resolution 110bB by substituting the word "consider" for the words "arrange for" in the first line (Resolution 110(bB) S-1) and the motion was seconded by Dr. Robert W. Williams, Florida.

Dr. W. Kelley Carr, Indiana, and Dr. Lawrence Scinto, Connecticut, spoke in opposition to the amendment.

On vote, the amendment to Resolution 110bB (Resolution 110(bB)S-1) was defeated.

On vote, the following resolution (Resolution 110bB) was adopted:

> 110(b)H-1976. **Resolved**, that the Board of Trustees arrange for a study of potential antitrust questions involved in the relationship between the American Dental Association and Delta Dental Plans Association and report to the 1977 House of Delegates.

The report of the Reference Committee continued as follows:

> Finally, the Committee feels impelled to initiate a further resolution in recognition of the feelings expressed during the hearing and, indeed, the feelings felt by the members of the Committee themselves. The Committee believes it imperative that every possible step be taken to give each member of this Association the assurance that his voice is heard and his concerns addressed. It is confident that the Association and all of its agencies join it in this resolve. Accordingly, the Committee offers the following resolution as a mechanism whereby continuing attention can be given to the matters related to this question.
>
> 177. **Resolved**, that the Council on Dental Care Programs be requested to send to each constituent society this resolution together with its report to the 1976 House of Delegates on the relationship between Delta Dental Plans Association and the American Dental Association, and be it further

Resolved, that each constituent society be invited to direct to the Council's attention all remaining concerns it may have with respect to this relationship that, in the view of that constituent society, have not been solved, and be it further

Resolved, that the Council give high priority to working with such societies on the resolution of these concerns and report to the 1977 House of Delegates.

Dr. Bomba moved the adoption of Resolution 177 and the motion was seconded.

Dr. Robert Murray, moved to amend Resolution 177 by adding the following first resolving clause:

Resolved, that the Council on Dental Care Programs Supplemental Report 2 be accepted, and be it further

The motion was seconded by Dr. Gerald A. Larson, Wisconsin.

On vote, the amendment proposed by Dr. Murray was adopted.

A motion was made and seconded to reconsider the amendment to Resolution 177.

On vote, the motion to reconsider was adopted.

Dr. Emil W. Lentchner, New York, moved to amend the amendment by substituting the word "received" for the word "accepted" and the motion was seconded by Dr. Eugene J. Truono, Delaware.

On vote, the amendment proposed by Dr. Lentchner was adopted.

On vote, the following resolution (Resolution 177 as amended) was adopted:

177H-1976. Resolved, that the Council on Dental Care Programs Supplemental Report 2 be received, and be it further

Resolved, that the Council on Dental Care Programs be requested to send to each constituent society this resolution together with its report to the 1976 House of Delegates on the relationship between Delta Dental Plans Association and the American Dental Association, and be it further

Resolved, that each constituent society be invited to direct to the Council's attention all remaining concerns it may have with respect to this relationship that, in the view of that constituent society, have not been solved, and be it further

Resolved, that the Council give high priority to working with such societies on the resolution of these concerns and report to the 1977 House of Delegates.

Report of Council on Dental Care Programs, Supplemental Report 3: (The Dental Society of the State of New York Resolution 35; Indiana Dental Association Resolution 46-1975; Ninth Trustee District Resolution 35S-1) The Committee reported as follows: (For final disposition see p. 847.)

Fee Reimbursement Differences: The Committee considered at length Supplemental Report 3 of the Council on Dental Care Programs (p. 57), carried out as a result of referral of a 1975 House Resolution (*Trans.* 1975:656). Because of the similarity of subject matter, the Committee considered, in conjunction with these matters, Resolution 35 of The Dental Society of the State of New York (p. 379).

The Committee believes that there can be a justifiable differential in fee reimbursements in recognition of the varied responsibilities that are assumed by the participating dentist by virtue of his contractual agreement. Thus, the Committee would not concur in a resolution that would flatly oppose any such differential. The Committee, consequently, would not recommend approval of either 1975 House Resolution 46 or Resolution 35.

The Committee does, however, join in the concern of the Council over differentials that are such as to exert economic pressure on the patient or the dentist. In general, the Committee believes that concerned efforts should be made to avoid such differentials where possible. With these considerations in view, the Committee offers a substitute resolution for 1975 House Resolution 46 and Resolution 35.

35RC. **Resolved**, that differentials in fee reimbursement be avoided whenever possible, and be it further
Resolved, that when such differential does exist, that it not be of such magnitude as to result in economic coercion.

Dr. Bomba moved to substitute Resolution 35RC for Resolutions 35 and 46-1975 and the motion was seconded.

Dr. Norman P. Tanz, New York, spoke in opposition to the substitution, stating ". . . The Council on Dental Care Programs in its report did accept the concept of a small differential in payment between participating and non-participating dentists and various third party payers. This is as much as to say that a little bit of inequity we can accept; a lot, we don't want. I think that if this Association is to stand in face of the public in a day of consumerism and talk for the benefit of our patients, we must not stand for any type and any amount of inequity. When one patient is reimbursed less in the same plan than another because the dentist belonged or did not belong as a participating dentist, because of a contractual relationship, then we have backed situations that are incorrect. . . . If the question arises that we need an economic differential to justify a man's having a contractual relationship with a third party, then I submit to you that he gets into disadvantages; first, by being listed so that his name is on the list; and, secondly, because he gets direct payment. . . . I move that this House oppose the substitution of this resolution and that we return to the original Resolution 35 as proposed by New York."

Dr. David B. McClure, Indiana, and Dr. Harry T. Sweeney, New York, spoke in opposition to the substitution.

Dr. Israel Shulman, District of Columbia, spoke in favor of the substitution, stating "It seems to me that the New York resolution is aimed at destroying the Delta Plan concept. I submit that the participating dentists, while they may have a certain economic advantage, also have a disadvantage in that they must accept a service benefit as total payment, whereas the non-participating dentist can accept whatever he is allowed. And, in addition, he can charge his patients whatever he cares to charge his patients. . . . The participating dentist trades off one thing for another, a small economic advantage for further responsibility. I believe that the reference committee has acted with the wisdom of Solomon in that it asks that differentials in fee reimbursement be avoided whenever possible, and yet it resolves that when such differential does exist, it not be of such magnitude to result in economic coercion."

Dr. Lawrence Scinto, Connecticut, called for the question and the motion was seconded. The motion to vote immediately was passed.

The Speaker asked for a division of the House on the question. On vote, the motion to substitute Resolution 35RC for Resolutions 35 and 46-1975 was adopted by a vote of 212 to 186.

Dr. Bomba moved the adoption of the substitute resolution (Resolution 35RC) and the motion was seconded.

Dr. W. Kelley Carr, Indiana, moved to amend the substitute resolution by adding the following third resolving clause:

Resolved, that the Council on Dental Care Programs determine on what level of differential payment economic coercion occurs.

The motion was seconded by Dr. Charles M. Kouri, Oklahoma.

On vote, the amendment proposed by Dr. Carr was defeated.

Dr. Robert Murray, Michigan, moved to substitute the following resolution for Resolution 35RC:

35S-1. Resolved, that there can be a justifiable differential in fee reimbursements in recognition of the valid responsibilities that are assumed by the participating dentist by virtue of his contractual agreement, and be it further
Resolved, that fee differentials be avoided whenever possible, and be it further
Resolved, that when such differential does exist, wherever possible it not be of such magnitude as to result in economic leverage on the dentist or on the patient's freedom of choice.

The motion was seconded by Dr. Louis V. Fourie, Illinois.

Dr. Gordon D. Marx, California, and Dr. Jack W. Gottschalk, Ohio, spoke in favor of the substitute proposed by Dr. Murray.

Speaking in opposition to the substitute proposed by Dr. Murray were Drs. W. Kelley Carr, Indiana; Lincoln L. Riley, California; Norman P. Tanz, New York; C. Robert Ricci, Indiana; Philip Barbell, New Jersey.

Dr. Israel Shulman, District of Columbia, called for the question and the motion was seconded. The motion to vote immediately was passed.

On vote, the substitute proposed by Dr. Murray (Resolution 35S-1) was defeated.

On vote, the following resolution (Resolution 35RC) was adopted:

35H-1976. Resolved, that differentials in fee reimbursement be avoided whenever possible, and be it further
Resolved, that when such differential does exist, that it not be of such magnitude as to result in economic coercion.

Report of Council on Dental Care Programs, Supplemental Report 4 and Supplemental Report 6: (Board of Trustees Resolution 126) The Committee reported as follows:

Diverse Policies: The Reference Committee reviewed Supplemental Reports 4 and 6 of the Council on Dental Care Programs (p. 60 and p. 76), both concerning diverse prepayment policies, and Resolution 126 of the Board of Trustees (p. 514).

The Committee joins with the Board in commending the Council for its efforts to carry out the directive from the 1975 House of Delegates. The Committee understands that the Council will continue to study this general area, utilizing existing resources of the Association, and is confident that the Council will gather all the information necessary for it to give proper attention to the matter.

While the Committee is in general agreement with Resolution 126 of the Board of Trustees, it would recommend one amendment by deleting the final phrase "without the use of a special purpose survey" and a second by the phrase "continue as necessary" for "pursue." Though the Committee does itself believe that, at this point in time, such a survey is not necessarily essential, it is reluctant in principle to propose assigning a project to an agency while, at the same time, precluding it from utilizing approaches that it may deem necessary in carrying out its responsibilities. The amended resolution would then read:

126RC. Resolved, that the Council on Dental Care Programs continue as necessary a study of the effect of diverse policies relating to prepayment on dentists' practices through normal administrative channels.

Dr. Bomba moved the adoption of the amendment and the motion was seconded.

On vote, the amendment was adopted.

Dr. Bomba moved the adoption of the amended resolution and the motion was seconded.

Dr. Emil W. Lentchner, New York, moved to amend the amended resolution by deleting the words "through normal administrative channels" and the motion was seconded by Dr. Robert T. Maberry, Texas.

On vote, the amendment proposed by Dr. Lentchner was adopted.

On vote, the following resolution (Resolution 126RC as amended) was adopted:

126H-1976. Resolved, that the Council on Dental Care Programs continue as necessary a study of the effect of diverse policies relating to prepayment on dentists' practices.

Report of Council on Dental Care Programs, Supplemental Report 5: The Committee reported as follows:

Fourth Party Closed Panel Programs: The Committee believes that the Council on Dental Care Programs is to be congratulated for its thorough status report on fourth party closed panel programs (p. 70) and records the fact that the report was the subject of favorable notice during the hearing. The Committee notes that the report makes clear that the Council will continue to monitor and take appropriate action on this vital area of concern to the profession.

Report of Council on Dental Health: (Council on Dental Health Resolutions 5 and 6; Board of Trustees Resolution 5B) The Committee reported as follows:

Annual Report: The Committee was pleased to review the work of the Council during the past year, taking special note of the activities related to health planning and preventive dentistry (p. 106). The Committee wishes to commend Dr. James A. Catchings of Michigan, retiring Council member, for his dedicated services to the Council and the Association.

"Suggestions for Dentists on Participating in the National High Blood Pressure Education and Screening Program": The Reference Committee considered Resolution 5 (p. 114) as presented by the Council on Dental Health in response to the 1974 House of Delegates' directive (*Trans.* 1974:643) and the 1975 House of Delegates' directive for revision (*Trans.* 1975:676). The Committee concurs with the Board of Trustees' recommendation to change item 2 (p. 480) of the revised *Suggestions,* making it clear that it is "in-service" training that is being discussed, especially with respect to dentists, and to focus on the local chapters of the American Heart Association or other recognized authorities as a source for consultation. The amended item 2 would then read:

2. Dentists and dental auxiliaries desiring in-service training in the technique of taking blood pressure should consult with local chapters of the American Heart Association or other recognized authorities.

Dr. Bomba moved the adoption of the amendment and the motion was seconded.

On vote, the amendment was adopted.

Dr. Bomba moved the adoption of the amended resolution and the motion was seconded.

On vote, the following amended resolution (Resolution 5B) was adopted:

5H-1976. Resolved, that the *Suggestions for Dentists on Participating in the National High Blood Pressure Education and Screening Program* be approved as amended.

The report of the Reference Committee continued as follows:

"Statement on National Health Service Corps": The Committee is in general agreement with the *Statement on National Health Service Corps* (p. 115) and with Resolution 6 (p. 114) which calls for the approval of the *Statement*. However, the Committee believes the *Statement* could be improved with the addition of the following introductory paragraph which is in conformance with existing policy (*Trans.* 1974:695; *Trans.* 1971:500).

> The current American Dental Association policy on dentally underserved areas includes recommending economic incentives for dentists to enter underserved areas as private practitioners.

Additionally, the Committee recommends amending the first sentence of the proposed *Statement* by deleting the word "supports" and substituting therefor the word "recognizes"; by deleting the phrase "a mechanism" and substituting therefor the phrase "one method"; and by adding the following sentence to the end of the first paragraph of the proposed *Statement:* "All National Health Service Corps dentists, at their earliest opportunity, should comply with licensure requirements and Board rules of the state in which they are assigned to practice dentistry." The amended *Statement* is to now read:

> The current American Dental Association policy on dentally underserved areas includes recommending economic incentives for dentists to enter underserved areas as private practitioners.
>
> The American Dental Association recognizes the concept of the National Health Service Corps as one method for making dental services available in areas without sufficient dental manpower and where additional private practitioners are not available. Accordingly, the Association believes that dentist placements should be assigned to areas where a need has been clearly identified and has been approved by the state and local dental societies. National Health Service Corps dentists, at their earliest opportunity, should comply with licensure requirements and Board rules of the state in which they are assigned to practice dentistry.
>
> To be in a position to assist in this appropriate implementation of the National Health Service Corps, the Association calls on state and local dental societies in consultation with representatives of the Corps to identify scarcities in their purview, using guidelines available from the Council on Dental Health. State dental societies should also promptly respond, in agreement or disagreement, to listings of scarcity areas issued by federal agencies for the purpose of making National Health Service Corps placements. Scarcity areas should not be identified on solely the basis of a dentist/population ratio since this cannot take into consideration variances in dentist productivity and public demand for care. Assessment of dental manpower should also be based on customary trade areas, crossing state boundaries if necessary, rather than on separate communities.
>
> The Association recommends that National Health Service Corps dental offices should be operated as closely as possible to a private practice fee-for-service basis to foster a transition to private practice and to encourage the Corps dentist to remain as a private practitioner. It is recognized that some of the Corps practitioners in these critical shortage areas will become self-sufficient while other areas can never financially support a practitioner and other funding provisions may be necessary for patients seeking dental care.
>
> National Health Service Corps sponsoring agencies in the community should make periodic evaluations of the Corps practice. They should be encouraged to call upon the local dental society for consultation and cooperation.

Dr. Bomba moved the adoption of the following resolution, and the motion was seconded.

> 6RC. Resolved, that the *Statement on National Health Service Corps,* as amended, be approved.

Dr. W. Kelley Carr, Indiana, moved to amend the *Statement* by substituting the words "a temporary" for the word "one" in the second line of the second paragraph, and the motion was seconded by Dr. David B. McClure, Indiana.

On vote, the amendment proposed by Dr. Carr was adopted.

On vote, the following resolution (Resolution 6RC as amended) was adopted:

> 6H-1976. Resolved, that the *Statement on National Health Service Corps,* as amended, be approved.

Joint Report of Councils on Dental Care Programs and Dental Health on Cosmetic Dentistry: (Board of Trustees Resolution 76) The Committee reported as follows:

> The Reference Committee carefully reviewed Board of Trustees' Resolution 76 (p. 474) which defined cosmetic dentistry in response to a directive from the 1975 House of Delegates (*Trans.* 1975:683), noting that it directs that all parties involved in dental prepayment receive the definition and that it be incorporated into the Council on Dental Care Programs' Glossary of Dental Prepayment Terms.
>
> The Committee agrees with the intent of the Board's resolution, but concluded that the definition is too vague and could lead to misinterpretations, especially with respect to "pathologic conditions."
>
> The Committee commends the Councils on Dental Care Programs and Dental Health for their continued and determined efforts. Recognizing that this issue of defining cosmetic dentistry has been an ongoing project for the past several years, the Committee considered the total efforts and feels that an earlier definition by the Council on Dental Health (p. 108) would be more useful and recommends this definition as a substitute resolution for adoption.
>
> > 76RC. Resolved, that cosmetic dentistry be defined as encompassing those services provided by dentists solely for the purpose of improving the appearance when form and function are satisfactory and no pathologic conditions exist.

Dr. Bomba moved to substitute Resolution 76RC for Resolution 76 and the motion was seconded.

On vote, the motion to substitute was adopted.

Dr. Bomba moved the adoption of the substitute resolution and the motion was seconded.

On vote, the following resolution (Resolution 76RC) was adopted:

> 76H-1976. Resolved, that cosmetic dentistry be defined as encompassing those services provided by dentists solely for the purpose of improving the appearance when form and function are satisfactory and no pathologic conditions exist.

Report of Bureau of Economic Research and Statistics, Supplemental Report 1: The Committee reported as follows:

> Price Index of Cost of Conducting a Dental Practice: The Reference Committee reviewed the report on the cost of conducting a dental practice (p. 284) and noted the significant con-

tribution of this economic analysis by the Bureau of Economic Research and Statistics. The Committee anticipates continuing efforts in this field of research by the Bureau.

Report of Bureau of Economic Research and Statistics, Supplemental Report 2: The Committee reported as follows:

Effect on Dental Distribution of Total Reciprocity: The Reference Committee considered the comprehensive report on the effect of total reciprocity on dental distribution (p. 299), called for by the 1975 House of Delegates (*Trans.* 1975:674). The Committee concurs with the Board of Trustees' comment that the complexity of factors affecting mobility of dentists makes it impossible to project future trends with certainty.

Report of Delta Dental Plans Association: The Committee reported as follows:

The Committee reviewed with care the annual report of the Delta Dental Plans Association (p. 349). The Committee is concerned over the matters discussed within the report relative to "Enforcement of Membership Standards" and urges Delta Dental Plans Association to make every effort to resolve the matter in a manner that will assure necessary uniformity without undue rigidity at the national level.

While fully recognizing the independent status of Delta Dental Plans, the Committee would anticipate the willingness of agencies of the American Dental Association to assist in the resolution of the difficulties noted in any appropriate way, where such assistance is requested.

Amendment of American Dental Association "Standards for Dental Prepayment Programs": (Arkansas State Dental Association Resolution 54) The Committee reported as follows:

The Committee reviewed Resolution 54 (p. 361) from the Arkansas State Dental Association to amend Standard 9 of the American Dental Association *Standards for Dental Prepayment Programs* (*Trans.* 1974:639). The Reference Committee recognizes the complexity and seriousness of the issue and agrees with the Board of Trustees' comments (p. 487) that further study by the Council on Dental Care Programs is necessary. Therefore, the Reference Committee recommends that Resolution 54 be referred to the Council on Dental Care Programs for study and report back in 1977 to the House of Delegates.

Dr. Bomba moved to refer Resolution 54 to the Council on Dental Care Programs for study and report back to the 1977 House of Delegates, and the motion was seconded.

Dr. W. M. Kaldem, Arkansas, spoke in opposition to the motion to refer, stating "This is truly a serious problem in the State of Arkansas. Patients with the same dentist receive a greater reimbursement than do the patients on the other side from the third party. Thus, he is, as a result of economic pressure, being forced to give additional benefits. The General Assembly of the Arkansas State Dental Association felt strongly enough about this issue to formulate the resolution that was submitted for your consideration. We feel the policy and sentiment of this House is in sympathy with our cause and our patients. Therefore, when the time comes to negotiate with the third party, we would like to have this resolution as part of ADA policy. . . ."

Dr. Eugene J. Truono, Delaware, stated "I am a member of the Council on Dental Care Programs and we are already in the process of attempting something in this particular area. . . ."

Dr. Charles M. Kouri, Oklahoma, spoke in opposition to the motion to refer. Speaking in favor of the motion to refer were Drs. Emil Lentchner, New York; James P. Kerrigan, District of Columbia; Donald R. Yent, California.

Dr. Anthony F. Posteraro, New York, called for the question and the motion was seconded. The motion to vote immediately was passed.

On vote, the following resolution (Resolution 54) was referred to the Council on Dental Care Programs for study and report back to the 1977 House of Delegates:

> 54. **Resolved,** that Standard 9 of the American Dental Association *Standards for Dental Prepayment Programs* be amended by the addition of the following at the end of the first sentence:
>
> > Schedules of benefits shall be as uniform as possible, particularly within a state, avoiding differences in scheduled benefits based on geographical areas within a state.

Study of the Dentist in All His Relationships: (Florida Dental Association Resolution 45) The Committee reported as follows:

> The Reference Committee reviewed the proposal for a feasibility study for conducting research on the dentist in all his relationships (p. 368). While clearly a thoughtful and worthwhile proposal, the costs associated with funding such a complex feasibility study would clearly be substantial. The Committee noted that potential funding sources may become identified as the Association pursues current activities in related areas and is hopeful that such funding would eventuate.
>
> The Committee regretfully concurs with the Board, however, that the project is simply not financially practical at this time (p. 488). Therefore, the Committee recommends that Resolution 45 be postponed indefinitely.

Dr. Bomba moved to postpone indefinitely Resolution 45 and the motion was seconded.

Dr. Stanley Sutnick, Florida, stated "Resolution 45 asks for a sociological, medical, behavioral, thermographic, and environmental research project to investigate suicide, divorce, and other stresses in the life of the dentist. This study can be as meaningful to the dentist, his family, and the community as anything that the American Dental Association has ever done. At this time, the Bureau of Economic Research and Statistics has received a grant of $4,700 from the Division of Dentistry, Department of Health, Education, and Welfare to convene a meeting of expert consultants to assist in determining the real liability of data on which research of this kind is based. The group of consultants and Association representatives will meet January 13-14, 1977. A summary report will be prepared, including proceedings and summary recommendations, for future research activity of major interested organizations. This activity is to consider the status of past and current research. The Great West Life Assurance Company has been approached and has expressed an interest in possibly funding a study of this type. We have also thought of the idea of approaching some of the foundations, possibly the Ford, Mott, or the Kellogg. In light of this, I feel that the possibility of a stigma being cast on this activity by the Committee's recommendation that it be postponed indefinitely does exist. Therefore, I would like to move that Resolution 45 be referred to the Board of Trustees for report back to the House of Delegates in 1977."

The motion to refer was seconded by Dr. Virgil H. Marshall, Virginia.

On vote, the motion to refer as proposed by Dr. Sutnick was defeated.

On vote, the following resolution (Resolution 45) was postponed indefinitely:

45. Resolved, that the American Dental Association determine the feasibility of conducting a sociological, medical, behavioral and environmental study of the dentist in all his relationships.

Publication and Distribution of Fee Information: (Illinois State Dental Society Resolution 48; Board of Trustees Resolution 48B) The Committee reported as follows:

> The Reference Committee discussed at length the profession's need for valid and complete economic data in order to speak out forcefully to the public about dental costs. It is the Committee's opinion that the availability of such information is so critical to dentistry that revision of current policy is essential.
>
> The Committee noted that distribution of fee information through publication allows for appropriate interpretation of data by the profession to be presented and that publication just of summary national ranges and averages eliminates potential misuse of data by individuals with respect to particular fees of a given area or in a particular office.
>
> The Committee is pleased to observe that the reporting of costs and overhead information is carefully separated from reporting related to fees.
>
> The Committee considers that substitution of Illinois Resolution 48 (p. 370) by Board of Trustees Resolution 48B (p. 491) will best serve the needs of the profession while being in accord with legal considerations and the rightful concerns of the profession about appropriate use of the information.
>
> The Committee notes an editorial addition to the first resolving clause of Resolution 48B of the words "and 90-1972-H" in order that Resolution 48B take action on all existing policy.

Dr. Bomba moved the adoption of the substitute resolution (Resolution 48B) and the motion was seconded.

Dr. W. M. Kaldem, Arkansas, moved to delete the words "and every two years thereafter" in the third resolving clause and the motion was seconded.

Dr. Sidney R. Francis, California, stated "I am speaking as a member of the Council on Dental Care Programs. I think the issue here basically is that we need data that is reliable in our everyday work with the third party carriers, the representatives of government, and all of those interested in health delivery systems. We need accurate data. We need valuable data. We cannot live with data that is developed by the *Readers Digest* that has been done in the last year. So we ask support for giving us fee surveys so we can work with data that we know are reliable. I would like to speak against the amendment on the basis that the House has the right to stop these whenever it so desires. But why not give us a progressive method of collecting proper fee data?"

On vote, the amendment proposed by Dr. Kaldem was defeated.

Dr. Robert J. Wilson, Maryland, moved to separate the first resolving clause from the remainder of the resolution and stated "The first resolving clause has to do with the well established policy of this House of Delegates. It was instituted in 1972, and every year since that time this has come up again. Every year since that time this House has sustained that policy. . . ."

The Speaker ruled that the first resolving clause would be divided from the remaining clauses of the resolution.

Dr. Robert J. Wilson, Maryland, moved to postpone indefinitely the first resolving clause of Resolution 48B and the motion was seconded by Dr. Ashur G. Chavoor District of Columbia.

Dr. Ashur G. Chavoor, District of Columbia, stated "I would say that we have historically established publishing material in *The Journal*. . . . It is being used and was used when it was published previously by consumer groups that would bring it into your office and compare your fees. I do not see why the information cannot be handled by agencies from the ADA through constituent offices to responsible parties. This in no way would mean that people dealing in insurance or government agencies cannot get these fees. All I have asked people is that we don't make them available and drop them by helicopter all over the country."

Mr. John P. Noone, assistant executive director for business affairs and house counsel, stated "The wider that fee data is made available, the less danger that the profession is trying to hide something for its own devious ends. . . . I should not say, however, that we should go ahead and give it to people voluntarily; but if they request it and we respond by giving it to them, it indicates we have nothing to hide and, therefore, you don't have to run the risk that you do by keeping it to yourselves. . . ."

Dr. John B. Queern, Jr., New York, stated "The effect of restricting publication has been to make our membership the last to have this information. The insurance companies could get this. They have their own way of compiling their own data. But when I have tried to get this information for myself . . . I have not been able to do so. . . .I would oppose postponing this resolution indefinitely."

Dr. Richard A. Shick, Michigan, called for the question and the motion was seconded. The motion to vote immediately was passed.

On vote, the motion to postpone indefinitely the first resolving clause of Resolution 48B was defeated.

Dr. Carlton H. Williams, California, moved the adoption of the first resolving clause and the motion was seconded by Dr. William E. Schiefer, California.

On vote, the following resolution (the first resolving clause of Resolution 48B) was adopted:

> 48(a)H-1976. **Resolved**, that Resolution 60-1972-H (*Trans.* 1972:680) and Resolution 90-1972-H (*Trans.* 1972:731) adopted by the 1972 House of Delegates, concerning the conducting of fee and overhead costs surveys and restricting the publication of such data, is hereby revoked.

Dr. Bomba moved the adoption of the remaining resolving clauses in Resolution 48B and the motion was seconded.

Dr. H. M. Sorrels, Texas, stated "It seems to me that we are speaking out of both sides of our mouth when we say that it is necessary for us to have current fee surveys, and then the next person comes up and says that the older they are, the better. I would urge defeat."

On vote, the following resolution (the remaining resolving clauses of Resolution 48B) was adopted:

> 48(b)H-1976. **Resolved**, that the 1975 fee survey data collected by the Association's Bureau of Economic Research and Statistics be published for historical informational purposes only, showing national fee summary statistics for given dental procedures, as soon as feasible, in *The Journal of the American Dental Association* and thereafter be distributed to anyone on request, and be it further

Resolved, that the Association's Bureau of Economic Research and Statistics conduct fee and overhead cost surveys in 1977 and every two years thereafter, and be it further

Resolved, that the results of the overhead cost surveys be published in *The Journal of the American Dental Association* as soon as completed and thereafter be distributed to anyone on request, and be it further

Resolved, that the results of the 1977 and subsequent fee surveys be published in *The Journal of the American Dental Association* not earlier than one year after such data has been gathered for historical informational purposes only, showing only national fee summary statistics for given dental procedures, and then be distributed to anyone on request.

Amendment to "Guidelines on the Use of Radiographs": (Michigan Dental Association Resolution 111) The Committee reported as follows:

> The Reference Committee, in considering the full implications of Resolution 111 (p. 375), is sympathetic to the needs attendant upon operation of a peer review system in a timely and responsive fashion. Nonetheless, the Committee is firmly of the opinion that the rights of the individual dentist with respect to his radiographs must properly take precedence. Passage of Resolution 111 would dilute those rights in an unacceptable fashion. The Committee, thus, recommends that Resolution 111 be postponed indefinitely.

Dr. Bomba moved to postpone indefinitely Resolution 111 and the motion was seconded.

Dr. Wilbert Fletke, Michigan, moved to refer the resolution to the Council on Dental Care Programs for further study and report back to the 1977 House of Delegates. The motion was seconded by Dr. Donald Stroud, Michigan.

Dr. Emil Lentchner, New York, stated "I would hope that you would not refer this to the Council. It is clear that without the written consent of the dentist, radiographs should not be taken by anybody, including the peer review committees. They are the property of the dentist and should not be transmitted. I would hope that you would postpone this indefinitely because of the clarity of the motion. Referring it to the Council will do nothing for it."

On vote, the motion to refer as proposed by Dr. Fletke was defeated.

On vote, the following resolution (Resolution 111) was postponed indefinitely:

> 111. Resolved, that the *Guidelines on the Use of Radiographs* (*Trans.* 1974: 653) be amended by substituting the following guideline for Guideline No. 11:
>
> > 11. Radiographs furnished to a peer review committee or third party agency shall not be transmitted to any agency other than a peer review body without written consent of the dentist.

Involvement of American Dental Association Delegates with Third Party Programs: (Texas Dental Association Resolution 52) The Committee reported as follows:

> The Committee reviewed with care Resolution 52 (p. 386) and the comments on it offered by the Board of Trustees (p. 495).
>
> The Committee is in full agreement with the Board that the House of Delegates is quite capable of judging debate on its intrinsic merits without taking steps, as contemplated by Resolution 52, to limit the freedom now exercised by component and constituent societies in deciding who they wish to have representing them in the House.

Further, the Committee was informed by the Standing Committee on Constitution and By-laws that Resolution 52 raised significant administrative problems by, in effect, creating a subclassification of active membership with denial to those in the subclassification of privileges normally associated with active membership. Resolution 52, in the view of the Standing Committee, could also open the Association to legal challenge from affected members as well as others.

The overriding consideration for the Committee, however, is its faith in the House to make judgements on the arguments it hears as well as the desire of the House, manifest throughout its history, to be open to full and candid debate. The Committee recommends that Resolution 52 be postponed indefinitely.

Dr. Bomba moved to postpone indefinitely Resolution 52 and the motion was seconded.

Dr. Robert D. Londeree, Jr., Texas, moved to refer Resolution 52 to the appropriate agency for study and development of a disclosure mechanism to prevent possible conflict of interest problems and report to the 1977 House of Delegates. The motion was seconded by Dr. Burton J. Kunik, Texas.

Dr. Isidore B. Codispoti, Ohio, spoke in opposition to the motion to refer, stating ". . . All one needs to do is to recall that portion from our history books relating to the reasoning why all that tea was dumped into the waters of Boston Harbor. It does surprise me that the founders of this resolution do not realize what the resolution actually does say. To me it says this, 'You, Dr. Consultant, are a graduate D.D.S. with all the rights and privileges your license entitles you to. You are also invited to become a member of our professional organization and pay your dues, but you no longer retain the right to represent yourself or others.' To me this violates the principle that was given our historic country 200 years ago that there shall be no taxation without the right of representation."

Dr. Burton J. Kunik, Texas, stated ". . . That was a beautiful presentation. Things, however, are not that way in many legislative bodies throughout the country, and conflict of interest is a serious matter. . . . We are elected to come here to represent 120,000 dentists who pay their dues to this organization to be represented. Most of them are full time practicing dentists, and there is nothing wrong with having a bias about who is paying you and where you spend your full time. You should have a bias to that organization, that corporation, or whatever that body may be. That bias, however, should not be here reflected in you as an elected official to make policy for an organization. I think it is time we get in tune with the times and represent the people who elect us and send us here. . . ."

On vote, the motion to refer proposed by Dr. Londeree was defeated.

Dr. Jacob H. Oxman, New Jersey, stated "If we really feel as strongly as we do and stand on principle on something of this nature, why can't we just stand up and be counted and defeat something like this instead of postponing indefinitely? . . . If we, indeed, do believe that we have a righteous place, rightfully given to us, to be members of this House of Delegates and also work within third party carriers, just postponing it indefinitely is a weak position to take. I think we ought to vote it in."

On vote, the following resolution (Resolution 52) was postponed indefinitely:

52. **Resolved,** that the American Dental Association *Bylaws* be amended to provide that no member of the American Dental Association House of Delegates be a salaried employee of any third party company.

Opposition to Government Intrusion into Private Practice of Dentistry: (Second District Dental Association of Pennsylvania Resolution 130) The Committee reported as follows:

> The Reference Committee considered, and fully concurs with, the Second District Dental Association of Pennsylvania Resolution 130 (p. 391). It believes that passage of the resolution by this House of Delegates would be a timely and appropriate step. The Committee recommends adoption of this resolution.

Dr. Bomba moved the adoption of Resolution 130 and the motion was seconded.
On vote, the following resolution (Resolution 130) was adopted:

> 130H-1976. **Resolved,** that the American Dental Association is opposed to any unnecessary intrusion, either by state or federal government, into the private practice of dentistry.

Development of a Unifying Philosophy on Private Practice: (Delegate W. Kelley Carr Resolution 132) The Committee reported as follows:

> The Committee reviewed Resolution 132 (p. 421) and concluded that it should be referred to the Council on Dental Health for study and implementation. The Committee believes that particular attention should be paid to the existing definition of private practice as presented to the 1975 House of Delegates (*Trans.* 1975:680). The Committee believes it would be appropriate for the Council to review its existing comments along with the additional concepts presented in Resolution 132 and notes that the author has stated his agreement to refer the resolution to the Council on Dental Health for study and report back to the 1977 House of Delegates.

Dr. Bomba moved to refer Resolution 132 to the Council on Dental Health for study and report back to the 1977 House of Delegates, and the motion was seconded.
On vote, the following resolution (Resolution 132) was referred to the Council on Dental Health for study and report back to the 1977 House of Delegates:

> 132. **Resolved,** that the function of private practice be defined as:
>
> 1. The action taken should result in quality care.
>
> 2. The action taken should serve the public well (i.e., we should serve by providing access to care, adequate volume, and protect our opportunities to have a productive practice in order to provide an economic service to the public).
>
> and be it further
>
> **Resolved,** that the unique aspects of private practice be defined as:
>
> 1. The dentist's personal financial responsibility for his practice. There are no subsidies.
>
> 2. Economical. To date there is no other dental delivery system which produced dental care so inexpensively.
>
> 3. The freedom for the patient and the doctor to develop a treatment plan without interference from third parties.
>
> 4. The patient's freedom to choose the dentist of his choice (without economic coercion), and the dentist's freedom to accept or reject the patient.
>
> 5. Has provided direct financial incentives to the dentist.
>
> and be it further

Resolved, that these definitions be used as guidelines for our members this coming year until such a time when the House of Delegates feels additional redefinition might be desirable.

Publication of Accurate Statements Concerning Income Realized by Providers Under Public Health Programs and of Salaries of Pertinent Governmental Administrators: (Delegates Paul Evans and Lyman Wagers Resolution 159) The Committee reported as follows:

> The Committee is in unanimous accord with the intent of Resolution 159, particularly its first resolving clause relating to dentists who provide dental care under public programs (p. 425). In the view of the Committee, the release of the receipts of health professionals participating in such programs often under substantial difficulties caused by maladministration and by inequitable reimbursement—without placing of the information in full context is irresponsible.
>
> The Committee, with respect to the second resolving clause, notes that the information requested is already available to members of the public from various sources.
>
> With these thoughts in mind, the Committee proposes a substitute resolution for Resolution 159 that, in its view, fully complies with the intent of the delegates who offered the original proposal.
>
> > 159RC. Resolved, that government agencies issuing income amounts paid to dentists for services rendered under public programs be strongly urged to release such information in a clear context accompanied by such facts as the number of practitioners represented in the payment, the number of patients cared for and the fact that these payments are gross receipts from which the dentist or dentists must pay all overhead costs, and be it further
> >
> > Resolved, that the Washington Office of the Association bring this matter forcefully to the attention of all federal agencies involved in such programs.

Dr. Bomba moved to substitute Resolution 159RC for Resolution 159, and the motion was seconded.

Dr. Lyman Wagers, Kentucky, moved to amend Resolution 159RC by inserting the following resolving clause as a second resolving clause of the resolution, and the motion was seconded by Dr. P. W. Evans, Kentucky:

> Resolved, that the American Dental Association exhort governmental agencies that there is yet other expense incurred by these public dental care programs. This expense includes pro rata governmental administrative expense and pro rata overhead expense of the facilities they use. In total fairness these additional expenses must be included in releases to the news media to reflect actual cost to the public, and be it further

On vote, the amendment proposed by Dr. Wagers was adopted.

On vote, the motion to substitute Resolution 159RC, as amended, for Resolution 159 was adopted.

Dr. Bomba moved the adoption of Resolution 159RC, as amended, and the motion was seconded.

On vote, the following substitute resolution (Resolution 159RC as amended) was adopted:

> 159H-1976. Resolved, that government agencies issuing income amounts paid to dentists for services rendered under public programs be strongly urged to

release such information in a clear context accompanied by such facts as the number of practitioners represented in the payment, the number of patients cared for and the fact that these payments are gross receipts from which the dentist or dentists must pay all overhead costs, and be it further

Resolved, that the American Dental Association exhort governmental agencies that there is yet other expense incurred by these public dental care programs. This expense includes pro rata governmental administrative expense and pro rata overhead expense of the facilities they use. In total fairness these additional expenses must be included in releases to the news media to reflect actual cost to the public, and be it further

Resolved, that the Washington Office of the Association bring this matter forcefully to the attention of all federal agencies involved in such programs.

Maldistribution: (Delegate Jack W. Gottschalk Resolution 154) The Committee reported as follows:

> The Committee, in reviewing Resolution 154 (p. 428), found itself in total sympathy both with the fundamental intent of the resolution and with the sense of urgency it conveys.
>
> The Committee is aware that a number of Association activities are now under way directed toward the objectives enunciated by Resolution 154. It believes, however, that the full implementation of the resolution may go beyond the present level of activity. Because of the critical nature of the question, the Committee does not believe that analysis and action can be postponed for a year. Nevertheless, it believes that the Association needs to examine the question of what further activities may be required and the funding and personnel that might need to be supplied. In order to move forward with all possible speed and yet be in accord with sound administration, the Committee offers the following substitute resolution for Resolution 154:
>
> > 154RC. **Resolved,** that the Council on Dental Health and the Bureau of Economic Research and Statistics provide the Board of Trustees at its Spring 1977 Session a full report on current activities directed toward the study of maldistribution problems and potential solutions together with recommendations and cost estimates on further activities required, and be it further
> >
> > **Resolved,** that funding be made available as soon as feasible to implement such activities as the Board of Trustees considers essential, including development of adequate criteria to measure maldistribution and of such professionally acceptable solutions as financial incentives for dentists locating in underserved areas, and be it further
> >
> > **Resolved,** that the Association actively seek concurrence with Congress and the Department of Health, Education, and Welfare on implementation of these solutions.

Dr. Bomba moved to substitute Resolution 154RC for Resolution 154, and the motion was seconded.

Dr. George R. Koch, California, moved to amend the resolution by deleting the third resolving clause, and the motion was seconded by Dr. E. Harold Faget, Louisiana.

Dr. Arnold J. Hill, Jr., Minnesota, stated "I think we should keep the third resolving clause because we have the problems of the National Health Service Corps and the confrontation between the profession and the Corps, and we have not been able to resolve it directly with the Corps. Therefore, I think we should leave the option open for us to resolve it by going back to Congress and the Senate and seeking amendments."

On vote, the motion to delete the third resolving clause was defeated.

On vote, the motion to substitute Resolution 154RC for Resolution 154 was adopted

Dr. Bomba moved the adoption of the substitute resolution and the motion was seconded.

On vote, the following resolution (Resolution 154RC) was adopted:

> 154H-1976. **Resolved**, that the Council on Dental Health and the Bureau of Economic Research and Statistics provide the Board of Trustees at its Spring 1977 Session a full report on current activities directed toward the study of maldistribution problems and potential solutions together with recommendations and cost estimates on further activities required, and be it further
> **Resolved**, that funding be made available as soon as feasible to implement such activities as the Board of Trustees considers essential, including development of adequate criteria to measure maldistribution and of such professionally acceptable solutions as financial incentives for dentists locating in underserved areas, and be it further
> **Resolved**, that the Association actively seek concurrence with Congress and the Department of Health, Education, and Welfare on implementation of these solutions.

Training in Cardiopulmonary Resuscitation: (Delegate Ronald I. Maitland Resolution 101; Board of Trustees Resolution 101B) The Committee reported as follows:

> The Reference Committee concurs with the intent of both Resolution 101 (p. 431) and the Board of Trustees' substitute Resolution 101B (p. 528), each of which points out the need for training in cardiopulmonary resuscitation and reemphasizes previous policy (*Trans.* 1964:275).
> The Reference Committee believes, however, that Board Resolution 101B, which requests that constituent and component societies promote and provide for continuing education courses, could be further improved by including auxiliary personnel. The Reference Committee submits the following amended substitute Resolution 101RC:
>
> > 101RC. **Resolved**, that constituent and component societies be encouraged to make regularly available to their members and their auxiliary personnel continuing education in cardiopulmonary resuscitation.

Dr. Bomba moved the adoption of the amendment and the motion was seconded. On vote, the amendment was adopted.

Dr. Bomba moved the adoption of the amended substitute resolution and the motion was seconded.

On vote, the following resolution (Resolution 101RC) was adopted:

> 101H-1976. **Resolved**, that constituent and component societies be encouraged to make regularly available to their members and their auxiliary personnel continuing education in cardiopulmonary resuscitation.

Reevaluation and Redesign of the Uniform Claim Form: (Delegate Alex J. McKechnie, Jr., Resolution 89; Board of Trustees Resolution 89B) The Committee reported as follows:

> The Reference Committee considered Resolution 89 (p. 433) regarding a directive to the Council on Dental Care Programs to redesign the uniform claim form. The Committee is sympathetic to the overall intent of this resolution, but agrees with the Board of Trustees' comments on the resolution (p. 528) and notes the wide acceptance of the claim form by dentists and third parties. Therefore, the Committee recommends that the Board of Trustees Resolution 89B be substituted for Resolution 89.

Dr. Bomba moved to substitute Resolution 89B for Resolution 89, and the motion was seconded.

On vote, the motion to substitute was adopted.

Dr. Bomba moved the adoption of the substitute resolution and the motion was seconded.

On vote, the following resolution (Resolution 89B) was adopted:

> 89H-1976. Resolved, that the Council on Dental Care Programs continue to evaluate the currently approved dental claim form, while actively pursuing the goal of uniform acceptance by all third parties, and be it further
> Resolved, that the Council on Dental Care Programs provide to practicing dentists information on preprinting techniques in connection with the uniform claim form for the purpose of reducing the administrative workload in dental offices.

Use of Procedure Codes: (Delegate Alex J. McKechnie, Jr., Resolution 90) The Committee reported as follows:

> The Committee examined Resolution 90 (p. 433) regarding the use of procedure codes. The Committee concurs with the observation of the Board of Trustees (p. 528) that the intent of the Code on Dental Procedures and Nomenclature is to facilitate administration within the dental office and further notes that there is no requirement that the dentist utilize the code numbers in addition to a description. The Committee recommends that the resolution be postponed indefinitely.

Dr. Bomba moved to postpone indefinitely Resolution 90 and the motion was seconded.

Dr. Alex J. McKechnie, Jr., Pennsylvania, moved to refer Resolution 90 to the Council on Dental Care Programs for report back to the 1977 House of Delegates, and the motion was seconded by Dr. Arthur C. McFeaters, Jr., Pennsylvania.

Dr. McKechnie stated ". . . I submit to you that the procedures you use on every patient are absolutely different. These cannot be put into a little number, which will come back to haunt you when the government takes all those tapes and says that everything you do has been computerized. . . . Regardless of what they say here in the Council, you do not have to put it in. We are going to be told that all the general practitioners and other dentists are doing it. . . . I submit to you that procedure codes are dangerous. I see danger in the future and I submit that I would like this referred to the Council rather than postponed."

On vote, the following resolution (Resolution 90) was referred to the Council on Dental Care Programs for study and report back to the 1977 House of Delegates:

> 90. Resolved, that procedure codes are terms used by third party carriers for administrative purposes and, as such, are not part of the description of dental services and shall not be required on any dental form submitted for payment by a dental office.

Overproduction of Dentists: (Delegate Robert J. Wilson Resolution 146) The Committee reported as follows:

The Reference Committee shares the concern expressed in Resolution 146 (p. 434). The Committee notes that pertinent data is now being gathered and analyzed and agrees that it is imperative that the data be available for use in a timely fashion. The Committee, thus, offers the following substitute resolution in recognition of the work now being done and to emphasize the high priority that should be given to the prompt analysis and dissemination of the information.

146RC. **Resolved,** that the Board of Trustees direct the appropriate agencies of the Association to continue to develop and analyze information on the supply and productivity of dentists and disseminate such information as it becomes available, and be it further

Resolved, that the House of Delegates be kept informed of these activities by means of appropriate agency reports.

Dr. Bomba moved to substitute Resolution 146RC for Resolution 146 and the motion was seconded.

On vote, the motion to substitute was adopted.

Dr. Bomba moved the adoption of the substitute resolution (Resolution 146RC) and the motion was seconded.

Dr. Robert J. Wilson, Maryland, moved to amend the substitute resolution by inserting the words "expedite as much as humanly possible their efforts" in lieu of the word "continue" in the first resolving clause. The motion was seconded by Dr. Joe N. Price, Maryland.

On vote, the amendment proposed by Dr. Wilson was adopted.

Dr. W. Kelley Carr, Indiana, moved to further amend the substitute resolution by inserting the word "actively" before the word "disseminate" in the first resolving clause. The motion was seconded by Dr. David B. McClure, Indiana.

On vote, the amendment proposed by Dr. Carr was adopted.

On vote, the following amended substitute resolution (Resolution 146RC as amended) was adopted:

146H-1976. **Resolved,** that the Board of Trustees direct the appropriate agencies of the Association to expedite as much as humanly possible their efforts to develop and analyze information on the supply and productivity of dentists and actively disseminate such information as it becomes available, and be it further **Resolved,** that the House of Delegates be kept informed of these activities by means of appropriate agency reports.

"After Care Guidelines: Full Dentures" and "After Care Guidelines: Removable Partial Dentures": (Board of Trustees Resolution 91) The Committee reported as follows:

The Committee reviewed *After Care Guidelines: Full Dentures* and *After Care Guidelines: Removable Partial Dentures* (p. 502) as developed by the Council on Dental Health and concurs with the Board of Trustees Resolution 91 (p. 480) that would adopt the *Guidelines* as Association policy. However, the Committee believes the term "complete dentures" to be more generally acceptable than the term "full dentures" and, therefore, the Committee recommends that the heading be amended by deleting the word "Full" and substituting the word "Complete" to make the head now read *"After Care Guidelines: Complete Dentures."* Accordingly, the Committee recommends the same editorial change on line 4 of the Introduction (p. 502).

Dr. Bomba moved the adoption of the amendments and the motion was seconded.

On vote, the amendments were adopted.

Dr. Bomba moved the adoption of the amended resolution and the motion was seconded.

On vote, the following amended resolution (Resolution 91RC) was adopted:

91H-1976. Resolved, that *After Care Guidelines: Complete Dentures* and *After Care Guidelines: Removable Partial Dentures* be adopted.

Fraud and Abuse in Medicare and Medicaid: (Board of Trustees Resolution 129) The Committee reported as follows:

The Reference Committee reviewed with care Board of Trustees Resolution 129 (p. 529). The Committee concurs that such a resolution is timely. However, the Committee feels that the proposed wording does not adequately reflect the Association's longstanding opposition to any fraudulent and illegal practices regardless of the circumstances or program. Therefore, the Committee recommends that the resolution be amended to add such a statement, the amended resolution to read:

129RC. Resolved, that the American Dental Association pledges its cooperation in the elimination of fraudulent and other illegal practices occurring in the Medicare and Medicaid programs as vigorously as it opposes such practices in all instances.

Dr. Bomba moved the adoption of the amendment and the motion was seconded. On vote, the amendment was adopted.

Dr. Bomba moved the adoption of the amended resolution and the motion was seconded.

On vote, the following amended resolution (Resolution 129RC) was adopted:

129H-1976. Resolved, that the American Dental Association pledges its cooperation in the elimination of fraudulent and other illegal practices occurring in the Medicare and Medicaid programs as vigorously as it opposes such practices in all instances.

Revocation of Certain Existing Policies Respecting Third Party Dental Prepayment Programs and Related Matters: (Board of Trustees Resolutions 118, 119, 120, 121, 122, 123, 124 and 125) The Committee reported as follows:

In reviewing the actions proposed by Board Report 9's seven resolutions (p. 599) the Committee first wants to emphasize the importance it places on legal staff and outside counsel continuing to work closely with the Council on Dental Care Programs to assure that no changes in existing policy are being or will be requested beyond those legally essential.

With that understanding, the Committee acquiesces in the actions recommended by Resolutions 118 to 124, understanding that they result from a continuing review to assure that, in the current legal climate, there are no policy statements that are inadvisable from a legal point of view.

Dr. Bomba moved the adoption of Resolutions 118 through 124 and the motion was seconded.

On vote, the following resolutions were adopted:

118H-1976. Resolved, that the title of the statement, "Principles for Determining the Acceptability of Plans for the Group Purchase of Dental Care"

(Revised 1957) (*Trans.* 1957:389) be amended to read "Guidelines for the Group Purchase of Dental Care," and be it further

Resolved, that the statement be amended by the deletion of the phrase, "with the advice and assistance of the dental society," in the second sentence of principle 7, to make the amended sentence read:

> Fee schedules should be developed in order that they may (1) make possible high standards of treatment in providing benefits under the plan and (2) be adjusted in accordance with changes in the economic level at reasonable intervals.

119H-1976. Resolved, that the "Statement of Policies on Dental Prepayment" (*Trans.* 1965:354) be amended by the deletion of the second sentence of the introductory paragraph reading as follows:

> The development and growth of dental prepayment plans, therefore, are encouraged, provided that they meet the principles and standards established by the dental profession in the interest of providing the best possible level of dental care.

and the substitution therefor of the following sentence:

> In the interest of assuring that the best level of dental care possible is being made available under dental prepayment programs, the following guidelines are offered for reference in the establishment and growth of dental prepayment plans.

and be it further

Resolved, that said statement be amended by the deletion of the section entitled "Evaluation of Dental Prepayment Plans," reading as follows:

> **Evaluation of Dental Prepayment Plans:** Constituent societies have the responsibility for evaluating dental prepayment plans which come within their jurisdiction, provided the societies' criteria are consistent with standards which have been established at the national level.

and be it further

Resolved, that said statement be amended by the deletion of the section entitled "Determination of Fees," reading as follows:

> **Determination of Fees:** The determination of policies relating to fees and methods of remuneration should be made at the state or local level by authorized representatives of the dental profession.

and be it further

Resolved, that the said statement be amended by the deletion of the phrase, "with the advice and assistance of the dental society" in the second sentence of numbered subsection 7 of the section entitled "National Criteria for Evaluation of Dental Prepayment Plans," to make the amended second sentence in subsection 7 read:

> Fee schedules and tables of allowance should be developed in order that they may (a) assure high standards of treatment in providing benefits under the plan and (b) be subject to adjustment at reasonable intervals in accordance with changes in the economic level.

and be it further

Resolved, that the said statement under the section entitled "Payment to Dentists" be amended by deleting the second sentence as follows:

> The method of payment should be determined by authorized representatives of the constituent societies within policies established by those societies.

120H-1976. Resolved, that Resolution 38-1966-H (*Trans.* 1966:347), stating that the qualifications of the dentist participating in publicly funded health programs should be the prerogative of governing bodies of component and constituent dental societies and state dental examining boards, be amended by deleting the phrase "governing bodies of component and constituent dental societies and," to make the amended resolution read:

> Resolved, that the American Dental Association support the position that the determination of the qualifications of the individual dentist participating in publicly funded health programs should be the prerogative of state dental examining boards.

121H-1976. Resolved, that Resolution 9-1966-H (*Trans.* 1966:311), reading as follows, be rescinded:

> Resolved, that in future negotiations with public or private agencies in relation to dental care programs, it shall be the policy of the American Dental Association that reimbursement for professional services on the basis of usual and customary fees shall be given priority consideration.

122H-1976. Resolved, that Resolution 30-1968-H (*Trans.* 1968:305), urging constituent societies and dental service corporations to initiate the confidential prefiling of fees, reading as follows, be revoked:

> Resolved, that the constituent society or dental service corporation in each state be urged to initiate the confidential prefiling of fees to enable the accumulation and determination of reliable fee data for the development of sound private and public care programs utilizing the usual, customary and reasonable concept of reimbursement for professional services.

123H-1976. Resolved, that the statement on "Dental Society Review Committees" as adopted by Resolution 49-1970-H (*Trans.* 1970:485) and amended by Resolution 21-1971-H (*Trans.* 1971:485), be amended by the deletion of the word "customary" in the first sentence, to make the amended sentence read:

> The functions of review committees are to determine the relevancy of the usual and reasonable fees, of treatment procedures to the terms of the contract, and may include assessment of quality of services rendered. However, these functions shall not include setting fees, determining practice or interfering in the dentist-patient relationship.

and by the deletion of numbered principle 5, reading as follows:

> 5. The committee through the sponsoring dental society should have available formal criteria for the determination of usual, customary and reasonable fees.

124H-1976. Resolved, that Resolution 55-1972-H (*Trans.* 1972:673) of the 1972 House of Delegates, adopting a statement on closed panels, reading as follows, is hereby revoked:

A closed panel practice is established when patients eligible for dental services in a public or private program can receive these services only at specified facilities by a limited number of dentists. When the services are provided in a group practice facility and are prepaid by some agency, the practice is more precisely termed "prepaid group practice."

The Association has longstanding policy opposing closed panels in principle because of certain inherent restrictions, particularly on free choice of dentist and convenient location for receiving care.

To protect patients' freedom to receive prepaid services from dentists of their choice, closed panel plans should be presented to consumers only as an alternative method of provision of dental benefits, along with a comparable plan which permits free choice of dentist. Under this dual choice system, the individual consumers should also have periodic options to change plans. There should be equal premium dollars available to both dental delivery systems in the dual choice framework. The closed panel option shall be financially capable to deliver the benefits called for in the contract.

Existing closed panels and panels being formed should submit their programs to the constituent society for evaluation to determine whether the program is capable of delivering the scope of benefits called for by the contract and to determine that the program is in the best interest of the patients.

Prepaid group practices or closed panels shall be under the direct supervision of a dentist or dentists legally licensed in the state, who shall conform to the *Principles of Ethics* of the American Dental Association and the local codes of ethics and shall maintain liaison with the constituent and component societies in the area.

and be it further

Resolved, that the following statement on closed panels be adopted:

A closed panel practice is established when patients eligible for dental services in a public or private program can receive these services only at specified facilities by a limited number of dentists. When the services are provided in a group practice facility and are prepaid by some agency, the practice is more precisely termed "prepaid group practice."

The Association has longstanding policy questioning the efficacy of closed panels in principle because of certain inherent restrictions, particularly limitations on free choice of dentist and convenient location for receiving care.

To protect patients' freedom to receive prepaid services from dentists of their choice, closed panel plans should be presented to consumers as an alternative method of provision of dental benefits, along with a comparable plan which permits free choice of dentist. Under this dual choice system, the individual consumers should also have periodic options to change plans. There should be equal premium dollars available to both dental delivery systems in the dual choice framework. The closed panel option shall be financially capable to deliver the benefits called for in the contract.

An existing closed panel and a panel being formed should make sure that its program is capable of delivering the scope of benefits called for by the contract and that the program is in the best interest of the patients.

Prepaid group practices or closed panels shall be under the direct supervision of a dentist or dentists legally licensed in the state.

The report of the Reference Committee continued as follows:

With respect to Resolution 125, the Committee believes that the language amending the first Guideline can be firmer and more precise and recommends that the first Guideline be amended to read: "1. The Association considers it unnecessary for determination of benefits for any third party's policy to attempt to require mandatory submission of radiographs in every instance or on an automatic basis." The Committee is informed that these modifications are acceptable from a legal point of view.

Dr. Bomba moved the adoption of the amendment and the motion was seconded. On vote, the amendment was adopted.

Dr. Bomba moved the adoption of the amended resolution (Resolution 125RC) and the motion was seconded.

On vote, the following amended resolution (Resolution 125RC) was adopted:

125H-1976. **Resolved**, that Resolution 50-1972-H (*Trans.* 1972:664) and Resolution 33-1974-H (*Trans.* 1974:654), adopting "Guidelines on Use of Radiographs in Dental Care Programs," are hereby revoked, and be it further

Resolved, that the following "Guidelines on Use of Radiographs in Dental Care Programs" be adopted:

The Association approves the following guidelines on the use of radiographs in dental care programs:

1. The Association considers it unnecessary for determination of benefits for any third party's policy to attempt to require mandatory submission of radiographs in every instance or on an automatic basis.

2. The use of radiographs should be only for determining the extent of liability of the program and in no case should infringe on the professional judgement of the dentist or on the dentist-patient relationship.

3. Radiographs taken by the dentist for his diagnosis are not the property of the patient but are part of the dentist's record.

4. Radiographs shall be mounted.

5. Radiographs are to be used only to obtain information which may clarify the benefits that the patient is entitled to under the terms of the contract.

6. Radiographs should be of such quality that they are properly diagnostic for clinical evaluation of the case involved.

7. Third party agencies should not require postoperative radiographs unless a part of proper dental treatment or for peer review purposes.

8. Radiographs shall be examined only by dentists.

9. Radiographs shall be returned to the dentist within ten days.

10. No third party agency should misuse records, either by making faulty judgements from such records or by making determinations which could not ordinarily be made without proper examination of the patient in question. Proper dental treatment is predicated on a diagnosis from many types of examination and not radiographs alone.

11. Radiographs furnished to a peer review committee or third party should not be transmitted to any other agency without written consent of the dentist.

REPORT OF REFERENCE COMMITTEE ON LEGISLATIVE AND RELATED MATTERS

The Report of the Reference Committee on Legislative and Related Matters was read by Dr. Rexford E. Hardin, Ohio, chairman. The other members of the Committee were Drs. F. Eugene Ewing, Pennsylvania; Earle W. Pulsifer, Maine; David E. Simms, New Mexico; Lyman Wagers, Kentucky.

Report of Council on Dental Laboratory Relations: The Committee reported as follows:

The Committee commends the Council for its continuing efforts in providing liaison between the Association and laboratory industry organizations and particularly acknowledges the Council's role in monitoring illegal dentistry activities (p. 116).

The Committee joins the Council in expressing its appreciation for the dedicated leadership and the many contributions made by Dr. Robert L. Taylor, who resigned from the Council following the 1975 annual session, and for the services of Dr. John J. Mingenback, who completed his term on the Council in 1975.

Definition of "Denturist" and "Denturism": (District of Columbia Dental Society Resolution 98; Ninth Trustee District Resolution 141) The Committee reported as follows:

The Reference Committee prefers Resolution 141 (p. 412) because its proposed definitions more accurately describe those individuals who seek to provide dental services in violation of dental practice acts than does current Association policy (*Trans.* 1973:743). The Committee further believes that Resolution 141, since it includes revised definitions for both "denturist" and "denturism," should be given preference over Resolution 98 (p. 368), which is confined to the definition of "denturism." Therefore, the Committee recommends that Resolution 141 be adopted.

Dr. Hardin moved the adoption of Resolution 141 and the motion was seconded.

Dr. James P. Kerrigan, District of Columbia, moved to amend Resolution 141 by deleting the word "therefore" in the first resolving clause, and the motion was seconded by Dr. James V. Barone, Michigan.

On vote, the amendment proposed by Dr. Kerrigan was adopted.

On vote, the following resolution (Resolution 141 as amended) was adopted:

141H-1976. **Resolved**, that when the words "denturist" or "denturism" are used in American Dental Association publications, the terms should be accompanied by a brief but prominent footnote indicating that a "denturist" is a person who is educationally unqualified and not licensed, for the necessary protection of the public, to practice dentistry in any form on the public and that "denturism" is the unqualified as well as the illegal practice of dentistry in any form on the public, and be it further

Resolved, that constituent and component societies act in concert with the American Dental Association.

Dr. James P. Kerrigan, District of Columbia, announced that the District of Columbia Dental Society would withdraw Resolution 98.

Conference on Illegal Dentistry: (Fourth Trustee District Resolution 151; Thirteenth Trustee District Resolution 151S-1) The Committee reported as follows:

The Committee considered Resolution 151 (p. 393) and agrees with the need for expediency in implementing this resolution. It therefore not only recommends that Resolution 151 be approved by the House of Delegates, but also suggests that the Board of Trustees assign highest priority to this conference and that it be scheduled for January 1977 if feasible. In conferring with Association staff, the Committee notes that $5,000 should be allocated to financially support the implementation of this resolution.

Dr. Hardin moved the adoption of Resolution 151 and the motion was seconded.

Dr. Dudley S. Moore, California, moved to substitute the following resolution (Resolution 151S-1) for Resolution 151, and the motion was seconded by Dr. Anthony J. Cusenza, California:

151S-1. **Resolved,** that a conference be sponsored by the American Dental Association to review all aspects of the illegal practice of dentistry regarding the profession's concern for protection of the public.

On vote, the motion to substitute Resolution 151S-1 for Resolution 151 as proposed by Dr. Moore was adopted.

On vote, the following resolution (Resolution 151S-1) was adopted:

151H-1976. **Resolved,** that a conference be sponsored by the American Dental Association to review all aspects of the illegal practice of dentistry regarding the profession's concern for protection of the public.

Illegal Dentistry: (Board of Trustees Resolution 114) The Committee reported as follows:

The Committee noted the comprehensive report on illegal dentistry submitted by the Board and Resolution 114 (p. 543) contained therein. The Committee sincerely urges each delegate to carefully consider the information in the report. In addressing Resolution 114, the Committee noted that the third resolving clause encourages the Association and its constituent and component societies to take immediate steps to remove barriers which exist that prevent certain individuals from full access to professional care.

The Committee believes that the Association should assist the societies by identifying and disseminating information on projects for improving access to care. The Committee was pleased to note that the joint demonstration project conducted by the Oregon Dental Association and American Dental Association is concentrating upon methods for improving access to dental care. The Committee, therefore, recommends that Resolution 114 be adopted.

Dr. Hardin moved the adoption of Resolution 114 and the motion was seconded.

On vote, the following resolution (Resolution 114) was adopted:

114H-1976. **Resolved,** that all Americans should have access to dental care provided by adequately trained and fully competent health care professionals, and be it further

Resolved, that the responsibility for the provision of denture care rests with the dentist, and the provision of substandard care solely through individuals of lesser training and competence is firmly opposed, and be it further

Resolved, that the American Dental Association and its constituent and component dental societies should take immediate steps to identify the economic and other barriers to full access to professional care within their jurisdictions and to seek remedies that will remove those barriers.

Position Statement on Commercial Dental Laboratory Industry: (Board of Trustees Resolution 127) The Committee reported as follows: (For final disposition see page 872.)

The Committee carefully considered Resolution 127 (p. 514) as well as a statement submitted to it by the Council on Dental Laboratory Relations during the Reference Committee hearing.

During discussion of Resolution 127, the Committee noted that the statement, as recommended by the Board, does not describe accurately the position of the Association and could be easily misinterpreted. The Committee was particularly concerned that individuals would assume that the statement in Resolution 127 supersedes Association policy regarding the

auxiliary status of commercial dental laboratory technicians. In the Committee's opinion, this could lead to confusion and might inappropriately lend support to the desire of the commercial dental laboratory industry to gain statutory regulation with independent regulatory boards. Therefore, to clarify the Association's position regarding the auxiliary status of dental laboratory technicians and to recodify current policy, the Committee submits a revised position statement with accompanying resolution and recommends that they be substituted for Resolution 127.

127RC. **Resolved,** that the "Position Statement on the Commercial Dental Laboratory Industry" be adopted.

Position Statement on the Commercial Dental Laboratory Industry

All personnel associated with the dentist in the delivery of health care are properly termed "auxiliary" in the sense of aiding the dentist to properly serve the public; however, the laboratory technician who performs a supportive function in an environment outside the dental office may also be properly termed a supportive or allied member of the dental health team. The commercial dental laboratory industry, furthermore, is comprised of independent, for-profit businesses whose services are exclusively dependent upon dentists who provide the laboratory with work authorizations for the processing of prosthetic or other dental appliances.

Dr. Hardin moved to substitute Resolution 127RC for Resolution 127 and the motion was seconded.

Dr. Lawrence Scinto, Connecticut, stated "You have that little position statement there and in that it says, 'supportive or allied members of the dental health team.' In other words, I may be reading it wrong, but I have the idea that you do not want to call a person who is a dental technician working in a commercial laboratory a dental auxiliary. Am I right or wrong?"

Dr. Daniel L. Flad, Pennsylvania, chairman of the Council on Dental Laboratory Relations, responded, stating "I think the problem here lies in the term, 'may also be properly termed a supportive or allied member of the dental health team.' We still, however, have not struck the accolade of 'auxiliary' whether they work in the professional office atmosphere or the commercial laboratory. That has not been dropped. We consider all laboratory technicians as auxiliaries."

Dr. George P. Hoffmann, South Carolina, moved to substitute the following resolution for Resolution 127RC, and the motion was seconded by Dr. William C. Draffin, South Carolina:

Resolved, that the development of a new category of dental auxiliaries is not accepted by the American Dental Association, and that only dental assistants and dental hygienists and dental laboratory technicians, including those technicians employed by the commercial laboratory industry, are recognized as dental auxiliaries, and be it further

Resolved, that the commercial dental laboratory industry is comprised of independent for-profit businesses whose services are exclusively dependent upon dentists who provide the laboratories with work authorizations for the processing of prosthetic or other dental appliances.

Dr. Hoffmann stated "I really believe that the Reference Committee of the Council on Dental Laboratory Relations and the Fifth Trustee delegation are after the

same thing. My concern, however, is that existing ADA policy specifies three categories of auxiliaries—the dental assistants, the dental hygienists, and the dental laboratory technicians. Now I feel that the policy statement needs to be strengthened. . . . In addition, I feel that the commercial laboratory industry needs to be defined. Further, I feel very strongly that both of these statements should be included in the same spot as ADA policy so that in the future they can never be misconstrued as being separate, distinct, and apart categories."

On vote, the motion to substitute Resolution 127RC for Resolution 127 was adopted.

Dr. Eugene J. Truono, Delaware, spoke in opposition to the substitute resolution presented by Dr. Hoffmann, and Dr. Harry W. F. Dressel, Jr., Maryland, spoke in favor of the substitute resolution.

Dr. Arthur L. Labelle, California, stated "I am a member of the Council on Dental Laboratory Relations and I would like to point out to you that this substitute resolution accomplishes very little. . . . I would like to assure you that the Council . . . is steadfast and unanimous in its determination to apply the term 'auxiliary' to all laboratory technicians wherever they practice their trade in an effort to make our work easier with the laboratory people. . . . The last part of this substitute is exactly the same as the last part of our Resolution 127RC. So I would suggest that this substitute, while it is being offered in good faith, really accomplishes very little. The Council's position as embodied in Resolution 127RC really accomplishes what we would like to have accomplished."

Dr. Lawrence Scinto, Connecticut, stated "I disagree with the previous speaker in the fact that what I get from his speech is that we are taking a defense position so that maybe the laboratory technician will not become a denturist. We are trying to make him feel good and let him call himself something else. He is an auxiliary and that is what he is, and we shouldn't have to take a defensive action. . . . I support the Council 100 percent, but I cannot see this approach. Things in this world are not always easy and if this makes it difficult for them, I am sorry but they are going to have to live with it."

Dr. Earle W. Pulsifer, Maine, stated "We received a great help from the ADA this last year in fighting this denturism bit in our legislature. In our House, however, this passed . . . by very few votes. I have served on this Reference Committee that considered this resolution. We tried to plan a fair way between telling the laboratory men that they were truly auxiliaries and yet, at the same time, giving a little bit so they would go along with us. This does not mean that we are trying to prevent some of our laboratory men from becoming denturists. What it does mean in actual fact is in our legislature and in our hearings that these laboratory men testified for us last year, and in the State of Maine there are only four or five individuals, not laboratories, that term themselves 'denturists.' If you are not going to come down from the ADA, or this House of Delegates, and suggest to us how we handle this problem . . . you put back to the state constituent societies the problem of how they shall handle this. You may call a laboratory man what you please, but don't kick the stool out from under us."

Dr. Robert E. Doerr, Michigan, called for the question and the motion was seconded. The motion to vote immediately was passed.

On vote, the substitute resolution proposed by Dr. Hoffmann was defeated.

Dr. Hardin moved the adoption of Resolution 127RC and the motion was seconded.

On vote, the following resolution (Resolution 127RC) was adopted:

127H-1976. Resolved, that the "Position Statement on the Commercial Dental Laboratory Industry" be adopted.

Position Statement on the Commercial Dental Laboratory Industry

All personnel associated with the dentist in the delivery of health care are properly termed "auxiliary" in the sense of aiding the dentist to properly serve the public; however, the laboratory technician who performs a supportive function in an environment outside the dental office may also be properly termed a supportive or allied member of the dental health team. The commercial dental laboratory industry, furthermore, is comprised of independent, for-profit businesses whose services are exclusively dependent upon dentists who provide the laboratory with work authorizations for the processing of prosthetic or other dental appliances.

Report of Council on Federal Dental Services: (Council on Federal Dental Services Resolutions 7 and 8; Fifth Trustee District Resolution 8S-1) The Committee reported as follows:

Annual Report: The Committee reviewed the report of the Council on Federal Dental Services (p. 137) and commends the Council in its efforts on behalf of the Association.

During the Committee hearing several delegates expressed concern over the failure of Congress to take action on American Dental Association developed legislation that is designed to ensure that Army and Air Force dental corps officers have proper command authority over their own professional operations. The Committee was encouraged by statements of the Army, Navy and Air Force Chief Dental Officers indicating that they would be willing to testify in support of the Army-Air Force Dental Corps bill when Congressional hearings are held on the legislation. The Committee wishes to reemphasize the importance of the legislation and urges the Council on Legislation to actively pursue Congressional consideration of the Army-Air Force bill.

The Committee wishes to join the Council on Federal Dental Services in acknowledging and expressing its appreciation of the dedicated leadership and numerous contributions of its retiring chairman, Dr. Joseph R. Salcetti of Washington, D.C.

Continuation Pay Eligibility for Military Dental Officers: The Committee agrees with the Council on Federal Dental Services and the Board of Trustees that the lowering of eligibility for continuation pay from five to three years would improve the capability of the uniformed services to retain career dental officers (p. 144). Accordingly, the Committee recommends adoption of the following resolution:

> 7RC. Resolved, that the American Dental Association urge appropriate agencies of the federal government to lower the required years of creditable service for continuation pay eligibility for dental officers in the uniformed services to become available at the end of the initial three year period of obligation.

Dr. Hardin moved to substitute Resolution 7RC for Resolution 7 and the motion was seconded. On vote, the motion to substitute was adopted.

Dr. Hardin moved the adoption of the substitute resolution (Resolution 7RC) and the motion was seconded.

On vote, the following resolution (Resolution 7RC) was adopted:

7H-1976. Resolved, that the American Dental Association urge appropriate agencies of the federal government to lower the required years of creditable service for continuation pay eligibility for dental officers in the uniformed services to become available at the end of the initial three year period of obligation.

The report of the Reference Committee continued as follows:

Utilization of Dental Auxiliaries in the Federal Dental Services: The Committee considered Resolution 8 (p. 144) as submitted by the Council and substitute Resolution 8S-1 (p. 398) submitted by the Fifth Trustee District. Both resolutions direct the Association to urge the federal dental services to increase the productivity of its present workforce of dentists rather than utilize dental auxiliary personnel in the performance of duties which are in conflict with American Dental Association policy. The Committee noted that Resolution 8 and the first resolving clause of Resolution 8S-1 are identical in this respect. While the Committee concurs in this objective, it believes that recognition must be made of the current efforts of the federal dental services to improve dental productivity. For that reason, the Committee recommends the insertion of the phrase "to continue" before the words "to improve" in the first resolving clause. It is the understanding of the Committee that the second resolving clause of Resolution 8S-1 is intended to address the training of expanded duty dental auxiliaries within the federal dental services as well as their subsequent utilization in the provision of dental care.

Although the Committee is supportive of this objective of Resolution 8S-1, it believes that the second resolving clause should be amended by adding, at the end, the words "which are in conflict with American Dental Association policy." This change will clarify those expanded duty dental auxiliary training programs with which the Fifth Trustee District and the Committee are concerned. Accordingly, the Committee recommends that Resolution 8RC be substituted for Resolutions 8 and 8S-1.

8RC. Resolved, that the American Dental Association strongly urge the federal dental services to continue to improve the productivity of its present workforce of dentists rather than utilize dental auxiliary personnel in the performance of duties which are in conflict with American Dental Association policy, and be it further

Resolved, that meetings be continued with the chiefs of all federal dental services in order to persuade them to discontinue the program of training and utilization of expanded duty dental auxiliaries which are in conflict with American Dental Association policy.

Dr. Hardin moved to substitute Resolution 8RC for Resolutions 8 and 8S-1 and the motion was seconded. On vote, the motion was adopted.

Dr. William Travis, Michigan, moved to amend the substitute resolution by deleting the word "chiefs" in the second resolving clause and substituting therefor the words "appropriate officials." The motion was seconded by Dr. Robert K. Bowen, Ohio.

On vote, the amendment proposed by Dr. Travis was adopted.

Dr. Hardin moved the adoption of the amended substitute resolution and the motion was seconded.

On vote, the following resolution (Resolution 8RC as amended) was adopted:

8H-1976. Resolved, that the American Dental Association strongly urge the federal dental services to continue to improve the productivity of its present workforce of dentists rather than utilize dental auxiliary personnel in the performance of duties which are in conflict with American Dental Association policy, and be it further

Resolved, that meetings be continued with the appropriate officials of all federal dental services in order to persuade them to discontinue the program of training and utilization of expanded duty dental auxiliaries which are in conflict with American Dental Association policy.

Military Dependent Care: (California Dental Association Resolution 57; Thirteenth Trustee District Resolution 57S-1; Fourth Trustee District Resolution 139) The Committee reported as follows: (For final disposition see page 875.)

The Committee carefully reviewed Resolution 57 (p. 364) and Resolution 139 (p. 397) and the delegate comments during the Reference Committee hearing concerning the need for a civilian based program of dental care for military dependents. During its discussion on the resolutions, the Committee observed that the Association has existing policy (*Trans.* 1974: 689) which clearly supports such a program. That policy states:

> **Resolved**, that the American Dental Association reaffirm its support of a comprehensive dental care program for dependents of military personnel to be provided through the offices of civilian dentists and that appropriate agencies of the Association make every effort to achieve enactment of legislation implementing this policy.

While the Committee shares the objectives which prompted the submission of these two resolutions, it is the opinion that the 1974 policy of the Association provides adequate direction on this issue. Therefore, the Committee recommends that Resolutions 57 and 139 be postponed indefinitely.

Dr. Hardin moved to postpone indefinitely Resolution 57 and the motion was seconded.

Dr. Dudley S. Moore, California, stated that the California Dental Association would withdraw Resolutions 57 and 57S-1.

Dr. Hardin moved to postpone indefinitely Resolution 139 and the motion was seconded.

Dr. S. N. Bhaskar, Army, moved to amend Resolution 139 to read as follows, and the motion was seconded by Dr. Dudley S. Moore, California:

> **Resolved**, that the American Dental Association strongly encourage the passage of legislation to amend the existing CHAMPUS legislation or enact separate legislation for the provision of dental care benefits under the free choice delivery system for all uniformed service dependents, and be it further
> **Resolved**, that the American Dental Association through its councils and offices undertake vigorous action to assure enactment of such legislation during the 95th Congress.

Dr. Bhaskar stated ". . . Since 1958, 19 different bills have been proposed in Congress to give dental care to the military dependents. Every time this bill comes through the Department of Defense, it is killed. The reason for this is that dental care is not considered as part of medical care. For example, today the military spends half a billion dollars on medical care and spends less than four hundred thousand dollars on dental care. . . . What I want from Congress is a fair share of the health care dollars which are being spent on military dependents, and that is 6.3 percent rather than 0.3 percent of the health care dollar which the Pentagon spends on military dependents and beneficiaries. What this resolution does is give us an added tool

to push the Congress to enact this legislation and introduce this bill. When the bill comes into the Department of Defense, the Army staff is behind this program and will help us get it through the Pentagon. Then we hope that the members of the Association will write perhaps three to five thousand letters to their Congressmen and Senators, and I think we can get this through the next session of the Congress. So I would like to speak in favor of this resolution because it really means more patients for civilian dentists and more dental care for the military dependents who, at the present time, are not adequately covered."

Dr. Grant A. MacLean, Illinois, inquired whether retired personnel were taken care of in some manner.

Dr. Bhaskar responded "The retired personnel are not taken care of under any other program. . . . What we are trying to do . . . is to first have a modest program, perhaps in the vicinity of 30 to 35 million dollars, which is the share for dental programs out of the CHAMPUS budget. When we get the 35 million dollars, I hope we spend it primarily on women and children and at some later time bring the retired into the program. This is the reason we have omitted the retired completely to get this legislation through as the next step."

Dr. William B. Milligan, Texas, inquired of Dr. Bhaskar what portion of the half billion dollars is spent on dependents.

Dr. Bhaskar replied "A half billion dollars is spent by the government . . . to provide medical care to dependents and retired, and the dependents of the deceased outside of the military installations. In other words, to put it very crudely, the Department of Defense gives a half billion dollars to the medical practitioners."

Dr. William B. Milligan, Texas, spoke against the amendment stating ". . . I would like to see the thrust of this Association go towards slicing up this half billion dollars in a different way rather than see us encourage creation of a new program."

Dr. B. C. Kingsbury, Jr., California, moved to further amend the amendment by inserting the phrase "in the offices of civilian dentists" after the word "benefits" in the first resolving clause. The motion was seconded by Dr. Dudley S. Moore, California.

On vote, the amendment proposed by Dr. Kingsbury was adopted.

On vote, the amendment proposed by Dr. Bhaskar was adopted.

Dr. Hardin moved the adoption of the amended resolution and the motion was seconded.

On vote, the following resolution (Resolution 139 as amended) was adopted:

> 139H-1976. **Resolved,** that the American Dental Association strongly encourage the passage of legislation to amend the existing CHAMPUS legislation or enact separate legislation for the provision of dental care benefits in the offices of civilian dentists under the free choice delivery system for all uniformed service dependents, and be it further.
>
> **Resolved,** that the American Dental Association through its councils and offices undertake vigorous action to assure enactment of such legislation during the 95th Congress.

Remote Status for Military Establishments: (California Dental Association Resolution 58; Fifth Trustee District Resolution 58S-1) The Committee reported as follows:

> The Committee reviewed Resolution 58 (p. 365) and Resolution 58S-1 (p. 399). These two resolutions concern the designation of military installations which are authorized to provide

dental care to dependents of military personnel. The Committee agrees with the intent of both resolutions which essentially are reaffirmations of existing Association policy. The Committee believes that Resolution 58S-1 is preferable to Resolution 58. The Committee understands, however, that review of designated installations is required only at three year intervals unless otherwise requested and therefore recommends that the words "annual renewal" in the second resolving clause of Resolution 58S-1 be deleted and the word "review" inserted in lieu thereof so that substitute Resolution 58RC will read as follows:

58RC. **Resolved,** that the American Dental Association vigorously opposes the designation of remote status of any military installation where the criteria for such designation under federal regulation cannot be met, and especially where a dental manpower shortage cannot be demonstrated to exist, and be it further
Resolved, that upon review of existing remote status designations, complete re-evaluation be performed with strict adherence to these criteria as promulgated for an original designation.

Dr. Hardin moved to substitute Resolution 58RC for Resolutions 58 and 58S-1 and the motion was seconded. On vote, the motion to substitute was adopted.

Dr. Hardin moved the adoption of the substitute resolution and the motion was seconded.

On vote, the following resolution (Resolution 58RC) was adopted.

58H-1976. **Resolved,** that the American Dental Association vigorously opposes the designation of remote status of any military installation where the criteria for such designation under federal regulation cannot be met, and especially where a dental manpower shortage cannot be demonstrated to exist, and be it further
Resolved, that upon review of existing remote status designations, complete re-evaluation be performed with strict adherence to these criteria as promulgated for an original designation.

U.S. Coast Guard Dental Advisor: (Fourth Trustee District Resolution 147) The Committee reported as follows:

The Committee reviewed Resolution 147 (p. 398) submitted by the Fourth Trustee District. During the Committee hearing on Resolution 147, representatives of the Fourth Trustee District indicated that the wording of the resolution fails to convey the precise objective intended. The Committee was advised that the Fourth Trustee District desires the adoption of a resolution urging the U.S. Coast Guard to appoint a qualified dental officer to the vacant Coast Guard position of Chief Dental Officer. The Committee concurs and recommends the adoption of a substitute resolution.

Dr. Hardin moved to substitute Resolution 147RC for Resolution 147 and the motion was seconded. On vote, the motion to substitute was adopted.

Dr. Hardin moved the adoption of the substitute resolution and the motion was seconded.

On vote, the following resolution (Resolution 147RC) was adopted:

147H-1976. **Resolved,** that the American Dental Association urge the U.S. Coast Guard to expeditiously appoint a dental officer to the position of Chief Dental Officer.

Veterans Administration Reimbursement Arrangements: (Board of Trustees Resolution 84) The Committee reported as follows:

> The Committee considered Resolution 84 (p. 501) as transmitted by the Board of Trustees and reviewed the report of the Council on Federal Dental Services (p. 137) which prompted the resolution. The Committee is supportive of the intent of Resolution 84, but believes it should be made clear that the Veterans Administration is responsible for the reimbursement arrangements it establishes. Accordingly, the Committee recommends the adoption of Resolution 84 as amended.

Dr. Hardin moved to substitute Resolution 84RC for Resolution 84 and the motion was seconded. On vote, the motion to substitute was adopted.

Dr. Hardin moved the adoption of the substitute resolution and the motion was seconded.

On vote, the following resolution (Resolution 84RC) was adopted:

> 84H-1976. **Resolved,** that the American Dental Association encourage the Veterans Administration to improve its efforts to obtain timely and accurate data on the cost of dental services before establishing reimbursement arrangements for dental services.

Dental Care for Veterans: (Board of Trustees Resolutions 85 and 86) The Committee reported as follows:

> The Committee considered Resolutions 85 and 86 (p. 502) submitted by the Board of Trustees regarding dental care for veterans. In its consideration of these resolutions, the Committee noted the report of the Council on Federal Dental Services (p. 137) and the recommendations of the Board of Trustees. The Committee concurs in the proposed amendments to Association policy and recommends the adoption of Resolutions 85 and 86 as transmitted by the Board of Trustees.

Dr. Hardin moved the adoption of Resolution 85 and the motion was seconded.

On vote, the following resolution (Resolution 85) was adopted:

> 85H-1976. **Resolved,** that the third resolving clause of Resolution 53-1953-H (*Trans.* 1953:232) be amended to strike "service-connected" wherever it appears, the amended resolution to read as follows:
>
> > **Resolved,** that nothing in this statement of policy should be construed to apply to the present system for providing dental services in Veterans Administration hospitals and domiciliary institutions or to the present system for providing outpatient dental care (1) to veterans whose dental conditions have been professionally determined to be aggravating a medical condition, and (2) to veterans whose conditions have been determined to be disabling and compensable.

Dr. Hardin moved the adoption of Resolution 86 and the motion was seconded.

On vote, the following resolution (Resolution 86) was adopted:

> 86H-1976. **Resolved,** that the Association encourage the Veterans Administration to approve the following extension of dental benefits by the Veterans Administration: emergency outpatient dental care for a non-service-connected dental condition but only to the extent required to relieve pain and/or control infection. Major restorations, therapy or prostheses would not be included.

Report of Council on Judicial Procedures, Constitution and Bylaws: (Council on Judicial Procedures, Constitution and Bylaws Resolutions 12, 13, 14, 15, 16 and 17; Board of Trustees Resolution 14B; California Dental Association Resolution 56) The Committee reported as follows:

Annual Report: The Reference Committee reviewed the annual report of the Council on Judicial Procedures, Constitution and Bylaws (p. 167) and noted with approval the activities undertaken by the Council. The Committee acknowledges the services of Dr. Elbert H. Smith of California who served during the past year as a consultant to the Council and who previously served for eight years as a member of the Council, the last three as Chairman. The Committee also notes that Dr. John W. Turner of Alabama will complete his term this year and gratefully acknowledges his contribution.

Announcement in More Than One Specialty Area: The Reference Committee reviewed Resolution 12 (p. 177) submitted by the Council on Judicial Procedures, Constitution and Bylaws in response to the moratorium on announcement in more than one specialty area adopted by the 1975 House of Delegates (*Trans.* 1975:726). The Committee also noted the approval of the Board of Trustees (p. 481).

However, the Committee is concerned with the effect that the lifting of the moratorium may have on the realignment of all of the dental specialties due to the increased number of dentists who are educating themselves in more than one specialty area and with the effect of some dental specialty laws which restrict announcement of limitation of practice to one specialty area. For these reasons the Committee recommends by a four to one vote a substitute resolution:

12RC. Resolved, that the Moratorium imposed by the 1975 House of Delegates (*Trans.* 1975:726) upon implementation of the privilege of announcing in more than one specialty under Section 18 of the *Principles of Ethics* be extended until a report from the Council on Dental Education is received and acted upon by the 1977 House of Delegates.

Dr. Hardin moved to substitute Resolution 12RC for Resolution 12 and the motion was seconded. On vote, the motion to substitute was adopted.

Dr. Hardin moved the adoption of the substitute resolution and the motion was seconded.

Dr. Edward F. Furstman, California, vice chairman of the Council on Dental Education, stated ". . . The Council on Dental Education has considered the issue related to dual announcement on four separate occasions. Its first consideration of this issue was in 1971. It was reconsidered in 1972, 1974 and 1975. On each occasion, and without exception, the Council has unanimously maintained the position that dentists should not be restricted to announcing in a single area providing they have met the educational requirements for each area in which they wish to announce. In my judgement, there is no reason to believe that the Council would change its stand on an issue that it has already considered at length four times. . . . The Council on Judicial Procedures, Constitution and Bylaws was apprised of the Council on Dental Education's position, and to refer would only mean further delay in establishing policy which should, without any doubt, be established. No additional information can be derived as the result of an additional study by the Council on Dental Education. . . ."

Dr. Charles L. Siroky, Arizona, spoke in opposition to the substitute resolution.

Dr. Edward F. Leone, Wisconsin, stated "I am in favor of the proposal to extend the moratorium. I beg to differ with the decision of the Council. I do not think we are being consistent if we depend merely on the qualifications as a reason to deter-

mine and to manifest what areas you are going to specialize in, or what areas you want to announce to the public. For instance, if you claim that the educational requirements for a specialty are adequate, then how about a general practitioner who meets all the requirements and then decides to specialize? He is still qualified to practice general dentistry and yet you don't permit him, ethically, to announce that he is a specialist and also a general practitioner. . . . I think the specialty should be dependent not only on the educational requirement, but the full time limitation of the practice to that one phase. I firmly believe that when you create someone who is supposed to be a specialist in two fields, you are actually creating an individual who is half a specialist in two fields.

Dr. Lyman Wagers, Kentucky, spoke in favor of the substitute resolution.

Dr. Edward A. Lusterman, New York, stated "It was not too many years ago that this question came up when the term 'specialist' was frowned upon, and this House decided at that time that the use of the term 'practice limited to' was much to be preferred over 'specialist.' Now we have the educational standards which say that your practice may be limited to a second specialty if you have fulfilled the educational requirements to so limit your practice. If we adhere to this specification, we would not have this problem. If you are limiting your practice to just the one specialty, it cannot be a dual specialty. I would think that it would be best for us to go back to that term rather than 'specialization.' "

Dr. Mark A. Price, Louisiana, called for the question and the motion was seconded.

The motion to vote immediately was passed.

On vote, the following resolution (Resolution 12RC) was adopted:

> 12H-1976. Resolved, that the Moratorium imposed by the 1975 House of Delegates (*Trans.* 1975:726) upon implementation of the privilege of announcing in more than one specialty under Section 18 of the *Principles of Ethics* be extended until a report from the Council on Dental Education is received and acted upon by the 1977 House of Delegates.

Recess: The House of Delegates recessed at 6:05 p.m.

THURSDAY, NOVEMBER 18, 1976

Call to Order: The fourth meeting of the House of Delegates was called to order at 8:30 a.m. by the Speaker of the House, Dr. Frank P. Bowyer.

Invocation: The invocation was offered by Reverend Melvin S. Steward, Trinity Temples, Assemblies of God, Las Vegas.

Report of Standing Committee on Credentials: Dr. William H. McKenna, Massachusetts, chairman of the Standing Committee on Credentials, reported a quorum present.

REPORT OF REFERENCE COMMITTEE ON LEGISLATIVE AND RELATED MATTERS
(continued)

Dr. L. Willard Parker, Tennessee, moved to reconsider Resolution 86 and the motion was seconded by Dr. Joseph M. Grana, Missouri.

On vote, the motion to reconsider was defeated.

The report of the Reference Committee continued as follows:

Scope of Specialty Practice and Referral Patterns: The Reference Committee notes that Resolution 13 (p. 178) resulted from the recommendations of the January 1976 Workshop Conference on Specialty Practice. The Committee concurs with the Council recommendation, approved by the Board of Trustees (p. 481), that guidelines relating to appropriate referral patterns would be helpful and recommends the approval of Resolution 13.

Dr. Hardin moved the adoption of Resolution 13 and the motion was seconded.

Dr. Gustave Lasoff, New York, moved to amend the resolution to read as follows, and the motion was seconded by Dr. Wilbur J. Prezzano, New York:

Resolved, that Section 7 of the *Principles of Ethics* be amended by the addition of a second paragraph to read as follows:

In addition, when a patient visits or is referred to a specialist or consulting dentist for consultation

1. It is the obligation of the specialist or consulting dentist, under ordinary circumstances, to observe the patient's post treatment condition and to then return the patient to the referring dentist for future care.

2. It is the obligation of the specialist when there is no referring dentist to refer the patient for general dental care when appropriate.

Dr. Theodore L. Jerrold, New York, spoke in favor of the amendment.

On vote, the amendment proposed by Dr. Lasoff was adopted.

Dr. Hardin moved the adoption of the amended resolution and the motion was seconded.

On vote, the following resolution (Resolution 13 as amended) was adopted:

13H-1976. **Resolved**, that Section 7 of the *Principles of Ethics* be amended by the addition of a second paragraph to read as follows:

In addition, when a patient visits or is referred to a specialist or consulting dentist for consultation

1. It is the obligation of the specialist or consulting dentist, under ordinary circumstances, to observe the patient's post treatment condition and to then return the patient to the referring dentist for future care.

2. It is the obligation of the specialist when there is no referring dentist to refer the patient for general dental care when appropriate.

The report of the Reference Committee continued as follows:

Listing of All Approved Specialties in the "Principles of Ethics" and Use of Term "Pediatric Dentistry": The Reference Committee has reviewed Resolution 14 (p. 178) submitted by the Council on Judicial Procedures, Constitution and Bylaws which would amend the *Principles of*

Ethics by specifying the recognized areas of specialty practice and their proper designations, including use of the term "Pediatric Dentistry." The Committee has also reviewed California Resolution 56 (p. 362) which would approve use of the specialty designation "Pediatric Dentistry."

The Committee has also reviewed Resolution 14B (p. 482) which omits the specialty designation "Pediatric Dentistry" together with the proposal of the Board of Trustees (p. 487) that those specializing in children's dentistry decide upon two specialty designations and the Board's subsequent recommendation (p. 515) that Resolution 56 be referred to the Council on Judicial Procedures, Constitution and Bylaws for report to the 1977 House of Delegates. The Committee notes that this recommendation will give the American Academy of Pedodontics an opportunity to officially decide upon two specialty designations from among the designations "Pedodontics," "Children's Dentistry," and "Pediatric Dentistry."

The Committee concurs with the recommendation of the Board of Trustees and recommends the approval of Resolution 14B.

Dr. Hardin moved to substitute Resolution 14B for Resolution 14 and the motion was seconded. On vote, the motion to substitute was adopted.

Dr. Hardin moved the adoption of the substitute Resolution (Resolution 14B) and the motion was seconded.

On vote, the following resolution (Resolution 14B) was adopted:

14H-1976. **Resolved,** that Section 18 of the *Principles of Ethics* be amended by the addition of a new paragraph following the first paragraph to read as follows:

The specialty areas of dentistry approved by the American Dental Association and the designations for ethical announcements of limitation of practice are:

Endodontics
Oral Pathology
Oral Surgery
(or Oral and Maxillofacial Surgery)
Orthodontics
Pedodontics
(or Dentistry for Children)
Periodontics
Prosthodontics
Dental Public Health

The report of the Reference Committee continued as follows:

For the same reasons, the Committee recommends that Resolution 56 be referred to the Council on Judicial Procedures, Constitution and Bylaws for report to the 1977 House of Delegates.

Dr. Hardin moved to refer Resolution 56 to the Council on Judicial Procedures, Constitution and Bylaws for report to the 1977 House of Delegates and the motion was seconded.

On vote, the following resolution (Resolution 56) was referred to the Council on Judicial Procedures, Constitution and Bylaws for report to the 1977 House of Delegates:

56. **Resolved,** that the 1976 House of Delegates of the American Dental Association approve the terminology "pediatric dentistry" to be synonymous with

the terms "pedodontics" and "dentistry for children," and the terminology "pediatric dentist" to be synonymous with the terms "pedodontist" and "dentist for children," and be it further

Resolved, that the American Dental Association Council on Judicial Procedures, Constitution and Bylaws take appropriate action to adopt an advisory opinion to the *Principles of Ethics* to permit the use of the words "pediatric dentistry" as an acceptable alternative for "pedodontics" and "dentistry for children."

The report of the Reference Committee continued as follows:

Moratorium on Disciplinary Actions Involving Advertising: The Reference Committee has very carefully reviewed the report of the Council on Judicial Procedures, Constitution and Bylaws (p. 171), the testimony presented to the Committee, the language of Resolution 15 (p. 178), and the recommendation of the Board of Trustees (p. 482).

The Committee was made aware of the imminent threat of antitrust litigation against both the American Dental Association and the Arizona State Dental Association by the Attorney General of the State of Arizona challenging not only Section 12 of the *Principles of Ethics*, but the vertical membership provision of the American Dental Association *Bylaws* and other portions of the *Principles of Ethics* which the moratorium proposed in Resolution 15 may well prevent. This litigation, in addition to being highly expensive for both the American Dental Association and the Arizona State Dental Association, would seriously undercut the persuasive value of the American Dental Association's friend of the court brief which the Association has just obtained the right to file in *Bates and Van O'Steen* v. *Arizona State Bar*, the United States Supreme Court case involving lawyers' advertising. The American Dental Association in its brief will vigorously support the right of professional associations to regulate advertising by members.

The Committee also noted the suggestion received in testimony that a number of potential legal challenges based upon advertising are pending in at least one other jurisdiction, and in this context, the Committee notes the Board of Trustees' reference to the Northern Virginia Dental Society's costly experience in the *Golec* case (p. 483). For these reasons, the Committee believes that it is essential to alert the constituent and component societies that enforcement of restrictions on advertising that cannot be clearly shown as an effort to solicit patients is extremely vulnerable to legal challenge. The Committee believes, then, that the Association's persuasive position in its friend of the court brief to be filed in the *Bates and Van O'Steen* case should be preserved, that the Attorney General of Arizona should be deterred from formally filing his threatened legal action, and that a potential proliferation of lawsuits suggested by testimony and by the Association's experience in the *Golec* case should be avoided.

However, the Committee believes that the term of the moratorium should be set to correspond with the anticipated time required for a decision in the *Bates and Van O'Steen* case. The Committee suggests a term of six months with the understanding that the Board of Trustees may permit the moratorium to lapse or extend its term in accordance with legal developments at that time.

In addition, the Committee believes that the extremely important questions presented by Resolution 15 should be divided by initially considering the first and third resolving clauses, as amended, and then by considering the second resolving clause.

The modification of Resolution 15 was approved with one dissenting vote.

Dr. Hardin moved to substitute Resolution 15RC for Resolution 15 and the motion was seconded.

Dr. Eugene J. Fortier, Jr., Louisiana, moved to refer Resolution 15RC back to the Board of Trustees with the request that the Board immediately alert all constituent and component societies to the need for unusual restraint in initiating disciplinary action under Section 12 of the American Dental Association *Principles of Ethics* and corresponding sections of the ethical codes of constituent and component dental societies. The motion was seconded by Dr. Daniel F. Gordon, California.

On vote, the motion to substitute was adopted.

On vote, the following resolution (Resolution 15RC) was referred to the Board of Trustees as proposed by Dr. Fortier:

> 15RC. **Resolved**, that constituent and component societies apply for six months, subject to extension by the Board of Trustees, a moratorium to disciplinary actions against dentists for ethical violations involving advertising with the exception of advertising that is designed to solicit patients, and be it further
> **Resolved**, that for the purpose of this resolution the term "solicit" means the attempt to obtain patients by persuasion or influence and includes but is not limited to a statement or claim which:
>
> 1. contains a misrepresentation of fact;
> 2. is likely to mislead or deceive because in context it makes only a partial disclosure of relevant facts;
> 3. contains a patient's laudatory statements about a dentist;
> 4. is intended or is likely to create false or unjustified expectations of favorable results;
> 5. implies unusual competence, other than as permitted under "Announcement of Limitation of Practice";
> 6. relates to dental fees other than a standard consultation fee or a range of fees for specific types of procedures without fully disclosing all variables and other relevant factors:
> 7. is intended or is likely to imply or to guarantee atypical results;
> 8. is intended or is likely to appeal primarily to a lay person's fears or similar emotions;
> 9. contains other representations or implications that in reasonable probability will cause an ordinary, prudent person to misunderstand or be deceived.
>
> and be it further
> **Resolved**, that the same moratorium apply to disciplinary actions against direct members of this Association.

The report of the Reference Committee continued as follows:

> **Nomination For and Election to Councils**: The Reference Committee reviewed Resolution 16 (p. 179), the alternative resolution considered by the Council on Judicial Procedures, Constitution and Bylaws (p. 481), and the recommendation of the Board of Trustees (p. 481). While the Committee concurs with the Council and Board that Resolution 16 has advantages, the Committee is persuaded that the alternative resolution is the better remedy. Therefore, the Committee recommends that the alternative resolution be substituted for Resolution 16. The language of the substitute resolution has been approved by the Standing Committee on Constitution and Bylaws.

Dr. Hardin moved to substitute Resolution 16RC for Resolution 16 and the motion was seconded. On vote, the motion to substitute was adopted.

Dr. Hardin moved the adoption of the substitute resolution and the motion was seconded.

On vote, the following resolution (Resolution 16RC) was adopted:

16H-1976. Resolved, that Chapter V, House of Delegates, Section 140, Election Procedure, of the *Bylaws* be amended by substitution to read as follows:

> Section 140. Election Procedure. Elective officers, members of the Board of Trustees and members of councils and committees shall be elected by the House of Delegates except as otherwise provided in these *Bylaws*. Voting shall be by ballot, except that when there is only one candidate for an office, council or committee, such candidate may be declared elected by the Speaker. The Secretary shall provide facilities for voting. The polls shall be open for at least three (3) hours.
>
> a. When one is to be elected, and more than one has been nominated, the majority of the ballots cast shall elect. In the event no candidate receives a majority of the votes cast on the first ballot, the two (2) candidates receiving the greatest number of votes shall be balloted upon again.
>
> b. When more than one is to be elected, and the nominees exceed the number to be elected, the votes cast shall be non-cumulative, and the candidates receiving the greatest number of votes shall be elected.

The report of the Reference Committee continued as follows:

> Admission of New Members: The Reference Committee has reviewed Resolution 17 (p. 179). The Committee believes that the resolution properly reflects the recent extension of requirements for due process and fair procedure to those seeking membership by extending the rights of appeal to those denied membership. Therefore, the Committee recommends approval of Resolution 17. The language of the resolution has been approved by the Standing Committee on Constitution and Bylaws.

Dr. Hardin moved the adoption of Resolution 17 and the motion was seconded.

Dr. Dudley S. Moore, California, moved to postpone indefinitely Resolution 17 and the motion was seconded by Dr. William R. King, California.

On vote, the following resolution (Resolution 17) was postponed indefinitely:

17. Resolved, that Chapter I, Membership, of the *Bylaws* be amended by the addition of a new Section 60 to read as follows:

> Section 60. Admission of Active Members. A prospective member whose application for membership is denied shall be entitled to appeal from that denial to the constituent society and the Council on Judicial Procedures, Constitution and Bylaws in that order in accordance with the procedure in Chapter XI, Section 20C and D of these *Bylaws* in the same manner and governed by the same provisions as those involving the discipline of members.

and be it further

Resolved, that Chapter IX, Councils, Section 110(M)(c), Duties of the Council on Judicial Procedures, Constitution and Bylaws, of the *Bylaws* be amended by substitution to read as follows:

> To consider appeals from members of the Association, from applicants for membership in the Association, or from component or constituent societies subject to the requirements of Chapter XI, Section 20 of these *Bylaws*.

Report of Council on Judicial Procedures, Constitution and Bylaws: (Council on Judicial Procedures, Constitution and Bylaws Resolutions 18, 19, 20, 21 and 22) The Committee reported as follows:

> Editorial Amendments to the "Bylaws": These resolutions are included in the Report on Non-Policy Items.

Guidelines for Dental Directories: (California Dental Association Resolution 55) The Committee reported as follows:

> The Reference Committee has reviewed Resolution 55 (p. 363) and concurs with its intent and objective. The Committee notes that the Board of Trustees has estimated the cost of implementing Resolution 55 at $5,000. The Committee recommends the adoption of Resolution 55.

Dr. Hardin moved the adoption of Resolution 55 and the motion was seconded.

Dr. David E. Simms, New Mexico, moved to amend the resolution by deleting the words "1977 House of Delegates for approval" and inserting in lieu thereof the words "March 1977 Session of the Board of Trustees for consideration and promulgation." The motion was seconded by Dr. Thomas Spier, New Mexico.

Dr. Ashur G. Chavoor, District of Columbia, spoke in opposition to the amendment.

Dr. William R. King, California, moved to further amend the resolution by deleting the word "promulgation" and adding the words "refer back to the 1977 House of Delegates." The motion was seconded by Dr. Ashur G. Chavoor, District of Columbia.

On vote, the amendment proposed by Dr. Simms, as further amended by Dr. King, was adopted.

Dr. Hardin moved the adoption of the amended resolution and the motion was seconded.

On vote, the following resolution (Resolution 55 as amended) was adopted:

> 55H-1976. Resolved, that the American Dental Association House of Delegates direct the American Dental Association Board of Trustees to cause to be developed guidelines for dental directories and that these guidelines be submitted to the March 1977 Session of the Board of Trustees for consideration and refer back to the 1977 House of Delegates.

Announcement of a Specialty: (District of Columbia Dental Society Resolution 99; Board of Trustees Resolution 99B; Fourth Trustee District Resolution 99S-1) The Committee reported as follows:

> The Committee has reviewed Resolution 99 submitted by the District of Columbia Dental Society (p. 367), Resolution 99S-1 submitted by the Fourth Trustee District (p. 395), and Resolution 99B from the Board of Trustees (p. 516). Testimony received by the Committee indicates that Resolution 99S-1 serves to amend Section 18 of the *Principles of Ethics* and conforms with the intent of Resolution 99. The Committee concurs with the intent of Resolutions 99 and 99S-1 and recommends the adoption of Resolution 99S-1.

Dr. Hardin moved to substitute Resolution 99S-1 for Resolutions 99 and 99B, and the motion was seconded.

Dr. James P. Kerrigan, District of Columbia, announced that both the District of Columbia Dental Society and the Fourth Trustee District would withdraw Resolutions 99 and 99S-1, respectively.

The Speaker declared Resolutions 99, 99B and 99S-1 withdrawn.

Amendment of Section of the "Principles of Ethics": (Illinois State Dental Society Resolution 46) The Committee reported as follows:

The Reference Committee has reviewed Resolution 46 (p. 368) and believes that the resolution is commendable in that criteria for an assumed dental practice name are set forth in the amendatory language. However, the Committee concurs with the recommendation of the Board of Trustees (p. 489), and recommends that Resolution 46 be postponed indefinitely.

Dr. Hardin moved to postpone indefinitely Resolution 46 and the motion was seconded.

Dr. Frank A. Schroeder, Illinois, stated "In submitting this resolution, we are fully aware of the precedence of the House; that is, the debate and rejection in the past years. Since there is, however, a great increase in group practice throughout the State of Illinois, we are hopeful that the House may have a change of heart. The position that the associates are placed in by the use of the principals' names only is one of the biggest objections we find. In the Chicagoland area it is a real problem."

On vote, the following resolution (Resolution 46) was postponed indefinitely:

46. **Resolved,** that Section 20 of the American Dental Association *Principles of Ethics* be amended to read as follows:

Subject always to applicable state statutes, a dentist may practice under his own name, the name of a dentist employing him who practices in the same office, a partnership name composed of the name of one or more of the dentists practicing in a partnership in the same office, or a corporate name composed of the name of one or more of the dentists practicing as employees of the corporation in the same office.

A dentist, if he prefers, may use the registered professional corporate name for his practice. Such names must be submitted to the appropriate component dental society for prior approval. The name selected should not imply any connection with any institutional or governmental unit or organization, or imply or specify the practice of any special area of dentistry. The full name selected shall be limited to the function of helping the patient identify the practice. Further, the name selected should not constitute any false, fraudulent, misleading, deceptive or unfair statement or claim as defined elsewhere in these *Principles.*

Use of the name of a dentist no longer actively associated with the practice may be continued for a period not to exceed one year.

The use of dentists' names in directories is covered entirely by Section 19.

Reaffirmation of Section 12 of "Principles of Ethics": (Louisiana Dental Association Resolution 50) The Committee reported as follows:

The Reference Committee has reviewed Resolution 50 (p. 374). The Committee notes that Section 12 of the *Principles* is designed to prohibit "advertising . . . to solicit patients." The friend of the court brief to be filed in the *Bates and Van O'Steen* case before the United States Supreme Court will be entirely consistent with this prohibition. The Committee concurs with the recommendation of the Board of Trustees (p. 492) and recommends that Resolution 50 be approved.

Dr. Hardin moved the adoption of Resolution 50 and the motion was seconded.

Dr. J. David Gaynor, California, moved to amend the resolution by deleting the first resolving clause, and the motion was seconded by Dr. Leo E. Young, California.

Dr. Eugene J. Fortier, Jr., Louisiana, requested to remove that portion of the first resolving clause regarding disciplinary actions and retain the portion regarding reaffirmation of Section 12. Dr. Gaynor accepted the suggested amendment.

Dr. Eugene S. Czarnecki, Pennsylvania, spoke against the amendment.

On vote, the amendment was adopted.

On vote, the following resolution (Resolution 50 as amended) was adopted:

50H-1976. **Resolved,** that the American Dental Association reaffirm Section 12 of the American Dental Association *Principles of Ethics,* and be it further **Resolved,** that the American Dental Association assume an aggressive posture in defending Section 12 of the *Principles of Ethics* against any action by the Federal Trade Commission, federal government, state government, or consumer protection agencies which would be in conflict with these *Principles.*

Position Statement on Advertising: (Washington State Dental Association Resolution 41; Fifth Trustee District Resolution 41S-1) The Committee reported as follows:

The Reference Committee reviewed Resolution 41 submitted by the Washington State Dental Association (p. 389) and Resolution 41S-1 from the Fifth Trustee District (p. 407) approved by the Board of Trustees. The Committee notes that the formulation of the policy position will to large extent be satisfied by the Association's friend of the court brief to be filed in the *Bates and Van O'Steen* case before the United States Supreme Court. The Committee concurs with the Board of Trustees (p. 524) and recommends the adoption of Resolution 41S-1.

Dr. Hardin moved to substitute Resolution 41S-1 for Resolution 41 and the motion was seconded. On vote, the motion to substitute was adopted.

Dr. Hardin moved the adoption of the substitute resolution and the motion was seconded.

On vote, the following resolution (Resolution 41S-1) was adopted:

41H-1976. **Resolved,** that the Board of Trustees develop a national policy position on advertising by dentists and bring to the 1977 House of Delegates.

Amendment of "Bylaws" on Disciplinary Penalties: (Thirteenth Trustee District Resolution 60) The Committee reported as follows:

The Committee reviewed Resolution 60 (p. 418) from the Thirteenth Trustee District, the recommendation of the Board of Trustees (p. 499), and the alternative language suggested by the Committee on Constitution and Bylaws. The Committee noted testimony questioning the clearness of the language proscribing an appeal from a finding of probation violation, but notes that the amendment to Subsection B states, "There shall be no right of appeal from a finding that the conditions of probation have been violated." The Committee concurs with the recommendation of the Committee on Constitution and Bylaws. That Committee has approved a substitute resolution.

Dr. Hardin moved to substitute Resolution 60RC for Resolution 60 and the motion was seconded. On vote, the motion to substitute was adopted.

Dr. Hardin moved the adoption of the substitute resolution and the motion was seconded.

On vote, the following resolution (Resolution 60RC) was adopted:

60H-1976. **Resolved,** that Chapter XI, Principles of Ethics and Judicial Procedures, Section 20, Discipline of Members, of the *Bylaws* be amended as follows:

1. Amend the final paragraph of Subsection B by adding the phrase "except as otherwise provided herein."

2. Amend Subsection B, Disciplinary Penalties, by the addition of a new paragraph at the end of the subsection to read as follows:

> Probation, to be imposed for a specified period and without loss of rights, may be administratively and conditionally imposed when circumstances warrant in lieu of a suspended disciplinary penalty. Probation shall be conditioned on good behavior. Additional reasonable conditions may be set forth in the decision for the continuation of probation. In the event that the conditions for probation are found by the society which preferred charges to have been violated, after a hearing on the probation violation charges in accordance with Chapter XI, Section 20(C), the original disciplinary penalty shall be automatically reinstated; except that when circumstances warrant the original disciplinary penalty may be reduced to a lesser penalty. There shall be no right of appeal from a finding that the conditions of probation have been violated.

3. Amend Subsection (C)(d), Disciplinary Proceedings, Decision, by substitution to read as follows:

> Decision. Every decision which shall result in censure, suspension or expulsion or in probation shall be reduced to writing and shall specify the charges made against the member, the facts which substantiate any or all of the charges, the verdict rendered, the penalty imposed or, when appropriate, the suspended penalty imposed and the conditions for probation, and a notice shall be mailed to the accused member informing him of his right of appeal. Within ten (10) days of the date on which the decision is rendered a copy thereof shall be sent by registered mail to the last known address of each of the following parties: the accused member, the secretary of the component society of which he is a member; the secretary of the constituent society of which he is a member; the chairman of the Council on Judicial Procedures, Constitution and Bylaws of this Association and the Executive Director of this Association.

Amendment to the American Dental Association "Principles of Ethics": (Thirteenth Trustee District Resolution 136) The Committee reported as follows:

> The Committee has reviewed Resolution 136 from the Thirteenth Trustee District (p. 418) to amend Section 22 of the ADA's *Principles of Ethics*. The amendment refers to the use of interpretations by constituent and component societies in resolving questions of ethics. The Committee calls attention to Article VII of the ADA *Constitution* and Chapter XI, Section 10, of the ADA *Bylaws*, however, which provide, in effect, that a member's professional conduct shall be governed by the ADA *Principles of Ethics* and component and constituent codes of ethics. The proposed amendment to Section 22 of the *Principles of Ethics* should not be interpreted or applied so as to conflict with the ADA *Constitution* or *Bylaws*. The Committee recommends that Resolution 136 be approved.

Dr. Hardin moved the adoption of Resolution 136 and the motion was seconded. On vote, the following resolution (Resolution 136) was adopted:

> 136H-1976. Resolved, that Section 22 of the American Dental Association *Principles of Ethics* be amended by deleting from that section the words, "of the code of ethics of the component society" and inserting in their place the words, "by the component and/or constituent society of their respective codes of ethics," so that the amended section will read:
>
> > Problems involving questions of ethics should be solved at the local level within the broad boundaries established in these *Principles of Ethics* and within the interpretation by the component and/or constituent society of their respective codes of ethics. If a satisfactory decision cannot be reached, the question should be referred on appeal, to the constituent society and the Council on Judicial Procedures, Constitution and Bylaws of the American Dental Association, as provided in Chapter XI of the *Bylaws* of the American Dental Association.

Amendment of Section 15 of "Principles of Ethics": (Delegate Paul J. McKenna Resolution 61; Board of Trustees Resolution 61B) The Committee reported as follows:

> The Reference Committee reviewed Resolution 61 (p. 434) from Delegate Paul J. McKenna, Massachusetts, and Resolution 61B (p. 499) recommended by the Board of Trustees. The Committee believes that dentists should continue to limit their use of degrees to their D.D.S. or D.M.D. degrees. Therefore, the Committee recommends that these resolutions be postponed indefinitely.

Dr. Hardin moved to postpone indefinitely Resolution 61 and the motion was seconded.

Dr. Paul J. McKenna, Massachusetts, spoke against the motion to postpone indefinitely, stating ". . . Our Council on Judicial Procedures, after hours of deliberation, not only recommended approval but had actually expanded the resolution submitted by me, and the Board of Trustees endorsed the Council's action unanimously. Our reference committee, after hearing only two individuals testify against this resolution, assumed a greater wisdom and reversed the decision of both the Council and the Board of Trustees. . . ."

Dr. Joseph G. DiStasio, Massachusetts, and Dr. Richard A. Shick, Michigan, spoke against the motion to postpone indefinitely.

Dr. Dale F. Redig, California, called for the question and the motion was seconded. The motion to vote immediately was passed.

On vote, the following resolution (Resolution 61) was postponed indefinitely:

> 61. Resolved, that Section 15 of the American Dental Association *Principles of Ethics* be amended by inserting the words "and any additional advanced academic degrees earned in health service areas" after the words "of D.M.D."; by deleting the words "a dentist who also possesses a medical degree may use this degree in connection with his name on cards, letterheads, office door signs and announcements"; and by deleting the words "if such usage is consistent with the custom of dentists of the community" to make the amended section 15 read as follows:
>
> > Use of Professional Titles and Degrees: A dentist may use the titles or degrees, Doctor, Dentist, D.D.S. or D.M.D. and any additional advanced academic degrees earned in health service areas. A dentist who has been certified by a national certifying board for one of the specialties approved by the American Dental Association may use the title "diplomate" in connection with his specialty on his cards, letterheads and announcements. A dentist may not use his title or degree in connection with the promotion of any commercial endeavor.
> >
> > The use of eponyms in connection with drugs, agents, instruments or appliances is generally to be discouraged.

Dr. Hardin moved to postpone indefinitely Resolution 61B and the motion was seconded.

Dr. Paul J. McKenna, Massachusetts, spoke against the motion to postpone indefinitely.

Dr. John T. Weatherall, Texas, called for the question and the motion was seconded. The motion to vote immediately was passed.

On vote, the following resolution (Resolution 61B) was postponed indefinitely:

61B. **Resolved**, that Section 15 of the American Dental Association *Principles of Ethics* be amended by inserting the words "any earned academic degrees" after the words "or D.M.D."; by deleting the words "a dentist who also possesses a medical degree may use this degree in connection with his name on cards, letterheads, office door signs and announcements"; and by deleting the words "if such usage is consistent with the custom of dentists of the community" to make the amended Section 15 read as follows:

> **Use of Professional Titles and Degrees:** A dentist may use the titles and degrees, Doctor, Dentist, D.D.S. or D.M.D. and any earned academic degrees. A dentist who has been certified by a national certifying board for one of the specialties approved by the American Dental Association may use the title "diplomate" in connection with his specialty on his cards, letterheads and announcements. A dentist may not use his title or degree in connection with the promotion of any commercial endeavor.
>
> The use of eponyms in connection with drugs, agents, instruments or appliances is generally to be discouraged.

Report of Council on Legislation: The Committee reported as follows:

> The Committee commends the Council for an excellent report of activities at both national and state levels (p. 182).

Report of Council on Legislation, Supplemental Report 1: The Committee reported as follows:

> The Committee urges the delegates to use the Council's supplemental report as a reference source for the accomplishments of the Council and the Washington Office during 1976 (p. 187). The outstanding achievement of the Washington Office was convincing both Houses of Congress that the Association's policies on health manpower legislation were not only essential to the nation's dental education system but also for the benefit of the public.

Professional Exemption from Antitrust Legislation: (California Dental Association Resolution 59) The Committee reported as follows:

> The Committee commends the California Dental Association for its farsighted approach to solving a critical problem (p. 364). Despite the obstacles that may emerge, the dental profession must join with the AMA, the ABA and other professional groups in a concerted drive for equity under the federal antitrust laws. The Committee notes the first year's expense is estimated to be $25,000. The Committee recommends that Resolution 59 be adopted.

Dr. Hardin moved the adoption of Resolution 59 and the motion was seconded.

Dr. Ronald E. Price, Kansas, moved to amend the resolution by deleting the word "health" and inserting in lieu therefor the word "professional." The motion was seconded.

On vote, the amendment proposed by Dr. Price was defeated.

Dr. Israel Shulman, District of Columbia, moved to amend the resolution by inserting the word "like" before the word "professions" and the motion was seconded by Dr. James P. Kerrigan, District of Columbia.

Dr. B. C. Kingsbury, Jr., California, suggested that the word "learned" be inserted following the word "like." Dr. Shulman accepted the change.

Mr. John P. Noone, assistant executive director (business affairs and house counsel),

stated "I would like to point out that in the preamble we talk about getting the cooperation of the American Bar Association. I am not saying that is a learned profession, but I do believe that your chance of getting legislation of this type would be better if we had our friends in the legal profession and the medical profession included. . . . I think the language that is being proposed now would make it broad enough so that we could have a concerted effort toward getting this legislation passed."

On vote, the amendment proposed by Dr. Shulman, and editorially changed by Dr. Kingsbury, was adopted.

Dr. Frank A. Schroeder, Illinois, moved to further amend the resolution by inserting the words "and legal" after the word "health" and the motion was seconded by Dr. Leonard Giannone, Illinois.

Dr. Robert L. Swanstrom, Minnesota, spoke in opposition to the amendment.

Dr. Schroeder then editorially changed his amendment to delete the word "legal" and insert instead the word "such."

Dr. John F. Barry, Jr., Connecticut, called for the question and the motion was seconded. The motion to vote immediately was passed.

On vote, the amendment proposed by Dr. Schroeder was defeated.

Dr. Bernard S. Snyder, Ohio, moved to amend the resolution by inserting the words "to be determined by the Board of Trustees" after the word "professions" and by deleteing the word "health" and inserting in lieu therefor the word "these." The motion was seconded.

On vote, the amendments proposed by Dr. Snyder were adopted.

On vote, the following resolution (Resolution 59 as amended) was adopted:

> 59H-1976. Resolved, that the American Dental Association, in cooperation with other like learned professions to be determined by the Board of Trustees, seek legislation either by amendment of existing statutes or by the creation of an entirely new bill that would exempt these associations from the enforcement jurisdiction of the Federal Trade Commission and the application of the federal antitrust laws.

Sharing and Coordination of Legal Expertise: (Ohio Dental Association Resolution 97; Board of Trustees Resolution 97B) The Committee reported as follows:

> The Committee reviewed Resolution 97 (p. 382) and Resolution 97B (p. 521). The annual cost involved is $100,000. The Committee understands that the Ohio Dental Association accepts the Board's suggested amendment. The Committee, therefore, recommends adoption of the Ohio resolution as amended by the Board of Trustees.

Dr. Hardin moved to substitute Resolution 97B for Resolution 97 and the motion was seconded. On vote, the motion to substitute was adopted.

Dr. Hardin moved the adoption of the substitute resolution and the motion was seconded.

On vote, the following resolution (Resolution 97B) was adopted:

> 97H-1976. Resolved, that the American Dental Association, through its legal department, develop a means by which its high level of legal expertise can be shared with constituent societies and their respectiye legal counsels when deemed appropriate, feasible and in the best interests of the dental profession, and be it further

Resolved, that the American Dental Association legal department establish a mechanism whereby the legal counsel of the various constituent societies may better coordinate and share expertise and information with respect to their common legal problems.

Conference on Legislation and Legal Issues: (Fourth Trustee District Resolution 140) The Committee reported as follows:

The Committee reviewed Resolution 140 (p. 394). The Committee agrees that a conference on current critical legal issues should have the highest priority. The conference cost is estimated as $5,000. The Committee submits an amendment to emphasize that the conference should concentrate upon antitrust legislation and not the full range of critical legislative issues affecting dentistry. The Committee's amendment would insert "antitrust" before "legislation" in the first line of Resolution 140.

Dr. Hardin moved to substitute Resolution 140RC for Resolution 140 and the motion was seconded. On vote, the motion to substitute was adopted.

Dr. Hardin moved the adoption of the substitute resolution and the motion was seconded.

On vote, the following resolution (Resolution 140RC) was adopted:

140H-1976. Resolved, that a conference on antitrust legislation and legal issues facing the profession be called by the American Dental Association to discuss problems connected with litigation and that presidents, presidents-elect, executive directors and attorneys for each constituent society be invited to participate in this conference, and be it further

Resolved, that the appropriate agency of the Association schedule such a conference as soon as possible.

Tax Exemption for Scholarships: (Fourth Trustee District Resolution 145) The Committee reported as follows:

The Committee studied Resolution 145 (p. 396) submitted by the Fourth Trustee District and recommends its adoption.

Dr. Hardin moved the adoption of Resolution 145 and the motion was seconded.

On vote, the following resolution (Resolution 145) was adopted:

145H-1976. Resolved, that the American Dental Association support legislation providing a tax exemption for scholarship assistance and stipends awarded to health professions students under federal programs.

National Health Service Corps: (Fourth Trustee District Resolution 148) The Committee reported as follows:

The Committee reviewed Resolution 148 (p. 394). The Committee recognizes that Association agencies have developed a commendable amount of information and criteria relating to the assignment of National Health Service Corps dental personnel, but believes that because of recently enacted legislation, up-dating of this material is desirable and of considerable urgency. The Committee, therefore, supports the intent of Resolution 148 but recommends minor language changes and presents them in the form of a substitute resolution.

Dr. Hardin moved to substitute Resolution 148RC for Resolution 148 and the motion was seconded. On vote, the motion to substitute was adopted.

Dr. Hardin moved the adoption of the substitute resolution and the motion was seconded.

On vote, the following resolution (Resolution 148RC) was adopted:

> 148H-1976. Resolved, that the appropriate agencies of this Association be directed to seek the necessary and timely input into the development of the criteria for utilization of the National Health Service Corps in underserved areas.

Support of Senate Bill 410: (Fourth Trustee District Resolution 152) The Committee reported as follows:

> The Committee studied Resolution 152 (p. 396) submitted by the Fourth Trustee District. The legislation addressed in Resolution 152 would affect all persons eligible for Social Security Retirement Benefits. S.410 would permit Social Security beneficiaries to receive benefits after age 65 despite their earnings from employment or self-employment. Approval of S.410 would add at least $2 billion to the Social Security Program. The Committee believes that the Association should refrain from adopting policies on legislation that have no special impact on dentists as such. The Committee also emphasizes that recent studies indicate that the Social Security Program might have to face retrenchment. An increase of $2 billion a year to the program has little chance of adoption by Congress. Therefore, the Committee recommends that Resolution 152 be postponed indefinitely.

Dr. Hardin moved to postpone indefinitely Resolution 152 and the motion was seconded.

Dr. Philip Schwartz, New Jersey, stated "I feel that it would be wrong to disregard this bill because there are so many benefits that could be derived by a great number of our profession. For example, there are a number of our men over 65 who have been retired and who are forced to retire due to ill health or other reasons and who are on limited incomes. They would be greatly benefited by this particular legislation. We seem to be able to ask for money for all other reasons. Why can't we do it for these men who are 65 and over and who are not able to earn a living beyond $2,500 to $2,700 a year? I appeal to you to try and keep this at least before the assembly here today. This is a very significant piece of legislation and, if enacted, would appeal the earnings lid for social security purposes. I realize it would cost the government a great deal of money, but requests have been given to the government on many occasions and we should give it on behalf of our own men."

On vote, the following resolution (Resolution 152) was postponed indefinitely:

> 152. Resolved, that the American Dental Association actively support Senate Bill 410 which if enacted will repeal "Earnings Test for Social Security Retirement Benefits."

Timing of Requests by Federal Agencies for Comment by the Dental Profession: (Fifth Trustee District Resolution 157) The Committee reported as follows:

> The Committee was informed that during the last year the American Dental Association joined with other health organizations in requesting the Department of Health, Education, and Welfare to revise its procedures with respect to providing adequate notice and time to submit comments on proposed regulations (p. 409). As a result, the Department indicated

that it intended to revise its procedures by publishing a notice of intent to publish regulations and extending the time for interested individuals or organizations to comment thereon. The Committee agrees with the intent of Resolution 157 but believes that its objectives can be more realistically achieved by adoption of a substitute resolution.

Dr. Hardin moved to substitute Resolution 157RC for Resolution 157 and the motion was seconded. On vote, the motion to substitute was adopted.

Dr. Hardin moved the adoption of the substitute resolution and the motion was seconded.

On vote, the following resolution (Resolution 157RC) was adopted:

157H-1976. **Resolved**, that the American Dental Association, through its appropriate agencies, actively support changes in federal administrative procedures in order to permit reasonable notice of, and time for, comment upon proposed regulations.

Establishment of Committee on Government Operation: (Tenth Trustee District Resolution 137) The Committee reported as follows:

The Committee reviewed Resolution 137 (p. 413) submitted by the Tenth Trustee District. The Committee shares the strong conviction underlying Resolution 137 to the effect that the American Dental Association should make every effort to advance and protect the private system of dental practice free from unnecessary governmental controls and interference. A large number of Association agencies are involved in activities and programs to accomplish this purpose under the mandate of the House of Delegates and the direction of the Board of Trustees. In this situation, the Committee believes that creation of a new committee on Government Operations, as proposed in Resolution 137, would duplicate ongoing activities and would entail a questionable expenditure of funds considerably in excess of the proposed $1,000 allocation. For these reasons, the Committee reached the conclusion that Resolution 137 should not be adopted.

Dr. Hardin moved to postpone indefinitely Resolution 137 and the motion was seconded.

Dr. Philip J. Maschka, Nebraska, stated "Government in the United States has grown over the past 200 years to the point where now one in every six persons of our population is employed by a governmental unit. This is more in terms of employees in the auto field and the oil industries combined. Emboldened by its tremendous size, governmental agencies have assumed ever increasing control and regulatory powers influenced by reports of these agencies. Congress has legislated matters that threaten liberty and freedom of private citizens, business, and the profession. In the area of dentistry, this has resulted in federally sponsored HMOs. . . . Since the ADA has the dual responsibility of representing individual dentists and the profession, both of which are threatened and harassed by the encroachment of government, it seems apropos that the organization should take a stand on opposing further erosion of our basic national principles. Since no council or committee of the ADA has been assigned the responsibility of examining the operations in government for the purpose of pointing out the abuse of governmental authority and infringement of personal freedom, it is suggested that a new committee be appointed for this purpose. . . . I would urge the House to oppose the motion to postpone indefinitely."

On vote, the following resolution (Resolution 137) was postponed indefinitely:

137. **Resolved**, that the American Dental Association establish a Committee on

Government Operations whose principal duty would be to focus on instances of mismanagement and harassment by government agencies and to report these instances to the Board of Trustees who in turn would report them to higher governmental authority and to the public through the press and news media, and be it further

Resolved, that $1,000 be allocated for the expenses of the committee in the 1977 budget.

Commendation of Washington Office and Hal M. Christensen: (Twelfth Trustee District Resolution 153) The Committee reported as follows:

This resolution (p. 416) is included in the Report on Non-Policy Resolutions.

Model State Dental Practice Act: (Delegate Eugene J. Fortier, Jr. Resolution 103; Board of Trustees Resolution 103B) The Committee reported as follows:

The Committee reviewed Resolution 103 (p. 428) and Resolution 103B (p. 526). The Committee received from Dr. Fortier a revised explanation of the intent of his resolution. The Committee is impressed by Dr. Fortier's desire to have state dental laws kept abreast of new legal concepts. Since Resolution 103 calls for a feasibility study, the cost of that study could be absorbed in the existing budget. The Committee concurs with Dr. Fortier and recommends adoption of Resolution 103.

Dr. Eugene J. Fortier, Jr., Louisiana, withdrew Resolution 103.

The Speaker declared Resolutions 103 and 103B withdrawn.

Report of Council on Relief: (Council on Relief Resolution 23) The Committee reported as follows:

Annual Report: The Committee reviewed the annual report of the Council on Relief (p. 200) and commends the Council on the manner in which it has conducted the affairs of the Relief and Disaster Funds. The Committee especially wishes to acknowledge the many contributions made to the Relief and Disaster Funds by members of the dental profession which totalled $280,300.

Amendment to the American Dental Association Relief Fund "Indenture of Trust": The Committee reviewed Resolution 23 (p. 201) and the Board's comments recommending that the resolution be approved (p. 483). The Committee agrees that the resolution as proposed more accurately describes the duties of the Council's Investment Committee and recommends that Resolution 23 be adopted.

Dr. Hardin moved the adoption of Resolution 23 and the motion was seconded.

On vote, the following resolution (Resolution 23) was adopted:

23H-1976. Resolved, that Article III of the American Dental Association Relief Fund *Indenture of Trust* be amended to read:

That part of the Trust Property which the Trustees deem available for investment shall be invested by them in assets legal from time to time for investment by trustees under the law of the State of Illinois. The Trustees shall from time to time, with the approval of the Board of Trustees of the Association, employ an investment counsellor. Such professional investment counsel shall be either advisory to the Investment Committee in all matters relating to the investment policies and practices of the Trust

property or may be given discretionary authority by the Investment Committee to buy and sell securities for the portfolio provided that the investment counsel promptly reports to the Trustees through the Council on Relief Secretary, each purchase and sale of a security as soon as completion of any such transaction is confirmed. The Trustees shall from time to time select two of their members who together with the Treasurer of the Association shall constitute the Relief Fund Investment Committee. The Committee shall monitor the activities of the investment counsel and make recommendations to the Trustees on investment programs.

REPORT OF REFERENCE COMMITTEE ON DENTAL EDUCATION AND RELATED MATTERS

The Report of the Reference Committee on Dental Education and Related Matters was read by Dr. Harry W. F. Dressel, Jr., Maryland, chairman. The other members of the Committee were Drs. DeWayne L. Briscoe, Washington; Duane M. Hunt, Nebraska; James F. Mercer, Ohio; Lawrence Scinto, Connecticut.

Report of Commission on Accreditation of Dental and Dental Auxiliary Educational Programs: The Committee reported as follows:

> The Reference Committee reviewed the report of the Commission on Accreditation (p. 84) and was pleased to note that the Commission is continuing with the practice of self-review for the purpose of enhancing its accreditation program. Further, it was pleased to note that the Commission is attempting to improve the quality and efficiency of the program without substantial increase in cost to the Association.

Report of Council on Dental Education: (Council on Dental Education Resolutions 1, 2, 3 and 4; Board of Trustees Resolution 4B; Fifth Trustee District Resolutions 4S-1 and 4S-2; Ohio Dental Association Resolution 95; Minnesota Dental Association Resolution 155) The Committee reported as follows:

> **Annual Report:** The Reference Committee considered the annual report of the Council (p. 87) and commends the Council for the effective manner in which it has discharged its many responsibilities during the past year. Of special interest to the Committee was the extensive interim report on the curriculum study and the development of instructional guidelines for teaching physical evaluation and orthodontics at the predoctoral level.
>
> **Eligibility for Board Examination:** The Reference Committee is in accord with the recommendation of the Council that clarification of the 1966 resolution (*Trans.* 1966:346) establishing the educational waiver for the American Board of Endodontics is needed. The Committee believes that the background information leading to the approval of the educational waiver clearly defines the intent of the House; however, as a free standing resolution it could be misinterpreted and subject to challenge. On the basis of testimony provided during the hearing, the Reference Committee believes that the resolution should be further clarified by identifying the American Board of Endodontics since the other certifying boards are not operating under an educational waiver. Therefore, the Reference Committee recommends that "the American Board of Endodontics" be substituted for the term "the Board" in the first resolving clause of Resolution 1 (p. 104).

Dr. Dressel moved the adoption of the amendment and the motion was seconded. On vote, the amendment was adopted.

Dr. Dressel moved the adoption of the amended resolution (Resolution 1RC) and the motion was seconded.

On vote, the following resolution (Resolution 1RC) was adopted:

1H-1976. **Resolved**, that in compliance with the intent of Resolution 36-1966-H (*Trans.* 1966:346) candidates who do not possess the required formal education and who did not apply to the American Board of Endodontics for examination prior to December 31, 1974 are ineligible for examination, and be it further

Resolved, that candidates who do not possess the formal education requirement but applied for examination prior to December 31, 1974 are ineligible for reapplication upon expiration of their board eligibility.

The report of the Reference Committee continued as follows:

Amendment of "Requirements for National Certifying Boards for Special Areas of Dental Practice": In considering Resolution 2 (p. 104), the Reference Committee agrees that the *Requirements for National Certifying Boards for Special Areas of Dental Practice* should be revised to require specifically that each board have on a continuing basis a sponsoring organization. The Reference Committee concurs that Resolution 2 as submitted by the Council is administrative in nature and supports the recommendation of the Council and the Board (p. 474) in the adoption of Resolution 2.

Dr. Dressel moved the adoption of Resolution 2 and the motion was seconded.

On vote, the following resolution (Resolution 2) was adopted:

2H-1976. **Resolved**, that the first paragraph of the *Requirements for National Certifying Boards for Special Areas of Dental Practice* adopted by the House of Delegates (*Trans.* 1959:204) be deleted and that the following be substituted therefor:

> In order to become, and remain, eligible for recognition by the American Dental Association as a national certifying board for a special area of practice, the area shall have a sponsoring or parent organization whose membership is reflective of the recognized special area of dental practice. A close working relationship shall be maintained between the parent organization and the board. Additionally, the following requirements must be fulfilled:

The report of the Reference Committee continued as follows:

Establishment of Voluntary National Program for Evaluation of Continuing Education Sponsors: The Committee reviewed the proposed national program for evaluation of continuing education sponsoring organizations (p. 94), developed by the Council in response to a directive by the 1975 House (*Trans.* 1975:708). The Committee agrees with the Board of Trustees (p. 474) and the Council that establishment of such a program would fulfill an apparent need within the profession.

The Committee endorses the concept of a standing national advisory committee under the auspices of the Council, which would develop the national standards for evaluation of continuing education sponsoring organizations, subject to approval by the 1978 House. Voluntary participation in the evaluation program by constituent societies serving as state-level evaluating agencies of the Council, also appears to be a workable and useful concept.

During deliberation of this issue, the Reference Committee also considered a substitute resolution submitted by the American Association of Dental Examiners that the advisory committee be composed of an equal number of representatives of the American Dental Association and the American Association of Dental Examiners. The Committee also received testimony that to do so would exclude educators who also play an important role in the delivery of continuing education.

While the Reference Committee is sympathetic to all concerns expressed, it believes both organizations have adequate representation on the Council to provide sufficient input. The Reference Committee wishes to emphasize that Resolution 3 (p. 105), responding to the 1975 request of the House, is merely an enabling resolution and no program will be implemented prior to approval by the House. If the program is adopted in 1978, representation of the national steering committee can be decided at that time. With this in mind, the Reference Committee believes that clarification of the resolution is needed and recommends that the following resolution be substituted for Resolution 3:

> 3RC. **Resolved,** that the Council on Dental Education of the American Dental Association, in cooperation with constituent dental societies, develop a proposal for a voluntary national program for the evaluation of continuing education sponsors, and be it further
> **Resolved,** that prior to implementation of the proposed program, standards, criteria, and procedures relating to the program be reported to the 1978 House of Delegates.

Dr. Dressel moved to substitute Resolution 3RC for Resolution 3 and the motion was seconded. On vote, the motion to substitute was adopted.

Dr. James P. Kerrigan, District of Columbia, moved to amend the substitute resolution by inserting the words "and state boards of dentistry" after the word "societies" in the first resolving clause. The motion was seconded by Dr. Israel Shulman, District of Columbia.

On vote, the amendment proposed by Dr. Kerrigan was adopted.

Dr. Dressel moved the adoption of the amended substitute resolution and the motion was seconded.

On vote, the following resolution (Resolution 3RC as amended) was adopted:

> 3H-1976. **Resolved,** that the Council on Dental Education of the American Dental Association, in cooperation with constituent dental societies and state boards of dentistry, develop a proposal for a voluntary national program for the evaluation of continuing education sponsors, and be it further
> **Resolved,** that prior to implementation of the proposed program, standards, criteria, and procedures relating to the program be reported to the 1978 House of Delegates.

The report of the Reference Committee continued as follows:

> **Educational Standards for Dental Hygiene:** The Reference Committee heard considerable testimony on Resolution 4 (p. 105), Resolution 4S-1 of the Fifth Trustee District (p. 398), Resolution 95 of the Ohio Dental Association (p. 381), Resolution 155 of the Minnesota Dental Association (p. 377) and the Board of Trustees' substitute Resolution 4B (p. 520). All relate to educational standards for dental hygiene. Resolution 155 was submitted too late for the Board to consider. However, the intent is the same as Resolution 95 which urges the American Dental Association to oppose efforts to train and qualify individuals for performance of dental hygiene functions through methods other than accredited educational programs. In considering the Fifth Trustee District's resolution, the Committee fully agrees with the Board's position (p. 519) that it would completely change the intent of the other resolutions and would reverse the Association's policy which supports formal education and the educational qualifications established by the profession for dental hygienists' licensure and practice.
>
> During the hearings, a suggestion was offered to amend the Board's substitute Resolution 4B by inserting the words "and/or certification" after the words "dental hygiene licensure examination" in the first resolving clause. After careful deliberation, the Committee came to the firm conclusion that insertion of the word "certification" would be misleading and could jeopardize the profession's responsibility for credentialling hygienists. Because dental hygien-

ists are licensed and there is no national certification program for dental hygienists, insertion of the word would imply that the Association would consider certification by a body or agency other than state boards as an appropriate alternative to licensure by boards of dentistry. Thus, the profession's responsibility for licensing dental hygienists could be undermined. In the Committee's judgement it is essential that state boards of dentistry retain responsibility for licensing dental hygienists.

It was also suggested during the hearings that the words "and/or practice" be inserted after the words "for dental hygiene licensure examination" in the first resolving clause of the Board's substitute Resolution 4B. The Committee concurs with and strongly supports the suggestion because it reinforces the position that the educational standards developed and supported by the profession are essential not only for licensure, but for dental hygiene practice.

For these reasons, the Reference Committee recommends that a substitute resolution for Resolutions 4, 4S-1, 95, 155 and 4B be adopted.

Dr. Dressel moved to substitute Resolution 4RC for Resolutions 4, 4S-1, 95, 155 and 4B and the motion was seconded. On vote, the motion to substitute was adopted.

Dr. Dressel moved the adoption of the substitute resolution and the motion was seconded.

On vote, the following resolution (Resolution 4RC) was adopted:

4H-1976. **Resolved**, that graduation from a dental hygiene program accredited by the Commission on Accreditation of Dental and Dental Auxiliary Educational Programs is the essential educational eligibility requirement for dental hygiene licensure examination, and/or practice, and be it further

Resolved, that the American Dental Association oppose efforts to train and qualify individuals to perform dental hygiene functions who have not completed an accredited dental hygiene education program.

Report of Council on Hospital Dental Service: The Committee reported as follows:

Annual Report: The Reference Committee reviewed the various activities of the Council on Hospital Dental Service identified in its annual report (p. 145). Of particular interest to the Committee were the Council's efforts to enhance its dental service approval program and the continuing campaign for Joint Commission on Accreditation of Hospitals corporate membership.

Single Medical Staff Requirement: The Reference Committee considered testimony from a representative of an institution requesting an exception status to the Association policy which requires there shall be a single medical staff, composed of physicians and dentists, rather than separate medical and dental staffs.

The Committee is cognizant of the long-standing efforts of the dental profession to realize co-equal status between physicians and dentists in the hospital environment. A significant accomplishment in this regard is the promulgation by the American Hospital Association, the American Medical Association and the Joint Commission on Accreditation of Hospitals of a single medical staff concept rather than two independent staffs—a medical staff and a dental staff, each reporting separately to the hospital governing body.

The Committee believes that granting exceptions to Association policy on this critical issue would substantially dilute the established uniform criteria concept of accreditation standards and additionally would have a deleterious effect on the recognition and participation of dentists in the hospital.

The Committee is sympathetic with the problems of the institution but feels that exceptions should not be granted. The Committee hopes the institution will use the resources offered by the Council on Hospital Dental Service in amelioration of the problems extant at that individual hospital.

Report of Council of National Board of Dental Examiners: The Committee reported as follows:

> The Reference Committee reviewed with interest the report of the Council of National Board of Dental Examiners (p. 196). The Committee compliments the Council for its responsiveness to concerns expressed by the American Association of Dental Examiners in establishing a joint examination review mechanism. The Committee anticipates that AADE input into development of National Board examinations will have a positive effect on examination quality.
>
> Also, it noted that the Council is studying National Board eligibility requirements as they relate to foreign trained individuals in a careful and deliberate manner.

Classification of Dental Laboratory Technicians: (Illinois State Dental Society Resolution 47) The Committee reported as follows:

> The Reference Committee heard considerable discussion on the resolution submitted by the Illinois State Dental Society (p. 369) which proposes that only dental laboratory technicians employed in private dental offices be considered as auxiliary to the profession. The Committee also considered the Board's position on the resolution (p. 489). The Committee agrees with the Board, the Council on Dental Education and the Council on Dental Laboratory Relations that the dentist's work authorization represents a request for services which are part of dental care provided by the dentist to his patient, and when fulfilling the work authorization, the laboratory technician is in fact assisting the dentist in his provision of dental services. The functions performed by dental laboratory technicians whether performed in a dental office setting or in a dental laboratory are the same. It appeared to the Committee that the basic concern addressed in the Illinois resolution cannot be solved by a simple change in terminology and agrees with the Board that priority should be given to a comprehensive study of the profession's relationship with the dental laboratory industry. The Committee recommends that Resolution 47 be postponed indefinitely.

Dr. Dressel moved to postpone indefinitely Resolution 47 and the motion was seconded.

Dr. Harold L. Martin, Illinois, stated "We in Illinois are ever mindful of the great volume of business to come before this House of Delegates . . . and have also respectfully observed that the democratic process involving debate and compromise was recognized with the result of a lack of support for our Resolution 47 so sincerely submitted by the Illinois Delegation. We graciously accepted it; however, as a member supportive of the allied dental team and even though we remain dedicated to our resolution, we yield our sentiments to the wishes of this reference committee. . . . We respectfully ask that the recommendation of this committee be accepted."

On vote, the following resolution (Resolution 47) was postponed indefinitely:

> 47. **Resolved**, that this Association recognize only dental laboratory technicians actually employed in the dental office as an auxiliary and that other technicians employed within the laboratory craft be considered to be a part of the dental laboratory industry.

Nondiscriminatory Policy for Accepting Dental Students: (Indiana Dental Association Resolution 109) The Committee reported as follows:

> The Committee reviewed the resolution submitted by the Indiana Dental Association (p. 371) requesting an amendment to the section of the *Requirements for an Accredited School of Dentistry* dealing with admissions. Specifically, the request is for inclusion of a statement supporting the principle of nondiscrimination in the admissions process.

During the hearings, it was pointed out that in May 1972 the Council on Dental Education and in February 1975 the Commission on Accreditation approved a more encompassing policy statement concerning support of nondiscrimination in admission of students or employment of faculty and staff. The statement is appended to the dental school *Requirements* document and does not appear as an integral part of the admissions section because the *Requirements* were revised in 1970, prior to development of the policy statement. The reason that the statement appears in the standards for auxiliary and advanced education programs is that these standards were revised subsequent to the development and approval of the Council and Commission's policy statement.

In reviewing the resolution, the Committee noted that the Board (p. 517) pointed out that the House of Delegates transferred the *Bylaws* authority for the approval of educational standards to the Commission. For this reason, the Committee agrees with the Board's rationale for amending the resolution to conform to the Association *Bylaws*. However, in considering the Board's amended resolution, the Committee is of the belief that adding the words "and that nondiscriminatory policies will be followed in admitting students" could be misleading in that dental school admissions committees do discriminate on the basis of preprofessional educational background and academic achievement. In the Committee's judgement, the intent of the Indiana resolution is in concert with the Council and Commission's policy statement which relates to use of nondiscriminatory practices based on sex, race, creed, religion or national origin.

For this reason, the Committee offers a substitute resolution.

Dr. Dressel moved to substitute Resolution 109RC for Resolution 109 and the motion was seconded. On vote, the motion to substitute was adopted.

Dr. Dressel moved the adoption of the substitute resolution and the motion was seconded.

On vote, the following resolution (Resolution 109RC) was adopted:

109H-1976. Resolved, that the Commission on Accreditation of Dental and Dental Auxiliary Educational Programs be requested to amend the *Requirements for an Accredited School of Dentistry* (*Trans.* 1970:54, 437) by adding the following words to the third paragraph under "Admissions":

> and that the principle which prohibits discrimination in educational programs on the basis of sex, race, creed, religion or national origin be followed in admitting students.

to make the paragraph read as follows:

> It is the opinion of the Commission that the selection of students for admission to dental schools should be based on estimates of their capacity for success in the study of dentistry as determined by evaluation of all available and significant information. Consideration of the qualifications of applicants for admission should include information regarding their character, the quality of their preprofessional education, health status and aptitude for and interest in a career in dentistry. The Commission emphasizes that the admission committee has the major responsibility for determining the qualifications of prospective students in the light of educational aims and objectives of the profession and that the principle which prohibits discrimination in educational programs on the basis of sex, race, creed, religion or national origin be followed in admitting students.

Problems Existing Between Medicine and Dentistry in the Hospital: (Second Trustee District Resolution 113; Board of Trustees Resolution 113B The Committee reported as follows:

The Reference Committee considered the resolution submitted by the Second Trustee Dis-

trict on problems existing between medicine and dentistry in the hospital (p. 391) and the amended resolution submitted by the Board of Trustees (p. 522). The Committee is strongly supportive of assisting The Dental Society of the State of New York in its attempts to ameliorate jurisdictional disputes between medicine and dentistry in the hospital. The Committee further believes that the amended resolution is precise and indicates appropriate support from the American Dental Association in seeking remediation of this critical issue. Accordingly, the Committee recommends adoption of Resolution 113B.

Dr. Dressel moved the adoption of Resolution 113B and the motion was seconded. On vote, the following resolution (Resolution 113B) was adopted:

113H-1976. Resolved, that the American Dental Association is strongly urged to assist The Dental Society of the State of New York to ameliorate jurisdictional disputes between medicine and dentistry in the State of New York in order to allow appropriately licensed dentists to practice dentistry within the parameters of their training, experience and demonstrated competence.

Need for Recognition of Training in Comprehensive Dental Practice: (Fourth Trustee District Resolution 144) The Committee reported as follows:

In considering Resolution 144 (p. 394) submitted by the Fourth Trustee District, the Reference Committee believes that there may be some merit in what the resolution suggests; however, the intent and purpose of the suggested survey are unclear. The Reference Committee also believes that the cost to implement the resolution as specified in the background statement would not be sufficient to conduct a survey of the magnitude suggested. For these reasons, the Reference Committee recommends that Resolution 144 be postponed indefinitely.

Dr. Dressel moved to postpone indefinitely Resolution 144 and the motion was seconded.

Dr. William H. McKenna, Massachusetts, moved to amend Resolution 144 by deleting the words "a recognized advanced education program" and inserting in lieu therefor the words "all types of postdoctoral programs including continuing education." The motion was seconded by Dr. Ashur G. Chavoor, District of Columbia.

Dr. Lawrence Scinto, Connecticut, stated "I would like to speak to this amendment and point out the fact that when we were told that we had all the facts we felt the resolution did not clarify what they meant by recognition of a postgraduate course in general dentistry because, according to ADA *Bylaws,* there is no procedure for recognizing any specialty other than the eight specialties that are listed. . . ."

Dr. Carlos J. Noya, Puerto Rico, spoke in favor of the amendment, stating ". . . I feel that in time it will make it definitely the way the general dentistry area is going. For general practice we have to establish that as such because it has not been fully defined which way we are going. We are not going to a specialty. We are going to support the backbone of the profession which is the general practice area. . . . I do not think, however, we can wait on this. It is very urgent. . . ."

Dr. Eugene J. Truono, Delaware, spoke in favor of the amendment, stating "As you know, every year we come here and we deal with the other concerns of other groups within the profession. I think it is about time that this body, which represents approximately 100,000 general practitioners, recognize that there is a deep concern among the general practitioners in this area. They are not looking for super dentists but they need some kind of program on the advanced educational courses. . . ."

Dr. Dominic J. Catrambone, Illinois, called for the question and the motion was seconded. The motion to vote immediately was passed.

On vote, the amendment proposed by Dr. McKenna was adopted.

On vote, the following resolution (Resolution 144 as amended) was postponed indefinitely:

> 144. **Resolved,** that the appropriate agencies of the American Dental Association develop and conduct a survey of general practitioners who are members of the Association to obtain their opinions as to the need, desirability, and method for recognizing those who study general dentistry in all types of postdoctoral programs including continuing education.

Revision of "Requirements for Approval of General Practice Residency Programs in Dentistry": (Twelfth Trustee District Resolution 143) The Committee reported as follows:

> In considering Resolution 143 submitted by the Twelfth Trustee District (p. 417) for revision of the *Requirements for Approval of General Practice Residency Programs in Dentistry,* the Reference Committee is obligated to advise the House that the Commission on Accreditation of Dental and Dental Auxiliary Educational Programs has *Bylaws* authority in matters related to the development and approval of educational standards. However, the Committee was advised that the Council on Dental Education, prior to the establishment of the Commission on Accreditation, determined that general practice residency programs could be developed and sponsored by institutions other than hospitals. Such programs are indeed being offered by institutions of higher learning, including dental schools and military installations, that can provide the didactic, clinical and hospital experiences stipulated by the *Requirements.* For these reasons, the Reference Committee does not believe it necessary to refer the resolution to the Commission for consideration, but recommends that Resolution 143 be postponed indefinitely.

Dr. Dressel moved to postpone indefinitely Resolution 143 and the motion was seconded.

Dr. Richard Gladziszewski, New York, moved to amend Resolution 143 by adding the words "with available hospital facilities" at the end of the resolving clause. The motion was seconded by Dr. Theodore L. Jerrold, New York.

On vote, the amendment proposed by Dr. Gladziszewski was adopted.

On vote, the following resolution (Resolution 143 as amended) was postponed indefinitely:

> 143. **Resolved,** that the Council on Dental Education undertake a revision of the *Requirements for Approval of General Practice Residency Programs in Dentistry* that allows advanced training programs in general practice to be based in either a hospital or a dental school with available hospital facilities.

Recision of Resolution 9-1960-H: (Delegate Joseph G. DiStasio Resolution 162) The Committee reported as follows:

> The Reference Committee reviewed the resolution submitted by Delegate DiStasio (p. 423) suggesting the recision of Resolution 9-1960-H which reads as follows:
>
> > **Resolved,** that the dental schools be requested to give consideration to programs under which an increased number of dentists and dental auxiliary personnel could be trained

to meet reasonable estimates of future needs based on an increased population and a greater public appreciation of dental health services, and be it further

Resolved, that the Council on Dental Education be requested to advise institutions of higher learning and other agencies of the need to give consideration to the development of additional facilities for educating dental students and dental auxiliaries in order to assist in meeting the needs of the nation for an adequate supply of dental personnel.

After careful consideration, the Committee acknowledged the fact that the resolution adopted in 1960 may not be reflective of current day manpower needs. However, the Committee also acknowledged the fact that manpower needs continue to vary in different geographic areas of the country and that in some areas, shortages may exist. The Committee was also aware of the fact that the results of a number of manpower studies are just becoming available and that mechanisms for determining future manpower needs are being developed. For this reason the Committee believes that this matter should be given continued study. The Committee therefore recommends that Resolution 162 be referred to the Council on Dental Education for study and that the results of the study be reported to the 1977 House of Delegates.

Dr. Dressel moved to refer Resolution 162 to the Council on Dental Education for study and report back to the 1977 House of Delegates and the motion was seconded. Dr. Joseph G. DiStasio, Massachusetts, and Dr. Dale F. Redig, California, spoke against the motion to refer.

On vote, the motion to refer to the Council on Dental Education was defeated.

Dr. Joseph G. DiStasio, Massachusetts, moved the adoption of Resolution 162 and the motion was seconded by Dr. Robert J. Wilson, Maryland.

Dr. DiStasio stated ". . . I am a little shocked to find that . . . the current policy of the Association is to recommend increase in the number of dental schools, dental auxiliary training programs and an increase in the number of graduates. . . . I beg you to rescind this. I would ask that the appropriate agency work on it and bring in a new policy, but I do not want to have this for another year as current policy."

Dr. Thomas J. Ginley, secretary of the Council on Dental Education, stated "If the resolution as stated is rescinded by the House of Delegates, the problem that the Council . . . expressed to the reference committee is not the difficulty that Dr. DiStasio mentioned when he indicated that the resolution was far too broad in terms of its emphasis on increases. Our concern for and request for referral was made to divide the issue regarding auxiliary education programs. There are many states . . . that request the active support of the Council on Dental Education to work with institutions of higher education to develop auxiliary programs. There are parts of this country that do not currently have a supply of auxiliaries. We have been working with the rural states in formulating such programs. . . ."

Dr. Robert J. Wilson, Maryland, called for the question and the motion was seconded. The motion to vote immediately was passed.

On vote, the following resolution (Resolution 162) was adopted:

162H-1976. Resolved, that Resolution 9-1960-H (*Trans.* 1960:207) be rescinded.

Study and Response to the 1976 Carnegie Commission Report "Progress and Problems in Medical and Dental Education": (Delegate Rexford E. Hardin Resolution 133) The Committee reported as follows:

The Committee reviewed the resolution submitted by Delegate Hardin requesting that the Board of Trustees study and respond to the 1976 Carnegie Commission Report (p. 429). During the hearing, it was brought to the attention of the Committee that the American Association of Dental Schools is also planning to study the Report and to comment on its content.

In view of the complexity of the Report and its potential impact on dental education, the Committee concurs with the intent of the resolution and therefore recommends its adoption.

Dr. Dressel moved the adoption of Resolution 133 and the motion was seconded. On vote, the following resolution (Resolution 133) was adopted:

133H-1976. Resolved, that the American Dental Association Board of Trustees study the 1976 Carnegie Commission report, *Progress and Problems in Medical and Dental Education,* the data used and the recommendations, and publish appropriate comment taking into consideration all additional data available to the Board of Trustees.

Changes in "Requirements for Advanced Specialty Education Programs": (Delegate Theodore L. Jerrold Resolution 161) The Committee reported as follows:

During its deliberation of Resolution 161 (p. 430) submitted by Delegate Jerrold, the Reference Committee noted that the Commission on Accreditation of Dental and Dental Auxiliary Educational Programs has *Bylaws* authority in matters related to educational standards. However, the Committee noted that while the *Requirements for Advanced Specialty Education Programs* do not permit the accreditation of educational programs specifically designed for part-time enrollment, an accredited full-time program may enroll students on a part-time basis providing the educational experience, including the clinical experiences and responsibilities, is the same as acquired by students enrolled on a full-time basis. Further, the resolution's accompanying background statement which refers to part-time in the *Requirements for National Certifying Boards for Special Areas of Dental Practice* is consistent and merely restated from the educational requirements to provide for those dentists who may have completed their education on a part-time basis. The Reference Committee believes it essential to emphasize that the two documents, both known as *Requirements,* were developed for two specific and unrelated purposes. The Reference Committee further supports the philosophy of the Commission on Accreditation that educational programs oriented to the health professions should be offered on a full-time basis. Full-time programs provide for an appropriately structured curriculum, optimal continuity and enhancement of the educational process. Part-time programs, not related to full-time programs, do not provide the same optimal continuity for patient care and curriculum. For these reasons, the Reference Committee recommends that Resolution 161 be postponed indefinitely.

Dr. Dressel moved to postpone indefinitely Resolution 161 and the motion was seconded.

Dr. Theodore L. Jerrold, New York, stated ". . . The reference committee makes several assumptions which are not true. They assume that part-time programs cannot be a program structured, nor can part-time programs have optimum continuation of educational process. This, of course, is without foundation because there have been many qualified and accredited part-time programs up until 1974 when this restriction went into effect. Before that time many well trained and qualified specialists were products of part-time programs. The committee states that part-time programs not related to full-time programs do not apply the same optimal continuity for patient care. I cannot understand this at all. . . . In conclusion, I believe that a program should be approved on its quality and not its length. There should not be a time restriction placed on education."

On vote, the following resolution (Resolution 161) was postponed indefinitely:

> 161. **Resolved,** that lines 166-167 be deleted from the *Requirements for Advanced Specialty Education Programs.*

Amendment of "Principles of Ethics" Regarding Oral and Maxillofacial Surgery: (American Society of Maxillofacial Surgeons Resolution 94) The Committee reported as follows:

> The Reference Committee considered Resolution 94 (p. 435) submitted by the American Society of Maxillofacial Surgeons, requesting that the *Principles of Ethics* be amended so that oral surgeons would not ethically be allowed to announce limitation of practice in oral and maxillofacial surgery, and that Resolution 47-1975-H (*Trans.* 1975:691) be rescinded so that the definition of oral surgery does not refer to the maxillofacial region.
>
> Subsequent to in depth discussion on this issue, the Committee is not persuaded that there is substantial basis for reconsideration of House of Delegates policy established in 1975. The Committee is of the opinion that Section 18 of the *Principles of Ethics* provides only for announcement as an "oral surgeon" or "oral and maxillofacial surgeon," not as a "maxillofacial surgeon." Further, the Committee believes that the revised definition of oral surgery correctly represents and clarifies the legitimate, current scope of clinical activity and does not change the traditional practice or scope of oral surgery.
>
> The Committee reviewed the comprehensive report of the Board of Trustees (p. 532), noted inaccuracies in the background statement of the resolution and is in full accord with the Board in recommending reaffirmation of the prior House of Delegates' policy. The Committee therefore does not believe a change in the *Principles of Ethics* or definition of oral surgery is indicated. Further the Committee encourages implementation of the proposed ADA-AMA conferences to address problems existing between medical and dental specialties. Therefore, the Committee recommends that Resolution 94 be postponed indefinitely.

Dr. Dressel moved to postpone indefinitely Resolution 94 and the motion was seconded.

On vote, the following resolution (Resolution 94) was postponed indefinitely:

> 94. **Resolved,** that the House of Delegates of the American Dental Association rescind the amendment to Section 18 of the *Principles of Ethics* which permits oral surgeons to identify themselves to the public as "maxillofacial surgeons," and be it further
>
> **Resolved,** that Resolution 47-1975-H be rescinded so that oral surgery is not defined using the name "maxillofacial."

REPORT OF REFERENCE COMMITTEE ON GUIDELINES FOR A NATIONAL HEALTH PROGRAM

The Report of the Reference Committee on Guidelines for a National Health Program was read by Dr. Joseph Cabot, Michigan, chairman. The other members of the Committee were Drs. Charles Foster, Utah; William W. Howard, Oregon; Charles McDermott, Pennsylvania; Robert J. Wilson, Maryland; Clark D. Danner, Kansas, consultant; James Wahl, Jr., Illinois, consultant.

"Guidelines for Dentistry's Position in a National Health Program" (Incorporating All Proposed Revisions): The Committee reported as follows:

The Reference Committee, in its deliberations and in the preparation of this report, was acutely aware of the need for brevity and clarity in presenting resolutions to this House of Delegates. For this reason, the Committee has confined remarks regarding its deliberations to this introductory section.

The Board of Trustees presented a proposed revision of *Guidelines for Dentistry's Position in a National Health Program* (p. 455), which by action of the 1971 House of Delegates (*Trans.* 1971:491) represents policy of the American Dental Association. The Committee carefully considered this proposed revision, as well as the existing *Guidelines* (p. 438).

In addition, the Reference Committee, in its deliberations, thoughtfully weighed the testimony presented in its hearings, as well as the substance of Resolution 156 presented by the Fifth Trustee District (p. 400) which offers amendments to the proposed *Guidelines*. Inasmuch as these amendments were also presented in the Committee's hearings by a Fifth Trustee District representative, they were included in the Committee's overall considerations of testimony.

The Committee remained cognizant throughout its deliberations of the interest and concern of the dental profession relative to these *Guidelines* and was especially guided by the expressed position that this document must represent the views of the majority of practicing dentists.

The Committee believes that, in recognition of the realities of today's political climate, the Association's elected officials and staff must have formal policy guidance to assist them in presenting dentistry's position to all segments of the public. In the development of the resolutions presented herein, the Committee was directed by the need for simplicity, brevity and flexibility, mindful that conflicts with existing policy must be avoided and seeking to avoid, wherever practicable, potential conflicts with new policies being developed by the House of Delegates, as it considers the reports of other reference committees.

In the hope of simplifying the deliberations of this House, the Committee presents, by sections and as a fresh document, the following *Guidelines for Dentistry's Position in a National Health Program,* which it has developed in keeping with the above-stated considerations.

Section on "Fundamental Principles": The Committee reported as follows:

The Reference Committee offers the following resolution and recommends that it be approved:

165. Resolved, that the following *Fundamental Principles* for *Guidelines for Dentistry's Position in a National Health Program* be approved:

Fundamental Principles

In the consideration of a national health program, the dental profession should take an active position in the design of a program that includes dental care.

It is the dental profession's firm belief that the dental component of any national health program should be founded upon the traditional private system of delivering dental care.

The dental profession is actively engaged in efforts to ensure that available dental care services are sufficient to meet the needs of the people of the nation, providing access to dental care for all.

It is the fundamental belief of the profession that the use of public funds for direct health benefits in a national health program should be limited to the provision of care only for those financially unable to pay for health services themselves.

Dr. Cabot moved the adoption of Resolution 165 and the motion was seconded.

Dr. W. Kelley Carr, Indiana, moved to amend the "Fundamental Principles" by deleting the words "meet the needs" and inserting in lieu thereof the words "serve the effective demand" in the third paragraph. The motion was seconded by Dr. Frank A. Schroeder, Illinois.

Dr. William E. Murphy, Nebraska, spoke in favor of the amendment.

On vote, the amendment proposed by Dr. Carr was adopted.

Dr. W. Kelley Carr, Indiana, moved to further amend the "Fundamental Principles" by inserting the word "efficient" following the word "traditional" in the second paragraph, and the motion was seconded by Dr. Frank A. Schroeder, Illinois.

On vote, the amendment proposed by Dr. Carr was adopted.

On vote, the following resolution (Resolution 165 as amended) was adopted:

> 165H-1976. Resolved, that the following *Fundamental Principles* for *Guidelines for Dentistry's Position in a National Health Program* be approved.
>
> **Fundamental Principles**
>
> In the consideration of a national health program, the dental profession should take an active position in the design of a program that includes dental care.
>
> It is the dental profession's firm belief that the dental component of any national health program should be founded upon the traditional efficient private system of delivering dental care.
>
> The dental profession is actively engaged in efforts to ensure that available dental care services are sufficient to serve the effective demand of the people of the nation, providing access to dental care for all.
>
> It is the fundamental belief of the profession that the use of public funds for direct health benefits in a national health program should be limited to the provision of care only for those financially unable to pay for health services themselves.

Dr. Robert L. Swanstrom, Minnesota, moved to reconsider Resolution 165H and the motion was seconded by Dr. D. Dean Ray, Iowa.

On vote, the motion to reconsider was adopted.

Dr. Swanstrom moved to amend Resolution 165H by deleting the fourth paragraph of the "Fundamental Principles" and substituting therefor the following:

> The dental profession continues to be in opposition to any national health program that uses public funds to provide health care for persons who are financially able to pay for health services themselves. This principle governs all provisions and recommendations of the American Dental Association with respect to national health programs.

The motion was seconded.

Speaking in favor of the amendment were Drs. Wilbert Fletke, Michigan; Emil Lentchner, New York; Ernest H. Besch, Texas. Dr. Robert J. Wilson, Maryland, spoke in opposition to the amendment.

The Speaker called for a division of the House on the question. On vote, the amendment was defeated by a vote of 175 to 189.

Dr. William E. Allen, California, moved to adopt Resolutions 166 through 175 in a body, and the motion was seconded by Dr. Larry S. Simpson, California.

On vote, the following resolutions (Resolutions 166 through 175) were adopted:

> 166H-1976. Resolved, that the following *Guidelines for Priorities and Benefits in a National Health Program* be approved:

Priorities and Benefits

The following guidelines are recommended in the development of a national health program.

1. Comprehensive dental services for children and emergency dental services for all eligible for the program should have the highest dental priority in any national health program, and any deferred inclusion of children that may be necessary should follow a progressive schedule beginning with the youngest age group feasible.

2. There follows a priority listing of other services which we consider appropriate for incorporation as defined.

Emergency Dental Care Services:

These services should be available to those eligible for the program from the first day of the program.

- -Control of oral and maxillofacial bleeding in any condition when loss of blood will jeopardize the patient's well-being. Treatment may consist of any professionally accepted procedure deemed necessary.

—Relief of respiratory difficulty from any oral and maxillofacial condition which can involve the airway (respiratory system) in a life-threatening manner. Treatment may consist of any professionally accepted procedure deemed necessary.

—Relief of severe pain accompanying any oral or maxillofacial conditions affecting the nervous system, limited to immediate palliative treatment only but including extractions where professionally indicated.

—Immediate and palliative procedures for (1) fractures, subluxations, and avulsions of teeth, (2) fractures of jaw and other facial bones (reduction and fixation only), (3) temporomandibular joint subluxations, and (4) soft tissue injuries.

—Initial treatment for acute infections.

—Emergency dental care services include (1) all necessary laboratory and preoperative work, including examination and radiographs and (2) appropriate anesthesia (local, general, sedative) for optimal management of the emergency.

Preventive Dental Services:

Preventive procedures, including dental health education.

Comprehensive Dental Health Services:

—Periodic examination and diagnosis, including radiographs when indicated and detection of oral manifestations of systemic disease.

—Elimination of infection or life-hazardous oral conditions, for example, oral cancer, cellulitis, fractures of the face and jaws, major handicapping malocclusion and congenital disfiguring oral deformities.

—Treatment of injuries.

—Elimination of disease of bone and soft tissue of the oral cavity and adjacent areas.

- -Treatment of anomalies.

—Restoration of decayed or fractured teeth.

—Retention or recovery of space between teeth when indicated.

—Replacement of missing permanent teeth when indicated.

—Treatment of handicapping malocclusion.

—Appropriate pain control procedures for optimal care of the patient.

3. After three years in operation or before considering expansion of any national health program's dental benefits, a comprehensive study of the program's cost-effectiveness and efficacy in providing dental health services should be carried out and appropriate modifications made. This study and any modification should be accomplished in consultation with the American Dental Association.

167H-1976. **Resolved**, that the following *Guidelines for Preventive Procedures and Dental Health Education in a National Health Program* be approved:

Preventive Procedures and Dental Health Education

The following guidelines are recommended in the development of a national health program.

1. A preventively oriented dental health educational program should be implemented in conjunction with a national dental health program for the purpose of informing and motivating people on personal oral hygiene care as well as on the most effective use of the program. Emphasis should be placed on reaching school children and their parents.

2. Funds should be provided for the purchase and installation of fluoridation equipment for communities and for rural school water supplies to maximize the cost effectiveness of dental health benefits. Incentives should be provided to states to take legislative or regulatory action to mandate fluoridation.

3. State dental societies should encourage and assist state legislatures to enact statewide fluoridation laws requiring the fluoridation of all community water supplies.

4. States and communities should be urged to provide dental health education and preventive programs for children to maximize the benefits included under a national dental health program. Consideration should be given to providing various types of topical fluoride applications, preventive education, and screening and referral.

168H-1976. Resolved, that the following *Guidelines for Education and Training in a National Health Program* be approved:

Education and Training

In all programs that provide funding for dental education this long-standing policy of the Association shall apply: "The government shall not exercise any control over, or prescribe any requirements with respect to, the curriculum, personnel, or administration of any school or the admission of applicants thereto." (*Trans.* 1949:244)

The American Dental Association recognizes the necessity for federal funding support of dental education to meet future dental needs and demands. These funds should be provided in relationship to the established needs as determined in consultation with the Association. Support of existing programs should be continued at levels necessary to assure the quality of these programs. Such funds should be restricted to institutions which are eligible for accreditation by the Commission on Accreditation of Dental and Dental Auxiliary Educational Programs.

The development of all types of dental and dental auxiliary education programs should be based on the determination of shortage and need in relationship to geographic consideration.

169H-1976. Resolved, that the following *Guidelines for Delivery of Services in a National Health Program* be approved:

Delivery of Services

The following guidelines are recommended in the development of a national health program.

1. All dental societies should establish emergency dental services that ensure ready accessibility of professional services at all times.

2. Federal legislation should provide reasonable financial arrangements including loan forgiveness features with dental students to pay the total cost of their dental education in return for practicing in underserved areas in the military or health agencies, for a specified period of time.

3. Dentists should be encouraged to practice in underserved areas through federal financial incentives including guaranteed loans and tax benefits.

4. To meet any additional demands generated by a national dental health program, national health service corps or other federal or federal-state health personnel programs should provide dental personnel only in areas where the existing dental work force is insufficient and

where an incentive program to attract private practitioners has been unsuccessful. Such arrangements should be temporary and should be contingent on the approval of component and/or constituent dental societies.

5. Community health centers, such as neighborhood health centers or outpatient facilities providing comprehensive health services, should include dental services only if the availability of dental care from the private sector is determined to be inadequate in consultation with constituent and component societies.

6. Extended health care facilities and hospitals should consider providing dental services as an integral part of comprehensive care.

7. A national health program should provide for research, experimentation, and development of programs to deliver dental care more effectively and efficiently to population groups with special handicapping or confinement problems.

8. There should be a moratorium on licensure, registration, or certification of additional kinds of dental auxiliaries until more definitive information is available about the relative role of the dentist and his expanded function auxiliaries.

9. Whenever a prepaid group practice is included in a program, program beneficiaries should be given a choice between the prepaid group practice and care by other practitioners, with options for periodic change and assurance of high quality of care delivered.

10. In a national health program that establishes health maintenance organizations for the delivery of comprehensive health services which include dental care, the American Dental Association is opposed to HMO legislation or regulations (1) that deny freedom for beneficiaries to choose between HMOs and the traditional private practice, fee-for-service system, (2) that award HMOs subsidies, (3) that permit HMOs to advertise in conflict with the unprofessional conduct provisions of state licensure laws, or (4) that permit participation by practitioners not licensed in the state where the services are rendered.

11. Dental societies or service corporations or both should be eligible along with other groups to qualify as dental components in health maintenance organizations.

170H-1976. Resolved, that the following *Guidelines for Payment Mechanisms in a National Health Program* be approved:

Payment Mechanisms

The following guidelines are recommended in the development of a national health program.

1. Private methods of reimbursement through the use of dental service corporations, insurance companies, and other private means should be strongly encouraged.

2. Various methods of reimbursement of dentists should be allowed in the dental component of a national health program so that the most efficient arrangements can eventually be determined by experience and by consumer choice. In the absence of such basis for determining efficiency, the usual, customary, and reasonable fee concept should be given priority. The table of allowance concept should be recognized as appropriate for use. The mandating of capitation as the only system should be opposed. Any concept used should realistically relate to the cost of delivery of dental services and should be clearly explained to all eligible for the program.

3. Patient participation in the costs of care in a dental component of a national health program preferably should be through copayment rather than through deductibles.

4. Deductibles or coinsurance should not be applied to basic services, such as periodic examinations, diagnoses, prophylaxes, fluoride topical applications, plaque control programs, and emergency treatment.

5. Programs should be encouraged that provide incentives to continuing maintenance by reducing the patient's coinsurance at stated time intervals, providing he avails himself of the necessary dental services on a regular basis.

171H-1976. Resolved, that the following *Guidelines for Funding in a National Health Program* be approved:

Funding

The following guidelines are recommended in the development of a national health program.

1. Public funds supporting dental health benefits for the needy should be provided through general revenue and should be clearly earmarked for such purposes.

2. Private funds expended in the private sector should provide the principal financial base for any national health program.

3. In structuring such funding, several methods may be considered, such as tax credits scaled to income, or employer-employee contributions.

172H-1976. Resolved, that the following *Guidelines for Dental and Dental Hygiene Licensure in a National Health Program* be approved:

Dental and Dental Hygiene Licensure

The following guidelines are recommended in the development of a national health program.

1. It is the right and responsibility of each individual state to protect the health and welfare of its citizens. Therefore, the American Dental Association recognizes the rights of the individual states to determine the professional qualifications of those who practice in the dental health professions.

2. Regional examinations for dentists and dental hygienists should be encouraged.

173H-1976. Resolved, that the following *Guidelines for Program Design and Administration in a National Health Program* be approved:

Program Design and Administration

The following guidelines are recommended in the development of a national health program.

1. The dental component of any national health program should be developed in consultation with the American Dental Association.

2. The preferred carriers for the dental component of a national health program should be non-governmental agencies.

3. The design and administration of the dental component of a national health program should take into consideration the differences between the delivery of dental care and other health services. The dental component of a national health program should make specific provision for conducting research on administrative, economic, and cost analysis aspects of dental services in prepayment programs.

4. Dental benefits included in a national health program should be clearly delineated and mandated in a manner identical with all other health benefits.

174H-1976. Resolved, that the following *Guidelines for Review Procedures in a National Health Program* be approved:

Review Procedures

The following guidelines are recommended in the development of a national health program.

1. Review of the dental component of a national health program must involve constituent and component societies of the American Dental Association.

2. Initially, program design and administration should be reviewed. Continuing review should encompass such matters as utilization of services, effectiveness in meeting the dental needs of the population, economy in administration, effect of benefit patterns on dental health and dental practice, provision of uniform forms and procedures, efficiency of administrative requirements, accessibility of dental care, utilization of fluoridation, and effectiveness of quality review procedures.

3. Review of dental care in a national health program should include assessment of the quality of services performed, the appropriateness of procedures, and whether the services were performed in accordance with professional standards.

4. Dental society review committees should be utilized in the dental component of a national health program for evaluation of professional matters. In the event Professional Standards Review Organizations are designated the review mechanism in a national health program, dentists should be afforded full and equitable participation at all levels of these organizations as they relate to the assessment of dental care.

5. Effective review procedures should include methods to resolve fee questions.

6. Effective procedures should be instituted, wherever necessary, to protect members of review committees.

7. A clear distinction should be maintained between quality assurance and cost control in any national health program.

175H-1976. Resolved, that the following *Guidelines for Consumers in a National Health Program* be approved:

Consumers in a National Health Program

The Association endorses the concept of consumer representation in any national dental health program. The Association accepts the following definition of consumer: A consumer is a person who uses dental health services, but does not depend upon these services for a livelihood.

The following guidelines for consumer representation set forth some general principles which will be subject to modification depending upon the nature of the national dental health program:

1. Consumer representatives should be involved in an advisory capacity in the development of regulations and procedures during the initial design of the program.

2. Consumer representatives should be selected on the basis of geographic region with particular attention given to appropriate broad representation of all segments of the population.

3. Consumer representatives should be involved at all levels of the program.

4. Consumer representatives should be retained subject to attendance at meetings and carrying out of assigned functions.

5. Consumer representatives should be involved in an advisory capacity on such issues in any proposed national dental health program as the following: review of the program, education of the public to prevention of dental disease and appropriate utilization of the program, grievance procedures established for the program, and administration and evaluation of the program.

Approval of New "Guidelines for Dentistry's Position in a National Health Program": Dr. Cabot moved the adoption of Resolution 176 and the motion was seconded.

On vote, the following resolution (Resolution 176) was adopted:

176H-1976. Resolved, that the *Guidelines for Dentistry's Position in a National Health Program* be approved, and be it further

Resolved, that the existing *Guidelines for Dentistry's Position in a National Health Program* (*Trans.* 1971:491), as amended (*Trans.* 1972:694, 716; *Trans.* 1973:402; *Trans.* 1975:730, 731), be rescinded.

Changes in Proposed "Guidelines for Dentistry's Position in a National Health Program": (Fifth Trustee District Resolution 156) The Committee reported as follows:

> Since the Reference Committee considered the substance of Resolution 156 (p. 400) in its deliberations and incorporated many of the resolution's suggestions into the new *Guidelines*, it is the recommendation of the Committee that Resolution 156 be postponed indefinitely.

Dr. Cabot moved to postpone indefinitely Resolution 156 and the motion was seconded.

On vote, Resolution 156 was postponed indefinitely.

Annual Review of "Guidelines for Dentistry's Position in a National Health Program": (Sixth Trustee District Resolution 181) Dr. William S. Brandhorst, Missouri, moved the adoption of Resolution 181 and the motion was seconded by Dr. Joseph M. Grana, Missouri.

On vote, the following resolution (Resolution 181) was adopted:

> 181H-1976. Resolved, that the *Guidelines for Dentistry's Position in a National Health Program* be reviewed by the Board of Trustees each year, beginning in 1977, with annual reports to the House of Delegates reflecting the changing views of the dental profession with particular emphasis on the views of the private practitioners as influenced by developing governmental policy and the needs of the public.

Dr. William Creason, Michigan, moved to reconsider Resolution 169H, stating "To me, as I read section 8 which says there should be a moratorium on licensure recertification for additional kinds of dental auxiliaries until more definitive information is available about the relative role of the dentist and his expanded function, I do not believe this beacon light should be in our guidelines for our legislators or health planners in Washington. I think it should be removed from this particular section. . . ."

Dr. Henry L. Homan, Michigan, seconded the motion for reconsideration.

On vote, the motion to reconsider was defeated.

REPORT OF REFERENCE COMMITTEE ON DENTAL LICENSURE AND RELATED MATTERS

The Report of the Reference Committee on Dental Licensure and Related Matters was read by Dr. Theodore R. Lerner, New York, chairman. The other members of the Committee were Drs. J. P. Chancey, Jr., Arkansas; Bruce Shrallow, Virgin Islands; Eugene M. Zuck, Washington; Charles E. Zumbrunnen, New Hampshire.

Report of Commission on Licensure: The Committee reported as follows:

The Reference Committee reviewed the annual report of the Commission on Licensure (p. 244) and wishes to call attention to four printing errors.

1. In the last sentence on page 248, the word "majority" should be "minority." The corrected sentence should read:

> Although objections to licensure by credentials were voiced by a minority of those responding to the Commission's request for input, the concerns expressed merit discussion.

2. The first complete sentence on page 254 was printed omitting the phrase "in the state" after the word "practice." The corrected sentence should read:

> The system of verifying activity while the dentist was not in practice in the state has avoided the possibility of multiple licenses being abused by the small percentage who might use a second license to escape adverse consequences of their actions.

3. As pointed out by the Board of Trustees (p. 483), the phrase "to develop a mechanism for issuing active and inactive licenses" was mistakenly deleted from Resolution 30 (p. 256). The resolution should read:

> Resolved, that each constituent society, in consultation with its state board of dentistry, be urged to develop a mechanism for issuing active and inactive licenses to enhance public protection.

4. The word "such" in Resolution 31 (p. 256) should read "each," to make the resolution read:

> Resolved, that each constituent society, in consultation with its state board of dentistry, be urged to study the need for greater state support for enforcement of the state dental practice act, and be it further
> Resolved, that, if need is established, the constituent society in consultation with its state board of dentistry, consider developing mechanisms to obtain additional state support for enforcement of the state dental practice act in the public interest.

Licensure for Protection of Public: (Commission on Licensure Resolution 25; Fifth Trustee District Resolution 25S-1) The Committee reported as follows:

> The Committee considered Commission on Licensure Resolution 25 (p. 255), Resolution 25S-1 submitted by the Fifth Trustee District (p. 399) and comments on both resolutions by the Board (pp. 483 and 523). The Committee agrees with the Fifth Trustee District and the Board that the words "and opposes the use of licensure for any other purpose" are implied in the first portion of the resolution which states that the purpose of licensure is solely for the protection of the public. Further, the Committee believes that some might infer from the last clause of Resolution 25 that licensure is being misused in some jurisdictions. In order to correct a technical deficiency in Resolution 25S-1, the Committee offers the following substitute resolution for Resolutions 25 and 25S-1.

Dr. Lerner moved to substitute Resolution 25RC for Resolutions 25 and 25S-1, and the motion was seconded. On vote, the motion to substitute was adopted.

Dr. Lerner moved the adoption of the substitute resolution and the motion was seconded.

On vote, the following resolution (Resolution 25RC) was adopted:

> 25H-1976. Resolved, that the American Dental Association believes licensure to be solely for the protection of the public.

State Board Review of Application for Licensure: (Commission on Licensure Resolution 26; Fifth Trustee District Resolution 26S-1) The Committee reported as follows:

> Comments received on Commission on Licensure Resolution 26 (p. 255) and substitute Resolution 26S-1 submitted by the Fifth Trustee District (p. 403) dealt with possible misinterpretation rather than intent. The Committee agrees with the Board (p. 523) that the original resolution is clear and does not exclude requests for data bearing on moral character. Further, the list of objectionable items in the substitute resolution is not all inclusive. Therefore, the Committee recommends adoption of Resolution 26.

Dr. Lerner moved the adoption of Resolution 26 and the motion was seconded.

Dr. H. M. Sorrels, Texas, moved to amend the resolution by adding the following sentence at the end of the resolution, and the motion was seconded by Dr. Robert J. Wilson, Maryland:

> However, this is not intended to exclude customary inquiries into the applicant's moral character, being found guilty of a felony, or having violated the dental practice act of another jurisdiction.

Dr. Lewis S. Earle, Florida, spoke in favor of the amendment.

On vote, the amendment proposed by Dr. Sorrels was adopted.

On vote, the following resolution (Resolution 26 as amended) was adopted:

> 26H-1976. Resolved, that the American Dental Association requests each state board of dentistry to review its application for licensure to insure that only data related to the individual's qualifications to provide dental treatment are required. However, this is not intended to exclude customary inquiries into the applicant's moral character, being found guilty of a felony, or having violated the dental practice act of another jurisdiction.

Verification of Credentials and Application Data of Licensure Candidates: (Commission on Licensure Resolution 27) The Committee reported as follows:

> The Committee considered Resolution 27 of the Commission on Licensure (p. 255) and comments of the Board of Trustees (p. 483). The Committee believes it important that credentials and application data of a licensure candidate be verified by the state board of dentistry prior to issuance of a license to practice. Therefore, the Committee recommends that Resolution 27 be adopted.

Dr. Lerner moved the adoption of Resolution 27 and the motion was seconded.

On vote, the following resolution (Resolution 27) was adopted:

> 27H-1976. Resolved, that the American Dental Association encourage state boards of dentistry to verify credentials and application data of all candidates for licensure before licenses are issued.

Approval of "Guidelines for Licensure": (Commission on Licensure Resolution 28; Fifth Trustee District Resolutions 28S-1 and 28S-2) The Committee reported as follows: (For final disposition see p. 919.)

Comments made in relation to Resolution 28 (p. 256) and substitute Resolution 28S-1 submitted by the Fifth Trustee District (p. 404) resulted from an organizational problem in the proposed *Guidelines for Licensure* (p. 256). The section titled "Licensure by Examination" deals briefly with the importance of each dentist obtaining at least his initial license by taking the appropriate examination. The fundamental concept proposed in the section, however, is that each state could accept recent examination results from other agencies, other state boards or the National Board, provided that the state board believes the examination conducted by the other agency to be appropriate. The Committee endorses this concept under conditions (a) through (e) proposed in the *Guidelines* for accepting results of examinations conducted by other agencies (p. 257).

In order to clarify *Guidelines for Licensure* and emphasize that they do not restrict examinations conducted at the state level, the Committee proposes the following substitute resolution for Resolutions 28 and 28S-1.

28RC. **Resolved**, that *Guidelines for Licensure* be amended by replacing the first two paragraphs with the following:

> Dental licensure is intended to insure that only qualified individuals provide dental treatment to the public. Among qualifications deemed essential are satisfactory theoretical knowledge of basic biomedical and dental sciences and satisfactory clinical skill. It is essential that each candidate for an initial license be required to demonstrate these attributes on examinations: a written examination for theoretical knowledge and a clinical examination for clinical skill. These guidelines suggest alternate mechanisms for evaluating the theoretical knowledge and clinical skill of an applicant for licensure who holds a dental license in another jurisdiction.
>
> **Licensure by Examination:** A candidate who is seeking licensure in several jurisdictions being required to demonstrate his theoretical knowledge and clinical skill on separate examinations for each jurisdiction seems unnecessary duplication.

and be it further

Resolved, that the *Guidelines for Licensure*, as amended, be approved and transmitted to each state board of dentistry for consideration.

Dr. Lerner moved to substitute Resolution 28RC for Resolutions 28 and 28S-1, and the motion was seconded. On vote, the motion to substitute was adopted.

Dr. Lewis S. Earle, Florida, moved to amend the *Guidelines* by deleting the word "ten" in the second and third paragraphs under "Licensure by Examination" and inserting in lieu thereof the word "five." The motion was seconded by Dr. William E. Schiefer, California.

Dr. Robert E. Doerr, Michigan, chairman of the Commission on Licensure, stated "I wish to speak against the adoption of this amendment. I believe the House will recall that last year the delegates approved the concept of licensure by credential. They referred the control statement back to the Commission for further study and input from a variety of groups. During this past year we have had input from constituent societies, state boards of dentistry, dental schools, auxiliary associations, and a number of others. The overwhelming response from those inquiries was a preference for ten years. Although I must confess to you that in adopting the ten year requirement, the Commission did not believe this was a magic figure. They did, however, consider the fact that there is no limitation currently on national board examination results. I would also like to remind you that these are simply guidelines. They are not establishing policy. They are merely suggestions for the various licensing jurisdictions. . . . Therefore, I would oppose making this amendment which makes licensure by examination more restrictive than the Commission feels is necessary."

Dr. William E. Schiefer, California, stated ". . . We were informed that the five year term has been suggested by the National Association of Dental Examiners and that is presently its policy."

Dr. W. Kelley Carr, Indiana, and Dr. Eugene J. Truono, Delaware, spoke in favor of the amendment.

Dr. John A. Stewart, Florida, called for the question and the motion was seconded. The motion to vote immediately was passed.

On vote, the amendment proposed by Dr. Earle was adopted.

Dr. Lewis S. Earle, Florida, moved to further amend the *Guidelines* by deleting (a) and (b) under "Licensure by Credentials" and inserting in lieu thereof the following items, and the motion was seconded by Dr. William E. Schiefer, California:

> (a) is currently licensed in another jurisdiction, such license to have been acquired within the last five years by satisfactory performance on a written and clinical examination at least equivalent to the states' own examinations;
>
> (b) has been in practice since being examined;

Dr. Mark A. Price, Louisiana, stated "I think we should be very careful in what we are doing here. I think with this five year limitation there is an inference that only the people who have practiced for five years, or the younger dentists, are qualified to practice and move around without examination. It somewhat discriminates against all the other dentists who have been practicing for many years in one location. . . . If we are going to give this privilege to anyone, we should give it to everyone."

Dr. Percy T. Phillips, New York, stated "I rise to speak for the acceptance of the *Guidelines for Licensure* as developed by the Commission on Licensure. The Commission . . . has felt these *Guidelines* were great protection with the proper controls necessary to protect the public. I feel the definition of licensing by credentials as stated (by the Commission) is valid. The criteria for licensing by credentials as developed by the Commission permits the states to protect their citizens, and certainly will not permit the licensing of dentists who are less qualified. This will fulfill the control obligation to the public. The licensing by credentials after a stated period repudiates the entire concept for which we have been striving. It would repudiate the entire charge given this Commission by the House of Delegates. I would urge you to accept the *Guidelines for Licensure* as developed by the Commission on Licensure."

Dr. Michael A. Segal, Massachusetts, called for the question and the motion was seconded. The motion to vote immediately was passed.

On vote, the amendment proposed by Dr. Earle was defeated.

Dr. Lewis S. Earle, Florida, moved to further amend the *Guidelines* by deleting the words "any one of these be considered sufficient to waive" in the third paragraph under "Licensure by Credentials" and inserting in lieu thereof the words "these methods be considered as possible alternatives to." The motion was seconded by Dr. William E. Schiefer, California.

On vote, the amendment proposed by Dr. Earle was adopted by a vote of 205 to 174.

Dr. Lewis S. Earle, Florida, moved to further amend the *Guidelines* by deleting the words "any one of these be accepted in lieu of" in the fourth paragraph under "Licensure by Credentials" and inserting in lieu thereof the words "these methods be considered as possible alternatives to." The motion was seconded by Dr. William E. Schiefer, California.

On vote, the amendment proposed by Dr. Earle was adopted.

Dr. Robert E. Doerr, Michigan, moved to amend the introductory paragraph under the *Guidelines for Licensure* to read as follows:

> Dental licensure is intended to insure that only qualified individuals provide dental treatment to the public. Among qualifications deemed essential are satisfactory theoretical knowledge of basic biomedical and dental sciences and satisfactory clinical skill. It is essential that each candidate for an initial license be required to demonstrate these attributes on examinations: a written examination for theoretical knowledge and a clinical examination for clinical skill. These guidelines suggest alternate mechanisms for evaluating the theoretical knowledge and clinical skill of an applicant for licensure who holds a dental license in another jurisdiction. Requiring a candidate who is seeking licensure in several jurisdictions to demonstrate his theoretical knowledge and clinical skill on separate examinations for each jurisdiction seems unnecessary duplication.

The motion was seconded by Dr. Richard A. Shick, Michigan.

The Speaker ruled to accept the amendment proposed by Dr. Doerr as an editorial change.

Dr. Lerner moved the adoption of the substitute resolution as amended, and the motion was seconded.

On vote, the following resolution (Resolution 28RC as amended) was adopted:

> 28H-1976. **Resolved,** that the *Guidelines for Licensure,* as amended, be approved and transmitted to each state board of dentistry for consideration.

Guidelines for Licensure

Dental licensure is intended to insure that only qualified individuals provide dental treatment to the public. Among qualifications deemed essential are satisfactory theoretical knowledge of basic biomedical and dental sciences and satisfactory clinical skill. It is essential that each candidate for an initial license be required to demonstrate these attributes on examinations: a written examination for theoretical knowledge and a clinical examination for clinical skill. These guidelines suggest alternate mechanisms for evaluating the theoretical knowledge and clinical skill of an applicant for licensure who holds a dental license in another jurisdiction. Requiring a candidate who is seeking licensure in several jurisdictions to demonstrate his theoretical knowledge and clinical skill on separate examinations for each jurisdiction seems unnecessary duplication.

Licensure by Examination: Written examination programs conducted by the Council of National Board of Dental Examiners have achieved broad recognition by state boards of dentistry. National Board dental examinations are conducted in two parts. Part I covers basic biomedical sciences; Part II covers dental sciences. It is recommended that satisfactory performance on Part II of National Board dental examinations within five years prior to applying for a state dental license be considered adequate testing of theoretical knowledge. National Board regulations require a candidate to pass Part I before participating in Part II. Consequently, this recommendation excludes Part I only from the time limit.

No clinical examination has achieved as broad recognition as have National Board written examinations. Clinical examinations used for dental licensure are conducted by individual state boards of dentistry and by regional clinical testing services. It is recommended that satisfactory performance within the last five years on any state or regional clinical examination at least equivalent in quality and difficulty to the state's own clinical examination be considered adequate testing for clinical skill provided that the candidate for licensure:

(a) is currently licensed in another jurisdiction;

(b) has been in practice since being examined;

(c) is endorsed by the state board of dentistry and the appropriate committee of the constituent society in the state of his current practice;

(d) has not been the subject of final or pending disciplinary action in any state in which he is or has been licensed;

(e) has not failed the clinical examination of the state to which he is applying within the last three years.

Licensure by Credentials: The American Dental Association believes that an evaluation of a practicing dentist's theoretical knowledge and clinical skill based upon his performance record can provide as much protection to the public as would an evaluation based upon examination. Issuing a license using a performance record in place of examinations is termed licensure by credentials.

All candidates for licensure by credentials might be required to fulfill basic education and practice requirements. It is recommended that graduation from a dental school accredited by the Commission on Accreditation of Dental and Dental Auxiliary Educational Programs be considered minimum satisfactory education for licensure by credentials. Further, it is recommended that licensure by credentials be available only to a candidate who:

(a) is currently licensed in another jurisdiction;

(b) has been in practice or full-time dental education for a minimum of five years immediately prior to applying;

(c) is endorsed by the state board of dentistry and the appropriate committee of the constituent society in the state of current practice;

(d) has not been the subject of final or pending disciplinary action in any state in which he is or has been licensed;

(e) has not failed the clinical examination of the state to which he is applying within the last three years.

Alternate ways that current theoretical knowledge might be documented follow. It is recommended that for a candidate who meets eligibility requirements for licensure by credentials, these methods be considered as possible alternatives to the written examination requirement.

1. Successful completion of an accredited advanced dental education program in the last ten years.

2. A total of at least 180 hours of acceptable formal scientific continuing education in the last ten years, with a maximum credit of 60 hours for each two-year period.

3. Successful completion of a recognized specialty board examination in the last ten years.

4. Teaching experience of at least one day per week or its equivalent in an accredited dental education program for at least six of the last ten years.

Possible documentation for current clinical skill appears in the following list. Provided that eligibility requirements for licensure by credentials are met, it is recommended that these methods be considered as possible alternatives to satisfactory performance on a clinical examination.

1. Successful completion of an accredited general practice residency or dental internship within the last ten years.

2. Successful completion of an accredited dental specialty education program in a clinical discipline within the last ten years.

3. A total of at least 180 hours of acceptable clinically oriented continuing education in the last ten years, with a maximum credit of 60 hours for each two-year period.

4. Clinical teaching of at least one day per week or its equivalent in an accredited dental education program, including a hospital-based advanced dental education program, for at least six of the last ten years.

5. Presenting case histories of patients treated by the candidate in the last five years, with preoperative and postoperative radiographs, covering procedures required on the state clinical examination, for discussion with the state board.

Recommendations to Constituent Societies: (Commission on Licensure Resolutions 29, 30, 31 and 32) The Committee reported as follows:

The Committee considered Resolutions 29, 30, 31 and 32 (p. 256) and noted that they are similar in that each resolution requests action of each constituent society, in consultation with its state board of dentistry, on a particular licensure subject. Issues addressed in these resolutions—licensure by credentials for dental specialists, active and inactive licenses, state support for enforcement of the state dental practice act and possible use of licensure by credentials in relicensure —merit attention. The Committee agrees with the Commission on Licensure and the Board of Trustees (p. 483) that these issues should be acted upon at the state level. Therefore, the Committee recommends adoption of Resolutions 29, 30, 31 and 32.

Dr. Lerner moved the adoption of Resolutions 29, 30, 31 and 32 and the motion was seconded.

Dr. John A. Stewart, Florida, moved to amend Resolutions 29 and 30 by deleting the word "develop" and inserting in lieu thereof the word "study." The motion was seconded by Dr. William C. Draffin, South Carolina.

Speaking in opposition to the amendment were Drs. Milton Jacobson, New York; Edmund R. Mihalski, Pennsylvania; Lawrence Scinto, Connecticut; Jacob H. Oxman, New Jersey.

Dr. Anthony F. Posteraro, New York, called for the question and the motion was seconded. The motion to vote immediately was passed.

On vote, the amendments proposed by Dr. Stewart were defeated.

On vote, the following resolutions (Resolutions 29, 30, 31 and 32) were adopted:

29H-1976. **Resolved,** that each constituent society, in consultation with its state board of dentistry, be urged to develop mechanisms of licensure by credentials for dental specialists.

30H-1976. **Resolved,** that each constituent society, in consultation with its state board of dentistry, be urged to develop a mechanism for issuing active and inactive licenses to enhance public protection.

31H-1976. **Resolved,** that each constituent society, in consultation with its state board of dentistry, be urged to study the need for greater state support for enforcement of the state dental practice act, and be it further

Resolved, that, if need is established, the constituent society, in consultation with its state board of dentistry, consider developing mechanisms to obtain additional state support for enforcement of the state dental practice act in the public interest.

32H-1976. **Resolved,** that each constituent society, in consultation with its state board of dentistry, study mechanisms of licensure by credentials that have the potential for use as relicensure standards.

Commendation to Commission on Licensure: (Fifth Trustee District Resolution 108) The Committee reported that Resolution 108 is included in the Report on Non-Policy Items.

Amendment of "Bylaws" on Duties of Council on Dental Education: (Board of Trustees Resolution 77; Fifth Trustee Resolution 77S-1) The Committee reported as follows:

> Implied in Board Resolution 77 (p. 477), which assigns consideration of licensure matters to the Council on Dental Education, is termination of the Commission on Licensure. The Committee agrees with the Commission, the Board and participants in the reference committee hearing that a separate agency for licensure is no longer necessary. A suggestion made during the hearing that the Council on Legislation would be a more appropriate agency to study licensure matters was considered. Other councils were also discussed. The Committee favors the intent of Resolution 77 as developed by the Board because the Council on Dental Education has tripartite structure. Past objections to this assignment were eliminated when authority for accreditation was transferred to the Commission on Accreditation of Dental and Dental Auxiliary Educational Programs. It should be noted that a minor technical change has been incorporated in the resolution by the Standing Committee on Constitution and Bylaws.

Dr. Lerner moved the adoption of Resolution 77 and the motion was seconded.

Dr. Daniel W. Benton, Utah, moved to amend the resolution by deleting the word "licensure" after the word "auxiliary" and by inserting in lieu thereof the word "credentialing." The motion was seconded by Dr. Charles E. Foster, Utah.

On vote, the amendment proposed by Dr. Benton was adopted.

Dr. Lewis S. Earle, Florida, moved to substitute the following resolution (Resolution 77S-1) for Resolution 77:

> 77S-1. **Resolved,** that Chapter IX, Councils, Section 110, Duties, Subsection N, Council on Legislation, of the *Bylaws* be amended by the addition to paragraph N of the following:
>
> > C. To study and make recommendations of policy on matters of licensure related to dentistry.
>
> and be it further
> **Resolved,** that the Board of Trustees be requested to support a *Bylaws* change which would create tripartite membership in the Council on Legislation.

The motion was seconded by Dr. William C. Draffin, South Carolina.

Dr. Earle stated ". . . The intent is to put the matters relating to licensure under the Council on Legislation rather than under the Council on Dental Education. The reason for this is very simple. The matters that relate to licensure . . . or any other type of licensure problem, including the denturist problem, is of prime concern to the American Dental Association as well as to the Council on Legislation. I think it is appropriate that people with expertise in dealing with legislative bodies and governmental agencies . . . should have the concern for this matter. . . ."

Dr. Ashur G. Chavoor, District of Columbia, stated "It is preferable to put it into the Council on Dental Education because there is a tripartite representation in the Council. The Board has representatives there; the educators are represented there. That gives representation to all of the people who are interested in licensure. The American Association of Dental Examiners has four representatives . . . and they are the people who deal directly with the state legislatures on matters dealing with state licensure. . . ."

Dr. Wilfred A. Springer, Jr., New York, moved to refer Resolution 77S-1 to the Board of Trustees for study and report back to the 1977 House of Delegates. The motion was seconded by Dr. Jeremiah Sachs, New York.

On vote, Resolution 77S-1 was referred to the Board of Trustees for study and report back to the 1977 House of Delegates.

On vote, the following resolution (Resolution 77 as amended) was adopted:

77H-1976. **Resolved**, that Chapter IX, Councils, Section 110, Duties, Subsection B, Council on Dental Education, of the *Bylaws* be amended by the addition to paragraph b of the following:

(7) Dental licensure and dental auxiliary credentialing.

Nominations to Commission on Licensure: (Board of Trustees Resolution 74) The Speaker declared action on Resolution 74 negated because of the adoption of Resolution 77H which transfers the duties of the Commission on Licensure to the Council on Dental Education.

REPORT OF REFERENCE COMMITTEE ON PRESIDENT'S ADDRESS AND MISCELLANEOUS MATTERS

The Report of the Reference Committee on President's Address and Miscellaneous Matters was read by Dr. Thomas J. Hicks, Jr., Georgia, chairman. The other members of the Committee were Drs. Truman J. Anderson, Iowa; Grant A. MacLean, Illinois; Wilfred A. Springer, Jr., New York; Stephen S. Yuen, California; Felix Sarcione, Rhode Island, consultant.

Report of President: (Reference Committee on President's Address and Miscellaneous Matters Resolution 163) The Committee reported as follows:

"One of the greatest pieces of writing I have seen in all my years of coming to these meetings," was the way one delegate characterized the outstanding Report of President Shira (p. 11). His magnificent leadership, particularly in these turbulent and challenging times, places him among the great presidents of the Association. His representation of the profession and particularly the private practitioner has been truly superb, and the Committee members feel privileged to salute him.

Terms of Office for Trustees: All who spoke on this topic at the Reference Committee favored President Shira's proposal to shorten the terms of trustees to a total of four years. Such a change will enlarge the number of dentists who can eventually serve on the Board, it will provide a continuing flow of new ideas, and it will assist the many multi-state trustee districts by making possible a speedier rotation system. The Committee recognizes that it is not possible to switch immediately to four-year terms but it believes that the action should be taken as quickly as possible.

The Committee believes, along with President Shira, that this matter need not and should not await the possible restructuring of trustee districts. The two topics can and should be considered separately.

Therefore the Committee submits the following resolution and strongly urges its adoption by the House of Delegates and its early implementation by the Board of Trustees.

Dr. Hicks moved the adoption of Resolution 163 and the motion was seconded.

It was moved and seconded to refer Resolution 163 to the Committee on Advance Planning. On vote, the motion to refer was defeated.

On vote, the following resolution (Resolution 163) was adopted:

> 163H-1976. **Resolved**, that the Board of Trustees is requested to prepare the necessary *Bylaws* changes and to develop the appropriate procedures to change the term of office of a trustee to two years, with a two term limit, and be it further
>
> **Resolved**, that the *Bylaws* changes be submitted to the 1977 House of Delegates so as to implement the change as early as practicable.

The report of the Reference Committee continued as follows:

> **Tenure of Delegates:** A few participants in the Committee's hearing favored the adoption of some sort of guidelines which would encourage states to limit the length of time that their representatives serve in the House of Delegates. One participant commented, candidly and colorfully, that "some delegates stay until the Lord comes for them."
>
> However, there was little discussion in favor of such an action during the hearing. In executive session, the Committee discussed the matter at length and concluded that no action should be taken in this area. The Committee supports and appreciates Dr. Shira's desire to bring new vitality and new ideas into this House of Delegates, but the Committee was most reluctant to move into an area which might give the appearance of interfering with the rights of constituent dental societies. The Committee urges societies to pick the best man for the job, the one most qualified, whatever his age. Certainly, new ideas should be sought, but experienced leadership should also be fully utilized.

Report of Council on International Relations: (Council on International Relations Resolutions 9 and 10) The Committee reported as follows:

> The Committee commends the Council on its outstanding programs and its success in assisting members of the American Dental Association who have an interest in international relations. Its annual report (p. 155) presents an impressive record of the breadth of the Council's activities.
>
> **Association Membership for U.S. Dentists Overseas:** The Committee fully supports the Council's recommendation for a *Bylaws* change in order to assist U.S. dentists practicing overseas in retaining their Association membership. Therefore, the Committee recommends adoption of Resolution 9 (p. 159).

Dr. Hicks moved the adoption of Resolution 9 and the motion was seconded.

On vote, the following resolution (Resolution 9) was adopted:

> 9H-1976. **Resolved**, that Chapter I, Membership, Section 20, Qualifications, Subsection A, Active Member, of the *Bylaws* be amended by the addition of the following phrase at the end of the first paragraph:
>
> > or is a member in good standing of this Association and licensed to practice in a state, the District of Columbia, the Commonwealth of Puerto Rico or a dependency of the United States, practicing in a country other than the United States and consequently not accepted for membership in a constituent and component society, if such exist.
>
> so that the first paragraph of Subsection A will read as follows:

> Active Member. A dentist shall be classified as an active member of this Association who is licensed to practice in a state, the District of Columbia, the Commonwealth of Puerto Rico or a dependency of the United States, providing he is a member in good standing of this Association, its constituent and component societies, if such exist, or is a member in good standing of this Association and licensed to practice in a dependency of the United States wherein a constituent society does not exist, or is a member in good standing of this Association and licensed to practice in a state, the District of Columbia, the Commonwealth of Puerto Rico or a dependency of the United States, practicing in a country other than the United States and consequently not accepted for membership in a constituent and component society, if such exist.

and be it further

Resolved, that Chapter I, Membership, Section 20, Qualifications, Subsection E, Affiliate Member, of the *Bylaws* be amended by the addition of the words "if such exists" following the words "national dental organization" so that Subsection E will read as follows:

> Affiliate Member. A dentist practicing in a country other than the United States who is a member of a national dental organization, if such exists, in such country may be classified as an affiliate member upon application to the Executive Director and upon proof of qualification.

The report of the Reference Committee continues as follows:

> Certificate of Recognition for Volunteer Service in a Foreign Country: The Committee supports the Council's recommendation to modify the criteria for awarding the Certificate of Recognition for Volunteer Service in a Foreign Country. However, in order to clarify the meaning of the phrase "in any given year" the Committee is submitting an amended version of Resolution 10 (p. 160), changing the phrase to read "in any twelve-month period." It should also be noted that the Committee is taking the liberty of changing the phrase "criteria 2 of the criteria" to read more properly "criterion 2 of the criteria."

Dr. Hicks moved to substitute Resolution 10RC for Resolution 10 and the motion was seconded. On vote, the motion was adopted.

Dr. Hicks moved the adoption of Resolution 10RC and the motion was adopted.

On vote, the following resolution (Resolution 10RC) was adopted:

> 10H-1976. **Resolved**, that criterion 2 of the criteria for awarding the Certificate of Recognition for Volunteer Service in a Foreign Country (*Trans.* 1974: 110, 699) be amended as follows:
>
> (1) by adding at the end of paragraph 2 the words "for a minimum of 14 days, either in one period or in several visits, in any twelve-month period," the amended paragraph to read:
>
> > have served in a foreign country in a program sponsored by a church or other recognized voluntary or nonprofit organization for a minimum of 14 days, either in one period or in several visits, in any twelve-month period.
>
> and (2) by adding at the end of paragraph 5 the words "federal dental service or dental school," the amended paragraph to read:
>
> > be nominated by his component or constituent society, federal dental service or dental school.

Report of Council on Journalism: (Council on Journalism Resolution 11; Board of Trustees Resolution 11B) The Committee reported as follows:

> The Committee offers high praise to the Council for the excellence of its programs which have proved to be of such great value to the editors of dental society publications. The entire profession can be proud of the state of dental journalism in this nation.
>
> "Standards" and Guidelines: The Committee supports the Council's recommendations for revising the *Standards* (p. 163) and the Board of Trustees' housekeeping amendment to rescind the previous *Standards* (*Trans.* 1969:312). The Committee gave particular attention to the Council's recommendation that the editor should be appointed or elected for a term of from three to five years. The Committee urges all dental societies to pay special attention to this recommendation in the interest of providing continuity in the editor's post and thereby enhancing the possibility of achieving real excellence in the publication. Therefore, the Committee recommends adoption of Resolution 11B (p. 481).

Dr. Hicks moved to substitute Resolution 11B for Resolution 11 and the motion was seconded. On vote, the motion to substitute was adopted.

Dr. Hicks moved the adoption of the substitute resolution and the motion was seconded.

On vote, the following resolution (Resolution 11B) was adopted:

> 11H-1976. Resolved, that the revised *Standards for Dental Publications* be approved, and be it further
> Resolved, that the *Standards for Dental Publications* approved by the House of Delegates in 1969 (*Trans.* 1969:312) be rescinded.

Report of Council on Scientific Session: The Committee reported as follows:

> The Committee is pleased to commend the Council on Scientific Session for the innovative programming in the past two years and for its unstinting efforts to develop a scientific session which will provide effective continuing education for the practitioner. The Committee was very pleased to receive the report that attendance at the current session has already set a record for Las Vegas. This is surely a tribute to the work of this Council.
>
> The Committee calls attention to the Council's comments on the difficulties it faced in operating programs at McCormick Place in Chicago (p. 205). In light of this fact and the generally low attendance (21,895), it is hoped that a thorough analysis of all such factors will be made before the Association considers holding its annual session in Chicago again.

Extend Ban on Smoking to Include Official Conferences of the American Dental Association: (Michigan Dental Association Resolution 160) The Committee reported as follows:

> The Committee fully agrees with the background statement submitted with Resolution 160 (p. 377). It is indeed time that the Association take a firmer stand on smoking and health and eliminate the use of smoking tobacco during its official conferences. The Committee strongly urges adoption of Resolution 160.

Dr. Hicks moved the adoption of Resolution 160 and the motion was seconded.

On vote, the following resolution (Resolution 160) was adopted:

> 160H-1976. Resolved, that the use of smoking tobacco be prohibited during official conferences of the American Dental Association.

Amendment of "Bylaws" on Scientific Session: (New Jersey Dental Association Resolution 34; Rhode Island Dental Association Resolution 38) The Committee reported as follows:

> The Committee reviewed the statements in support of Resolution 34 (p. 378) and Resolution 38 (p. 385) but did not find them persuasive. These resolutions are identical to Resolution 32 (*Trans.* 1975:740) rejected by the 1975 House of Delegates. The Committee completely supports the position of the Council on Scientific Session and the Board of Trustees that a new section on oral medicine is unnecessary and might, in fact, be counterproductive to the interests of oral medicine. The subject is adequately covered in virtually all sections of the scientific session and, therefore, the Committee recommends that Resolution 34 and Resolution 38 be postponed indefinitely.

Dr. Herbert N. D. Cahan, New Jersey, withdrew Resolution 34.

Dr. Hicks moved to postpone indefinitely Resolution 38 and the motion was seconded.

On vote, the following resolution (Resolution 38) was postponed indefinitely.

> 38. Resolved, that Section 40(A), Chapter XV, of the *Bylaws* be amended by the addition of "o. Oral Medicine" after "n. Oral Pathology."

Introduction of New Business in House of Delegates: (Washington State Dental Association Resolution 39; Seventh Trustee District Resolution 39S-1; Fifth Trustee District Resolution 39S-2) The Committee reported as follows: (For final disposition see p. 929.)

> The Committee found strong sentiment for adoption of some sort of earlier deadline for introduction of resolutions in the House of Delegates. All who testified supported an earlier cutoff; but at the same time there was an underlying concern that the democratic process not be compromised. The Committee considered three alternatives: (1) the Washington State Resolution (p. 386) calling for a deadline 45 days in advance of the annual session; (2) a suggestion which was strongly supported in the hearings for a deadline 15 days in advance of the annual session, and (3) a deadline at the close of the first meeting of the House of Delegates on Sunday. Of the three, the Committee favors the second—a cutoff date 15 days prior to the annual session.
>
> It is believed that such a deadline will accomplish the intent of the Washington State Resolution, without being quite so restrictive. At the same time, it will permit all resolutions to be considered by the Board of Trustees prior to introduction in the House of Delegates; the Committee believes strongly that the comments of the Board members can be of immense value to the deliberations of the delegates.
>
> The Committee also calls to the attention of the delegates the fact that urgent business can still be introduced in the House after the deadline if this business is sufficiently important to gain the support of a trustee district and of three-fourths of the members of the House.
>
> The Committee, therefore, recommends adoption of the following amended resolution.
>
> > 39RC. Resolved, that Chapter V, House of Delegates, Section 120(Ad), Introduction of New Business, of the *Bylaws* be amended to read as follows:
> >
> > > d. Introduction of New Business. No new business shall be introduced into the House of Delegates less than 15 days prior to the opening of the annual session, unless submitted by a Trustee District and with the consent of three-fourths of the delegates present and voting. No new business shall be introduced into the House of Delegates at the last meeting of a session except by unanimous consent; approval of such new business shall require a unanimous vote. Reference Committee recommendations shall not be deemed new business.

and be it further

Resolved, that the *Manual of the House of Delegates* be amended by the deletion of the paragraph entitled "Introduction of New Business" and substitution therefor of the following paragraph:

> **Introduction of New Business:** No new business shall be introduced into the House of Delegates less than 15 days prior to the opening of the annual session, unless submitted by a Trustee District and with the consent of three-fourths of the delegates present and voting. No new business shall be introduced into the House of Delegates at the last meeting of a session except by unanimous consent; approval of such new business shall require a unanimous vote. Reference Committee recommendations shall not be deemed new business.

Dr. Hicks moved the adoption of the amendment and the motion was seconded.

Dr. Eugene M. Zuck, Washington, stated "It is apparent that we are all numb from the deluge of new resolutions we are forced to cope with after we arrive at the House. . . . It does a disservice to our profession and the public because we do not have the time to always grasp the intent and ramifications of this new complex material. . . . The Washington State Dental Association considered this. We felt that if all resolutions were in the delegates' hands 30 days before the House session, it would allow the time necessary to digest this material and get maximum input from our constituency. It will not stifle individual constituent or trustee expression as it will allow for resolutions after we come to the House as long as they relate to the business that is already on the agenda. What it does do is create a more informed House that understands the basic issues and, therefore, can understand the changes that may be proposed. The Reference Committee has listened to all aspects of this problem and agrees with the content of the Washington resolution, but apparently feels a compromise in cut-off time is called for. Therefore, Washington and the Eleventh Trustee District, in the interest of brevity and harmony, will support the amended resolution. We urge your support of Resolution 39RC."

Dr. H. M. Sorrels, Texas, moved to amend the resolution by deleting the words "and with the consent of three-fourths of the delegates present and voting" in both paragraphs titled "Introduction of New Business." The motion was seconded by Dr. John T. Weatherall, Texas.

It was moved and seconded to insert the words "and/or constituent societies" after the word "District."

Dr. Harold E. Barlow, Ohio, and Dr. James P. Kerrigan, District of Columbia, spoke in favor of the amendments. Dr. Joseph A. Devine, Wyoming, and Dr. Joseph D. McNally, Washington, spoke in opposition to the amendments.

Dr. Ernest H. Besch, Texas, called for the question and the motion was seconded. The motion to vote immediately was passed.

On vote, the motion to insert the words "and/or constituent societies" was defeated.

On vote, the amendment proposed by Dr. Sorrels was adopted.

Dr. Robert J. Wilson, Maryland, spoke in opposition to the amended resolution, stating ". . . We have adequate regulation of the introduction of new business before this assembly. A delegate may introduce business through the close of the session on Sunday. This allows him to get down to present something that he may have lost at home. It gives him that individual privilege. . . . I submit to you that what we have on the books is sound; it is good. I also submit to you . . . that this, if passed, would merely lead to a deluge of amendments, substitutions and other diverse ways to get new business before this House. It is a sham. . . ."

Dr. Israel Shulman, District of Columbia, and Dr. Ernest H. Besch, Texas, spoke in opposition to the amended resolution.

On vote, the following resolution (Resolution 39RC as amended) was adopted, the first resolving clause by the necessary two-thirds majority vote:

39H-1976. **Resolved,** that Chapter V, House of Delegates, Section 120(Ad), Introduction of New Business, of the *Bylaws* be amended to read as follows:

d. Introduction of New Business: No new business shall be introduced into the House of Delegates less than 15 days prior to the opening of the annual session, unless submitted by a Trustee District. No new business shall be introduced into the House of Delegates at the last meeting of a session except by unanimous consent; approval of such new business shall require a unanimous vote. Reference Committee recommendations shall not be deemed new business.

and be it further

Resolved, that the *Manual of the House of Delegates* be amended by the deletion of the paragraph entitled "Introduction of New Business" and substitution therefor of the following paragraph:

Introduction of New Business: No new business shall be introduced into the House of Delegates less than 15 days prior to the opening of the annual session, unless submitted by a Trustee District. No new business shall be introduced into the House of Delegates at the last meeting of a session except by unanimous consent; approval of such new business shall require a unanimous vote. Reference Committee recommendations shall not be deemed new business.

Consumer Directories of Practicing Dentists: (Board of Trustees Resolution 115) The Committee reported as follows:

The Committee discussed extensively Resolution 115 (p. 547) and the Board of Trustees' comments on it. The Committee members recognize that the whole topic of consumer directories is currently a confused area. Nader-type consumer groups have issued some so-called directories which at best can be called useless. On the other hand, several dental societies have cooperated with consumer groups in producing worthwhile consumer information materials. The Committee is persuaded that this is an area in which the Association needs policy in order to guide those societies which wish to produce such directories. Adoption of Resolution 115 can provide policy in an area which is now void, and it can serve as a good-faith act, perhaps demonstrating to certain governmental agencies that the profession is moving to provide useful information to the public on the selection of a dentist. The Committee urges that the guidelines be produced as soon as possible and that the agencies charged with preparing the guidelines consult widely with dental societies on the type of information that should be included. The Committee was not comfortable with the word "meaningful" in the first resolving clause, believing that this can be widely interpreted. Instead, the Committee suggests the word "appropriate." Therefore, the Committee submits an amendment to Resolution 115 and recommends adoption of the amended resolution.

115RC. **Resolved,** that constituent and component dental societies be encouraged to produce or cooperate in producing ethical "consumer directories" of dentists in their areas which will provide appropriate information to the public, and be it further

Resolved, that constituent and component societies consider cooperating with responsible state or local consumer organizations in the production of such directories, and be it further

Resolved, that appropriate agencies of the Association develop guidelines and report these guidelines to the March 1977 session of the Board of Trustees for consideration and promulgation.

Dr. Hicks moved the adoption of the amendment and the motion was seconded. On vote, the amendment was adopted.

Dr. Ernest H. Besch, Texas, moved to delete the third resolving clause of Resolution 115RC and the motion was seconded by Dr. Mark A. Price, Louisiana.

On vote, the motion to delete the third resolving clause of Resolution 115RC was adopted.

Dr. Hicks moved the adoption of the amended resolution (Resolution 115RC as amended) and the motion was seconded.

On vote, the following resolution (Resolution 115RC as amended) was adopted:

> 115H-1976. **Resolved**, that constituent and component dental societies be encouraged to produce or cooperate in producing ethical "consumer directories" of dentists in their areas which will provide appropriate information to the public, and be it further
> **Resolved**, that constituent and component societies consider cooperating with responsible state or local consumer organizations in the production of such directories.

The Public Education Program: (Reference Committee on President's Address and Miscellaneous Matters Resolution 164) The Committee reported as follows: (For final disposition see p. 933.)

> Strong support for the Public Education Program was expressed in the Committee hearing, along with strong support for an expanded 1977 budget. There was also repeated testimony for placing more emphasis on assistance to the state and local societies and for reaching the "grassroots" members with PEP's message. A second major theme in the comments cited the need to include the fight against illegal dentistry in PEP.
>
> The Committee was very impressed by the number of dentists from state and local areas who volunteered statements on how PEP had provided specific assistance in meeting severe crises in their areas.
>
> It is the Committee's unanimous belief that PEP should be fully funded in 1977 and that it should address itself to the communications problems posed by illegal dentistry. Therefore, the Committee strongly urges approval of Resolution 164.

Dr. Hicks moved the adoption of Resolution 164 and the motion was seconded.

Dr. Jack H. Harris, Texas, moved to amend the second resolving clause of the resolution to read as follows, and the motion was seconded by Dr. Mark A. Price, Louisiana:

> **Resolved**, that the Board is requested to appropriate $327,000 in additional funds to the Public Education Program, from reserves if necessary, to combat illegal dentistry.

Dr. Harris stated "I have been hearing for two days from this House about its concern for the public. I have also heard about the seriousness of the illegal dentistry problem that we have confronting us. The two obviously go hand in hand. The House has, to this point, not shown its good faith in this situation. Certainly earmarking these funds for the combat of illegal dentistry will show our membership, and I hope will show the public, that we are definitely opposed to illegal dentistry because it is the most dangerous thing for dental health in the country today."

Dr. Lloyd J. Phillips, Indiana, trustee of the Seventh District, spoke in opposition to

the amendment, stating ". . . Part of the problem, or part of the total problem that exists with respect to the fight to combat illegal dentistry, has been the lack of a definite answer to how we should do it. . . . The program in Oregon (POW) is an attempt to see whether an entirely new method should and can work, and then should be adopted by the American Dental Association. We were told that we would get the results of that by the end of the year. The amount of $327,000 may be totally inadequate to fight the illegal practice of dentistry. When a definitive program is made available, it is within the duty and the responsibility of the Board of Trustees to spend a million dollars to fight it, if necessary; and it is within the Board's jurisdiction and power, in its management position for this Association, to make that decision. . . . I would ask you not to decimate the content of the Public Education Program. . . If you want to fight the illegal practice of dentistry, give the power to the Board of Trustees to spend the reserve funds. . . ."

Dr. Eugene J. Truono, Delaware, stated ". . . The $327,000 represents an allocation of possibly $6,000 in each of the 50 jurisdictions across the country. . . . I think the time is now that we put up our money or we shut up, or we are not going to have anything to go with in the future. I honestly feel that $1.1 million would be utilized in the most effective way, and I would like to give the Board of Trustees the direction for the use of that money."

President Robert B. Shira stated "If you pass this, the entire $327,000 goes to the Public Education Program Committee for its use. . . . I would call to your attention that there are other agencies in the American Dental Association which are also charged with this same problem. . . . I think, therefore, you should look twice before you say where that money is going to go. I think you should put it into the hands of the trustees and let them decide how it should be divided."

On vote, the amendment proposed by Dr. Harris was defeated.

Dr. William Travis, Michigan, moved to substitute the following resolution for Resolution 164, and the motion was seconded:

> **Resolved,** that $1.1 million in additional funds, from reserves if necessary, be appropriated to combat illegal dentistry in this country, and be it further
> **Resolved,** that the Board of Trustees supervise the expenditure of these funds.

President-elect Frank F. Shuler, requested a point of personal privilege, stating ". . . It was mentioned in previous debate that the Board of Trustees decimated the Public Education Program to the tune of $1,100,000. I would like to point out for the information of this House that the Board of Trustees also decimated other budgets by an additional $1,100,000 to fulfill its *Bylaws* responsibility to bring you a balanced budget. . . . If you want an illegal dentistry program . . . I would trust that you would give the responsibility for management and dispensing of funds and the development of programs to the Board of Trustees . . . and not give it to another committee. . . ."

Dr. Joseph P. Cappuccio, Maryland, trustee of the Fourth District, stated "I rise to support this substitute resolution because I believe that the very essence of our profession is embodied in the principle of this resolution. There was allusion to the fact that we would deplete our reserves by $1.1 million. I pose the question before this House—what good would our reserve funds be if illegal dentistry would prosper in this nation and take over? We would not have a profession left to have reserve money for. I believe the most critical and the highest priority issue is the illegal prac-

tice of dentistry by unqualified individuals. It has been enunciated time and time again during the deliberations of this House. I believe the time has come for our House of Delegates to put up or shut up. . . ."

Dr. Burton H. Press, California, stated ". . . I would like for us to ante up. . . . I want you to understand that the House, acting as a committee of the whole and as PR experts to redesign everything that has been done . . . really doesn't make sense to me. The money as appropriated for PEP . . . would be used under the direction of the Board of Trustees by the PEP Committee in whatever directions were so designated and proper. . . . We have to ante up and gamble on all the mistakes we have made so far and keep going along with a research and development program and find our doctors who will prevent the intrusion of federal bureaucracy into the American health delivery system. . . . I would like the $1.1 million. I trust the PEP Committee and I trust the Board of Trustees. . . ."

Dr. Israel Shulman, District of Columbia, called for the question and the motion was seconded. The motion to vote immediately was passed.

On vote, the motion to substitute proposed by Dr. Travis was adopted.

Dr. James V. Barone, Michigan, moved to delete the words "illegal dentistry" in the substitute resolution and insert in lieu thereof the word "denturism." The motion was seconded.

Dr. Israel Shulman, District of Columbia, stated "I think we would solve the problem by calling it 'unqualified.' The term 'unqualified' would solve the problem because a person who may be licensed to practice in the State of New York could not legally practice in New York because he would not be qualified. . . ."

President Robert B. Shira stated "As I understand it, you want to give the $1.1 million. But if it goes like this, the Board of Trustees is pretty well tied down to spending it for combating illegal dentistry. I would like to see somebody amend to say 'illegal dentistry and other threats to private practice' and then go on with it."

Dr. DeWayne L. Briscoe, Washington, called for the question and the motion was seconded. The motion to vote immediately was passed.

On vote, the amendment proposed by Dr. Barone was defeated.

Dr. Eugene A. Savoie, Arizona, trustee of the Fourteenth District, stated "I am . . . a member of the PEP Committee. When this was brought to the PEP Committee, we discussed various programs. It was felt that the Association needs to combat the threat to the private practice, fee-for-service system in 1977. We developed a program and I presented it to the reference committee. . . . What I see up here is that you are giving $1.1 million to the Board, which is fine. Either way, I am probably going to get it, but that does not solve PEP's problems. . . . I wish you would say something about the program that my fellow members and I on this Committee are trying to develop at the grassroots level—taking PEP down to the local area, not necessarily where we have been but where we are going. Right now, you are taking that away from PEP. Everything we try to do is going to the Board, and from there I do not know where it is going. I am asking you, is that what you want?"

Dr. Arthur L. Labelle, California, spoke in support of the substitute resolution, stating ". . . There is no reason why this Association should not be fighting denturism nationally instead of in one state. There are many states involved and this expenditure of funds will help not only in that course but in the area of public education."

Dr. Israel Shulman, District of Columbia, called for the question and the motion was seconded. The motion to vote immediately was passed.

On vote, the following substitute resolution was adopted:

164H-1976. Resolved, that $1.1 million in additional funds, from reserves if necessary, be appropriated to combat illegal dentistry in this country, and be it further

Resolved, that the Board of Trustees supervise the expenditure of these funds.

Dr. DeWayne L. Briscoe, Washington, moved to reconsider Resolution 88 which was referred to the 1977 House of Delegates for action. The motion to reconsider was seconded by Dr. John W. Richards, Washington.

On vote, the motion to reconsider Resolution 88 was defeated.

Non-Policy Resolutions: The Committee reported as follows:

The Committee believes that Resolutions 49, 92, 131, 135 and 142 fall within the provision of the "non-policy items" as approved by the House of Delegates (*Trans.* 1975:622). These resolutions have been transmitted for appropriate submission to the House of Delegates.

REPORT ON NON-POLICY RESOLUTIONS

The following Report on Non-Policy Resolutions was read by Dr. Thomas J. Hicks, Jr., chairman of the Reference Committee on President's Address and Miscellaneous Matters.

In accordance with the *Manual of the House of Delegates*, the following resolutions have been determined by the Speaker of the House of Delegates to be non-policy resolutions and are therefore being presented *en bloc* for adoption:

Council on Judicial Procedures, Constitution and Bylaws: Amendment of *Bylaws* on Student Membership and Active Member Dues—Resolution 18 (p. 179)

Council on Judicial Procedures, Constitution and Bylaws: Amendment of *Bylaws* on Appeals of Disciplined Members—Resolution 19 (p. 180)

Council on Judicial Procedures, Constitution and Bylaws: Amendment of *Bylaws* on Privileges of Active Member Under Sentence of Suspension—Resolution 20 (p. 181)

Council on Judicial Procedures, Constitution and Bylaws: Amendment of *Bylaws* on Constituent Societies—Resolution 21 (p. 181)

Council on Judicial Procedures, Constitution and Bylaws: Amendment of *Bylaws* on Council on Relief—Resolution 22 (p. 181)

Indiana Dental Association: Commendation to Dr. Lloyd J. Phillips—Resolution 49 (p. 371)

Kentucky Dental Association: Commendation to Dr. Charles D. Carter—Resolution 92 (p. 373)

Fifth Trustee District: Commendation to Commission on Licensure—Resolution 108 (p. 401)

Massachusetts Dental Society: Commendation of Dr. James W. Etherington—Resolution 131 (p. 374)

Tenth Trustee District: Commendation of Dr. Jack H. Pfister—Resolution 135 (p. 413)

Fourth Trustee District: Commendation to Board of Trustees—Resolution 142 (p. 393)

Twelfth Trustee District: Commendation to Washington Office—Resolution 153 (p. 416)

178. Resolved, that Resolutions 18, 19, 20, 21, 22, 49, 92, 108, 131, 135, 142 and 153 be adopted.

Dr. Hicks moved the adoption of Resolution 178 and the motion was seconded. On vote, the following resolution (Resolution 178) was adopted:

178H-1976. Resolved, that Resolutions 18, 19, 20, 21, 22, 49, 92, 108, 131, 135, 142 and 153 be adopted.

REPORT OF REFERENCE COMMITTEE ON SCIENTIFIC MATTERS

The Report of the Reference Committee on Scientific Matters was read by Dr. Louis V. Fourie, Illinois, chairman. The other members of the Committee were Drs. S. N. Bhaskar, Army; James D. Mendenhall, West Virginia; John H. Mosteller, Alabama; Frank F. Trice, Texas.

Report of Council on Dental Materials and Devices: The Committee reported as follows:

The Reference Committee reviewed with approval the annual report of the Council on Dental Materials and Devices (p. 120). The Committee noted the extensive amount of work accomplished by this Council and made special note that the Council staff has started the third year of a five year grant supported by the National Institute of Dental Research to assist in activities of the American National Standards Committee MD156.

Reports of Complaints and Defects in Dental Materials and Devices: The Committee noted with interest that the complaint reporting program of the Council has assisted many members in settling complaints with industry. All complaints regarding a defect or technical difficulty with the product have been settled to the satisfaction of the dentist. The majority of complaints regarding non-delivery of prepaid materials and unsatisfied requests for refunds were lodged against two companies, Applied Health Services and its companion firm, Metrodent Corporation. These two companies have filed a joint petition for permission to reorganize under the federal bankruptcy laws. On behalf of the many members who are creditors, one of the Association's staff attorneys sought to be and was named by the federal court as Chairman and Secretary of the Creditors Committee. This committee is now making every effort to protect the interests of all creditors to the maximum extent possible with a view to achieving a satisfactory settlement of all amounts due and owing creditors.

Mercury Hygiene: The House of Delegates in 1975 adopted the following resolution submitted by the Fourth Trustee District (*Trans.* 1975:742):

> Resolved, that the Council on Dental Materials and Devices of the American Dental Association recommend certain basic requirements and standards to the manufacturers of mercury and the manufacturers of both manual and mechanical instruments and devices used in handling mercury in dental offices to prevent spillage and contamination.

The Council has implemented the resolution by the establishment of new projects in American National Standards Committee MD156 to formulate standards for mechanical amalgamators, capsules and proportioners. Drafts of such standards were reviewed at the meeting of ANSC MD156 subcommittee on March 24, 1976 and are being revised in accordance with comments received. Draft documents should be available for review by the Council by the end of 1976.

The Committee was pleased to note that the Council continued its review of this area and published a recommended semi-quantitative mercury vapor survey procedure based upon "film badge indicator" (*JADA* 91:610, September 1975).

Acknowledgments: The Committee wishes to express its sincere appreciation to Dr. Floyd A. Peyton for his meritorious contributions towards the increased quality of dental products throughout almost 40 years of research and for his administrative accomplishments in leading dental standards development in the United States since 1964. The Committee also wishes to express its appreciation to Dr. Richard D. Norman for his service on the Council.

Report of Council on Dental Research: The Committee reported as follows:

The Reference Committee reviewed the report of the Council on Dental Research (p. 128) and was disappointed that because of new federal legislation the Council program "Traineeships in Dental Research for Prebaccalaureate College Students" had to be discontinued by the National Institute of Dental Research. The Committee, however, was gratified to know that in the 12 years in which the program was active, 30 percent of the 315 students had enrolled in or graduated from dental school, 33 percent had enrolled in or graduated from medical school and 37 percent were seeking or had obtained a doctorate in the basic sciences.

Protection of Human Subjects: The Committee noted with interest that all clinical research requires the informed consent of each patient, regardless of the degree of risk involved. The Committee agrees that the Council should issue an advisory report to the profession on this aspect of research as soon as all new information had been properly assessed.

Fiftieth Anniversary of the American Dental Association Health Foundation Research Unit, National Bureau of Standards: The Committee was interested to learn that the Research Unit at the National Bureau of Standards which is sponsored by the American Dental Association will celebrate its 50th anniversary in 1978. The Committee concurs with the Council members that appropriate plans for celebrating this important event be formulated and presented to the Board of Trustees for approval.

Report of Council on Dental Therapeutics: The Committee reported as follows:

The Reference Committee reviewed the annual report of the Council on Dental Therapeutics (p. 132) and commends the Council on the pertinent and important activities described. The Committee was interested in the strong liaison the Council has with the Food and Drug Administration and hopes that this will be continued.

Inhalation Anesthetics: The Committee noted that an Ad Hoc Committee on Trace Anesthetic Gases had been appointed and assigned to the Council on Dental Therapeutics. The Committee expressed concern in this area of dental practice and was hopeful that the Council would be helpful in solving the problem in the best interest of the practicing dentist. The Committee was concerned upon learning that the National Institute of Occupational Safety and Health document which contains the standards for the use of nitrous oxide and halothane will impose the same stringent requirements for both the dental operatory and the hospital operating room. The Ad Hoc Committee should attempt in every way possible to convince NIOSH to develop a separate document for dentistry or an addendum to the present one.

N_2: The Committee was pleased to note that the Council is progressing in its efforts to establish protocols for testing the safety and efficacy of the N_2 type formulations. The protocol has now been received from the American Endodontic Society and has been submitted to several consultants for evaluation. The formula proposed for use in the protocol has been simplified from some 11 or 12 ingredients, previously contained in N_2 (RC_2B) formulations to 4 ingredients, thus eliminating several major areas of controversy. The Committee feels that this fact alone is a giant step towards an early resolution of the controversy. Paraformaldehyde now remains the only ingredient having therapeutic implications in the proposed formulation which needs to be evaluated for safety and efficacy when used as a component of a root canal filling material.

"Hepatitis Workshop": The Committee congratulates the Council upon the excellent publication on this important subject that appeared in *The Journal* (*JADA* 92:153, January 1976). The Committee noted that the carrier state, the prevalence of the disease in dentists, and its transmission and possible prevention are discussed in this paper in a question and answer format which makes it exceedingly easy to read and understand.

Acknowledgment: The Committee wishes to express sincere appreciation to Dr. N. Wayne Hiatt for his many contributions during his six years of service to the Council.

Report of American Dental Association Health Foundation: The Committee reported as follows:

The Reference Committee reviewed the report of the American Dental Association Health Foundation and found it to be informational in nature (p. 332).

Report of American Dental Association Health Foundation Research Institute: The Committee reported as follows:

The Reference Committee studied the report of the American Dental Association Health Foundation Research Institute (p. 333). The Committee noted the grants and contracts sponsored by outside agencies were in the amount of $149,465 with $19,488 in indirect costs.

Research Activities: The Committee was particularly interested in the following research activities which they believe to be of particular significance to dentistry:

1. The technique of intraoral source radiography, supported by a contract from the Food and Drug Administration, is being developed in order to produce an improved image and reduce the exposure of the patient to radiation.
2. A project has been initiated to develop improved, non-radioactive additive materials to dental porcelains to produce optical properties that are similar to natural teeth, in order to eliminate the current need for uranium to produce this effect.
3. A collaborative effort between the Divisions of Developmental Biology and Chemistry is currently evaluating gross and tissue responses of laboratory animals exposed to nitrous oxide during selected intervals of pregnancy in order to provide biological correlates for evaluating this agent as a potential problem of health hazard to the dental profession.
4. Studies in the Division of Chemistry are attempting to determine the biological basis of the adverse gingival responses seen in many patients after diphenylhydantoin administration.
5. Some of the craniofacial malformations seen in humans, such as cleft palate, have been produced in monkeys in order to evaluate new techniques of surgical repair and the effect that these lesions have on subsequent postnatal facial growth.

Report of American Dental Association Health Foundation Research Unit at the National Bureau of Standards: The Committee reported as follows:

The Reference Committee has reviewed the report of the American Dental Association Health Foundation Research Unit at the National Bureau of Standards (p. 342). It was noted with considerable interest that the funding received through the granting and the contract mechanism has increased considerably over previous years and is $475,218 for the present reporting period, including indirect costs of $117,354. The Committee noted that the Research Unit continues to carry on its broad research program which related chiefly to the prevention of dental disease and to facilitate its treatment through the characterization of dental materials and hard tissues, development of new materials and procedures and improvement of existing materials. The Committee noted with special interest the following research projects:

1. Research directed toward increasing the resistance to wear of the composite restorations is well under way.

2. There is a research program which involves the study of casting behavior of base metal alloys, to displace costly gold alloys for use in dental crowns and bridges.

3. Biological clinical tests are being initiated and patent rights are being sought on the manganese containing amalgam alloy developed by the Research Unit. The manganese additive eliminates the undesirable tin-mercury phase from these alloys and improves the "creep" properties, making this type of alloy a promising candidate for improved dental amalgam.

4. There is a program to develop investment materials that will permit precision casting of dental restorations at the higher temperatures required by base metal substitutes for gold alloys and under the variable conditions found in dental laboratories.

5. Research has led to a discovery that points to possible further improvement of single-step topical fluoride treatments.

6. The Research Unit does goal-directed basic research in addition to development of new materials and improvement of materials already on the market.

Acknowledgment: The Committee commends Dr. George C. Paffenbarger who was the recipient of the 1976 Hollenback Award from the Academy of Operative Dentistry and honors from Ohio State University College of Dentistry.

Identification of Dental Procedures by Scientific Term: (Pennsylvania Dental Association Resolution 51) The Committee reported as follows:

The Reference Committee considered Resolution 51 (p. 385) and the Board's comments that "the Board recommends the fullest use of the American Dental Association *Procedure Code and Nomenclature*" (p. 495). The Committee agrees with the Board's comments that it would not be possible to enforce such a resolution and that passage of such a resolution may have antitrust implications. Therefore, the Committee recommends that Resolution 51 be postponed indefinitely.

Dr. Fourie moved to postpone indefinitely Resolution 51 and the motion was seconded.

On vote, the following resolution (Resolution 51) was postponed indefinitely:

51. **Resolved**, that all dental procedures shall be identified or designated by a strictly scientific term or terms, and be it further

Resolved, that the use of proprietary terms such as manufacturers' trade names, personalized descriptions and the like shall not be used to determine or identify a treatment or procedure or method of payment.

UNFINISHED BUSINESS

Amendment of "Bylaws" Regarding Composition of Board of Trustees: (Fourth Trustee District Resolution 180) Dr. Robert J. Wilson, Maryland, moved the adoption of Resolution 180 and the motion was seconded by Dr. Joe N. Price, Maryland.

Dr. Wilson stated "This Association has had many great presidents. Currently, we have one of the greatest. To lose this man's talents to this Association would be a great shame and a great waste of knowledge and experience. I urge you to support this resolution so that Bob Shira can serve with us yet another year."

Dr. William R. Alstadt, Arkansas, past president of the Association, stated ". . . This resolution is just a clever and perhaps a cynical way to circumvent the will of this

House of Delegates. . . . Let me say, at the very outset, that I am opposed to creating an office of Immediate Past President or Trustee-at-large, and yet I favor retention of the First and Second Vice President. I want this House to clearly understand that I think Bob Shira has made one of the greatest presidents we have ever had. . . . I do, however, want to call the attention of the House to the fact that each president has shown by his ability . . . that he is capable of being president, and his administration is responsible and does the very best it possibly can. I do not think it is fair to any president to have someone who preceded him looking over his shoulder . . . and, in effect, have an influence on programs that he should not have. I can see, too, that this would increase the staff's burden. . . . Most important of all, it would create a conflict among the Board of Trustees, the staff, and a conflict with the president and president-elect. . . . It has been shown time and time again that a past president has the right of the floor in the House of Delegates and may even engage in debate, but obviously he cannot make motions nor can he vote. I think that is as it should be. I do think, however, that you have to have one chief executive and that chief executive is the president. I can only see confusion and certainly no advantage to such a resolution. . . ."

Dr. John J. Timmermans, New York, called for the question and the motion was seconded. The motion to vote immediately was passed.

On vote, the motion to adopt the following resolution (Resolution 180) was defeated:

> 180. **Resolved**, that Chapter VI, Board of Trustees, Section 10, Composition, of the *Bylaws* be amended by substituting the following sentence for the second sentence:
>
> > Such fourteen (14) trustees, a trustee at-large who shall be the Immediate Past President, the President-elect, and the two Vice Presidents shall constitute the voting membership of the Board of Trustees.
>
> and be it further
> **Resolved**, that the amendment take effect upon the installation of officers and trustees on November 18, 1976.

National Health Service Corps Placements: (Fifth Trustee District Resolution 182) Dr. Guy R. Willis, North Carolina, withdrew Resolution 182.

Adjournment: The 117th session of the House of Delegates adjourned *sine die* at 3:16 p.m.

Opening Ceremony

Call to Order: The Opening Ceremony of the 117th Annual Session of the American Dental Association was called to order at 9:35 AM, Sunday, November 14, 1976, in the Rotunda of the Las Vegas Convention Center, Las Vegas, Nevada, by President Robert B. Shira. Following a welcome by Dr. Shira, a film entitled, "America--Lest We Forget," was presented and the National Anthem was sung by Mr. G. Barney Rawlings.

Invocation: The invocation was offered by Rabbi Stephen Weisberg, Congregation Ner Tamid.

Introduction of Distinguished Guests: President Shira introduced the following retiring officers and members of the Board of Trustees: Dr. James W. Etherington, Treasurer, Massachusetts; Dr. Charles D. Carter, Sixth District Trustee, Kentucky; Dr. Lloyd J. Phillips, Seventh District Trustee, Indiana; Dr. Jack H. Pfister, Tenth District Trustee; Dr. Irving E. Gruber, First Vice President, New York; Dr. George E. Kearns, Second Vice President, Illinois.

President Shira also introduced Dr. Maynard K. Hine, president, *Fédération Dentaire Internationale;* Dr. Jan Erik Ahlberg, executive director, *Fédération Dentaire Internationale;* Dr. Renton Newbury, immediate past president, Australian Dental Association; Dr. M. J. Cripton, president, Canadian Dental Association; Dr. Ruben C. Navia, president, Philippine Dental Association.

Messages of Greeting: Mr. Aaron Williams, Clark County Commissioner, was introduced and made a presentation to President Shira. Mr. Paul J. Christenson, Las Vegas City Commissioner, was also introduced and presented greetings on behalf of the Mayor and citizens of Las Vegas.

Dr. Louis J. Hendrickson, general chairman, Committee on Local Arrangements, was introduced and extended a welcome on behalf of the members of his committee. Brief messages of welcome were also presented by Dr. Harry P. Massoth, president, Nevada Dental Association, and Dr. Stanton Schmutz, president, Clark County Dental Society.

Keynote Address: The keynote address was presented by Senator-Elect Daniel P. Moynihan.

Introduction of Nominees for Honorary Membership: President Shira introduced the nominees for honorary membership in the American Dental Association (see p. 462) and they were recognized by the audience.

1976 Distinguished Service Award: President Shira introduced Dr. Percy T. Phillips who was named by the American Dental Association's Board of Trustees to receive the 1976 Distinguished Service Award. The presentation of the Award was made by President Shira and Dr. Phillips briefly responded.

Presentation of ADA Science Writers Awards: President Shira made the presentation of the following ADA Science Writers Awards: Mrs. Patricia McCormack, family health editor for United Press International, first place winner in the newspaper division; Ms. Constance Bille, free-lance writer, Philadelphia, first place winner in the magazine division.

International Science Fair Program for High School Students: President Shira introduced the following first place winners in the Dental Division of the 27th International Science Fair which was held in Denver, Colorado: Miss Deborah Malone, Grants, New Mexico, and Mr. Stephen Budak, Michigan City, Indiana.

1976 ADA Community Preventive Dentistry Award: President Shira presented the 1976 ADA Community Preventive Dentistry Award to Miss Patricia E. West, Birmingham, Alabama.

Presentation to Dr. Floyd Peyton: On behalf of the officers and trustees of the American Dental Association, President Shira presented a citation to Dr. Floyd Peyton in recognition of his meritorious contributions toward the increased quality of dental products throughout 40 years of research and for his administrative accomplishments in leading dental standards development in the United States since 1964. Dr. Peyton briefly responded.

Presentation from Philippine Dental Association: Dr. Ruben C. Navia, president of the Philippine Dental Association, presented President Shira with a plaque and President Shira briefly responded.

Entertainment: Musical entertainment was presented by "Jubilation Seventy-Seven" from Western High School under the direction of Mr. James Garoufes.

Adjournment: The Opening Ceremony adjourned at 11:30 a.m.

Scientific Session

The annual scientific session was held November 14-17, 1976 at the Las Vegas Convention Center, Las Vegas, Nevada. The scientific program was under the direction of the Council on Scientific Session, composed of the following members: Dr. Lyle A. Brecht, Minneapolis, Minnesota, chairman; Dr. John F. Chimienti, Overland Park, Kansas; Dr. Alfred A. Lanza, New York, New York; Dr. Leon E. Oursland, San Diego, California; Dr. John T. Sowle, Rockford, Illinois; Mr. Daryl I. Miller, secretary. The following participated in the scientific session:

Abbey, Louis M.
Abrams, Albert M.
Abrams, Herbert
Adams, David R.
Ahl, Dennis R.
Alabama in Birmingham, University of
Albanese, Anthony A.
Alcox, Ray W.
Alexander, C. Moody
Alexander, William N.
Allen, Gerald D.
American Academy of Dental Electrosurgery
American Academy of Implant Dentistry
American Academy of Oral Medicine
American Analgesia Society
American Board of Forensic Odontology
American Dental Assistants Association
American Dental Association, Council on Dental Health
American Dental Society of Anesthesiology
American Dentists for Foreign Service
Aptekar, Robert G.
Archacki, Paul V.
Ashman, Charles W.
Askin, Haskell
Association of American Women Dentists
Augsburger, Robert A.
Augsburger, Russell H.
Austin, J. Duncan

Bachman, Lillian H.
Backenstose, W. Michael
Bailey, Dennis R.
Baker, Bill R.
Baranko, John G.
Barkin, Paul R.
Barkmeier, Wayne W.
Barnett, Edward M.
Barrett, F. M.
Barrett, I. Mullen
Barrickman, Robert W.
Baum, Lloyd
Baylor University
Beaudry, Douglas L.
Beck, James O., Jr.
Belinfante, Louis S.
Bell, A. Milton
Bell, Dewey
Bell International
Bennett, Jim
Bergen County Dental Society
Bergen County Health Department
Berger, Joel E.
Berman, Charles L.
Bicoll, Norton J.
Biddington, W. Robert
Billingham, William
Bimestefer, L. W.
Biofeedback Workshop
Birmingham, University of
Birtcil, Robert F., Jr.
Bishop, Tom W.
Bissada, Nabil F.
Biven, Glenn M.
Blaes, Joseph A.
Bloch, Milton
Blozis, George G.
Bobulsky, William P.
Bonica, John J.
Bonk, James
Bonomo, Edward C.
Booker, Brooks W.
Boone, Malcolm E.
Borman, William
Boston University
Bottomley, William K.
Bowen, William
Bradford, Brant A.
Bramer, Max L.
Brearley, Anne
Brecht, Lyle A.
Brickbauer, Gustave P.
Brown, Charles A.
Brown, William T.
Brussell, Irving J.
Bruzzese, Joseph D.
Bryan, Jimmy L.
Buchalter, Daisy N.
Bucher, John F.
Budak, Stephen J.
Burke Rehabilitation Center
Burns, Gary

Cagle, Tyler W.
Cahill, James M.
California, University of, Los Angeles
California, University of, San Francisco
Callaway, James A.
Cameron, Bruce G.
Camp, Joe H.
Carlos, James P.
Carnahan, Harold D.
Carpenter, James E.
Carr, Bernard
Case Western Reserve University
Cataldo, Gennaro L.
Catchings, James A. A.
Ceen, Richard F.
Charbonnet, Pierre N., Jr.
Chase, Douglas G.
Chasko, Lawrence
Chemetron Corp.
Chiang, Philip
Chiarenza, Angelo
Chimienti, J. Frank
Choudhary, Suresh C.

Christian Dental Society
Christian, Duane E.
Chubin, Myron
Cigel, Louis A.
Ciola, Benjamin
Clark, Jack T.
Clarke, Roger
Claus, Dorothy C.
Claus, Everett C.
Clay, Don
Cloonan, Richard A.
Cochiaro, Sam
Cohen, Lawrence
Cohen, Lois K.
Collard, Earl W.
Colorado, University of
Columbia University
Colvin, Charles J.
Connecticut, University of
Cooksey, Donald E.
Cooley, Robert L.
Cooley, William E.
Coplin, Donald S.
Cox, Frederick L.
Crandall, S. Kendrick
Creighton University
Crouse, Robert C.
Custer, Frederic
Cutler, Marvin
Cutright, Duane E.

Dalise, David
Darvish, Manouch
Davis, James L.
De Feo, Louis F.
De Sai, Rajendra J.
De Vore, Duane T.
Del Ricco, Richard A.
Delta Dental Plans Association
Demer, Walter J.
Dennison, Joseph B.
Dentsply International
Deranian, H. Martin
Derry, Robert H.
Detroit, University of
Dibble, Arthur E.
Didactic Films, Ltd.
Diedrichsen, Lloyd
Disraeli, Richard I.
Dodge, Charles A.
Doherty, Hugh F.
Driscoll, Edward J.
Drobotij, Elias
Dropkin, Stuart I.
Du Puis, Jean Jacque
Dugoni, Arthur A.
Dunkelberger, Fred B.
Dusek, Thomas O.

Earl, J. Lawrence
Eastman Chemical Products, Inc.
Edelson, A. Herbert
Edwards, Richard C.
Edwards, Sandra M.
Eglitis, Ilze Irene
Egol, Arthur B.
Eissman, Harold F.
Elinger, Royal F.
Elliott, Robert W., Jr.
Emory University
Ence, G. Dwayne
Ence, Kenneth G.
Engstrom, Alta M.
Epker, Bruce N.
Epstein, Louis C.
Erickson, Donald
Evans, James C.

Faber, Richard
Fagan, Maurice J.
Fairleigh Dickinson University
Faustina, Leonard M.
Federation of Orthodontic Associations
Federick, David R.
Fillingham, Mary
Fine, Louis
Fleming, Glen
Florida, University of
Flynn, Margrit
Francavilla, Vincent J.
Francis, Sidney
Frank Allen Dental Seminar
Frantz, Wayne R.
Frei, N. Richard
French and Polyclinic Medical School and Health Center
Frere, Jules T.
Friedman, Jay W.
Furgason, Richard L.

Gabriel, Richard L.
Garabedian, Haig D.
Garcia, Manuel
Garefis, Paris
Gargiulo, Anthony W.
Geistfeld, Ronald E.
Gelbman, Joel C.
General Mills, Inc.
Georgetown University
Georgia, Medical College of
Gershon, Sol D.
Getter, Lee
Gibbens, Cheryl Briggs
Gibbs Oral Hygiene Service
Gibilisco, Joseph A.
Gift, Helen C.
Gilgenbach, Caterine A.
Giovannoli, Ralph T.
Girard, Howard W.
Girard, Kenneth R.
Girard/Promident, Inc.
Glandt, Lori
Glenn, John F.
Glover, Joel F.
Gluski, Kenneth S.
Goepp, Robert A.
Golden, Gary L.
Golden, Jacob M.
Goldfarb, Charles W.
Goldman, Melvin
Goldstein, Marvin C.
Golec, Thomas
Goll, Robert D.
Goodsell, Joseph F.
Goodwin, Michael D.
Gorlin, Robert J.
Gottlieb, David
Gough, J. Edward
Gourley, James V.
Grant, Ben E.
Grant, Daniel A.
Grayson, Allan
Grayson, Eugenia
Greco, Thomas A.
Greene, B. David
Greene, Raymond W.
Greenfield, William
Gribben, Patrick P., Jr.
Grossman, Louis I.
Guaccio, Richard
Gubler, Kay N.

Habercam, Julian W.
Halko, Gary J.
Hall, Bruce K.
Hall, Jean
Halseth, Daniel R.
Halvorson, Edwin W.
Hanks, Stephen
Hannon, Sue
Hansen, Burdette R.
Hardymon, Stephen A.
Harris, Hillary J.
Harris, Ronald K.
Harrison, James D.
Harvard University
Hass, Martin A.
Hauschka, Barbara T.
Haw, Richard C.
Haw, Ruth
Hawkins, Ralph
Hawthorne, Eugene P., Jr.
Haynes, Leonard
Hefferren, John J.
Heintz, William D.
Heller, Alfred L.
Henry, Joseph L.
Herrera, Carl M.
Herrman, Edward E.
Herschfus, Leon
Hicks, Wesley L., Jr.
Hirsch, Gerald P.
Hodder, Alfred A.
Hoffman, Howard

Hollingshead, Michael G.
Holt, Donald R.
Hooker, Southern P.
Hoops, Donald F.
Hourigan, Matthias J.
Howard University
Howard, Berne M., Jr.
Howard, Joan W.
Huhn, David C.
Hull, William W.
Hurst, Peter
Hyman, Richard M.

Illinois University
Indiana University
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*AADE—American Association of Dental Examiners
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Jones, James, *chairman,* Las Vegas, Nevada
Zundel, Don, *vice-chairman,* Reno, Nevada
Clark, Steve, Las Vegas, Nevada
Glover, Joel, Reno, Nevada
Holt, Donald, Las Vegas, Nevada
Ripplinger, Dan, Las Vegas, Nevada
Romero, Fred, Las Vegas, Nevada
Thomas, K. P., Las Vegas, Nevada
Thomason, William L., Carson City, Nevada
Whitehead, R. C., Las Vegas, Nevada
Williams, Gary B., Minden, Nevada

Committee on Ladies' Activities

Hett, Mrs. Ann, *chairman,* Las Vegas, Nevada
Frei, Mrs. Janet, *chairman, Seminar Committee,* Las Vegas, Nevada
Scheer, Mrs. Mary, *chairman, Tour Committee,* Las Vegas, Nevada
Marshall, Mrs. Carol, *chairman, Hospitality Committee,* Henderson, Nevada
Anderson, Mrs. Dana, Las Vegas, Nevada
Bruzzese, Mrs. Elaine, Las Vegas, Nevada
Hamilton, Mrs. Carole, Las Vegas, Nevada
Hargrave, Mrs. Linda, Las Vegas, Nevada
Hollingshead, Mrs. Sue, Las Vegas, Nevada
Maule, Mrs. Joan, Las Vegas, Nevada
Stafford, Mrs. Marsha, Las Vegas, Nevada
Taylor, Mrs. Penny, Reno, Nevada
Yoshida, Mrs. Dottie, Las Vegas, Nevada

Historical Record

The American Dental Association was organized at Niagara Falls, N.Y., August 3, 1859. President of this organizing convention was W. W. Allport and the Secretary was J. Taft. Permanent organization was effected in Washington, D.C., July 3, 1860, when the officers *pro tem* were succeeded by regularly elected officers. In 1861 no session was held, owing to the Civil War; since then, the sessions have been held annually with the exception of 1945, when no session was held because of World War II. In 1897 the Association united with the Southern Dental Association, and the name was changed to the "National Dental Association", which name was retained until 1922, when the earlier name was resumed. A complete list of the officers and sessions follows:

AMERICAN DENTAL ASSOCIATION

Term	President	Corresponding Secretary	Recording Secretary	Date of Meeting	Place of Meeting
1860-61	W. H. Atkinson	W. M. Rogers	J. Taft		No Meeting
1861-62	W. H. Atkinson	W. M. Rogers	J. Taft	1862	Cleveland
1862-63	Geo. Watt	J. F. Johnson	J. Taft	1863	Philadelphia
1863-64	W. H. Allen	C. R. Butler	J. Taft	1864	Niagara Falls
1864-65	J. H. McQuillen	G. W. Ellis	J. Taft	1865	Chicago
1865-66	C. W. Spalding	L. D. Shepard	J. Taft	1866	Boston
1866-67	C. P. Fitch	A. Hill	J. Taft	1867	Cincinnati
1867-68	A. Lawrence	C. R. Butler	J. Taft	1868	Niagara Falls
1868-69	Jonathan Taft	J. McManus	Edgar Park	1869	Saratoga Springs
1869-70	Homer Judd	I. A. Salmon	M. S. Dean	1870	Nashville
1870-71	W. H. Morgan	I. A. Salmon	M. S. Dean	1871	White Sulphur Springs, W. Va.
1871-72	G. H. Cushing	I. A. Salmon	M. S. Dean	1872	Niagara Falls
1872-73	P. G. C. Hunt	J. Taft	M. S. Dean	1873	Put-in-Bay, O.
1873-74	T. L. Buckingham	J. Taft	M. S. Dean	1874	Detroit
1874-75	M. S. Dean	G. L. Field	C. S. Smith	1875	Niagara Falls
1875-76	A. L. Northrop	J. H. McQuillen	C. S. Smith	1876	Philadelphia
1876-77	Geo. W. Keely	J. H. McQuillen	C. S. Smith	1877	Chicago
1877-78	F. H. Rehwinkel	M. H. Webb	M. S. Dean	1878	Niagara Falls
1878-79	H. J. McKellops	A. O. Rawls	G. H. Cushing	1879	Niagara Falls
1879-80	L. D. Shepard	M. H. Webb	G. H. Cushing	1880	Boston
1880-81	C. N. Peirce	A. M. Dudley	G. H. Cushing	1881	New York City
1881-82	H. A. Smith	A. M. Dudley	G. H. Cushing	1882	Cincinnati
1882-83	W. H. Goddard	A. W. Harlan	G. H. Cushing	1883	Niagara Falls
1883-84	E. T. Darby	A. W. Harlan	A. H. Peck	1884	Saratoga Springs
1884-85	J. N. Crouse	A. W. Harlan	A. H. Peck	1885	Minncapolis
1885-86	W. C. Barrett	A. W. Harlan	G. H. Cushing	1886	Niagara Falls
1886-87	W. W. Allport	A. W. Harlan	G. H. Cushing	1887	Niagara Falls
1887-88	Frank Abbott	F. A. Levy	G. H. Cushing	1888	Louisville
1888-89	C. R. Butler	F. A. Levy	G. H. Cushing	1889	Saratoga Springs
1889-90	M. W. Foster	F. A. Levy	G. H. Cushing	1890	Excelsior Springs
1890-91	A. W. Harlan	F. A. Levy	G. H. Cushing	1891	Saratoga Springs
1891-92	W. W. Walker	F. A. Levy	G. H. Cushing	1892	Niagara Falls
1892-93	J. D. Patterson	F. A. Levy	G. H. Cushing	1893	Chicago
1893-94	J. D. Patterson	F. A. Levy	G. H. Cushing	1894	Old Point Comfort
1894-95	J. Y. Crawford	E. E. Chase	G. H. Cushing	1895	Asbury Park, N.J.
1895-96	J. Y. Crawford	E. E. Chase	G. H. Cushing	1896	Saratoga Springs
1896-97	James Truman	F. A. Levy	G. H. Cushing	1897	Old Point Comfort

NATIONAL DENTAL ASSOCIATION

1897-98	Thomas Fillebrown	E. E. Chase	G. H. Cushing	1898	Omaha
1898-99	H. J. Burkhart	E. E. Chase	G. H. Cushing	1899	Niagara Falls
'99-1900	H. Holley Smith	E. E. Chase	G. H. Cushing	1900	Old Point Comfort
1900-01	G. V. Black	M. E. Gallup	G. H. Cushing	1901	Milwaukee
1901-02	J. A. Libbey	J. D. Pfeiffer	G. H. Cushing	1902	Niagara Falls
1902-03	L. G. Noel	W. D. Tracy	A. H. Peck	1903	Asheville, N.C.
1903-04	C. C. Chittenden	C. S. Butler	A. H. Peck	1904	St. Louis (Business only)
1904-05	W. E. Boardman	C. S. Butler	A. H. Peck	1905	Buffalo
1905-06	M. F. Finley	C. S. Butler	A. H. Peck	1906	Atlanta
1906-07	A. H. Peck	B. L. Thorpe	C. S. Butler	1907	Minneapolis
1907-08	William Carr	B. L. Thorpe	C. S. Butler	1908	Boston
1908-09	V. E. Turner	H. C. Brown	C. S. Butler	1909	Birmingham
1909-10	B. L. Thorpe	H. C. Brown	C. S. Butler	1910	Denver
1910-11	E. S. Gaylord	C. W. Rodgers	H. C. Brown	1911	Cleveland
1911-12	A. R. Melendy	C. W. Rodgers	H. C. Brown	1912	Washington, D.C.
1912-13	F. O. Hetrick	C. W. Rodgers	H. C. Brown	1913	Kansas City, Mo.

Reorganized July 10, 1913

		General Secretary	Treasurer		
1913-14	H. C. Brown	Otto U. King	H. B. McFadden	1914	Rochester, N.Y.
1914-15	D. M. Gallie	Otto U. King	A. R. Melendy	1915	San Francisco (H. of D. only)
1915-16	T. P. Hinman	Otto U. King	A. R. Melendy	1916	Louisville
1916-17	L. L. Barber	Otto U. King	A. R. Melendy	1917	New York
1917-18	W. H. G. Logan	Otto U. King	A. R. Melendy	1918	Chicago
1918-19	C. V. Vignes	Otto U. King	A. R. Melendy	1919	New Orleans
1919-20	J. V. Conzett	Otto U. King	A. R. Melendy	1920	Boston
1920-21	H. E. Friesell	Otto U. King	A. R. Melendy	1921	Milwaukee

AMERICAN DENTAL ASSOCIATION

		Secretary	Treasurer		
1921-22	T. B. Hartzell	Otto U. King	A. R. Melendy	1922	Los Angeles
1922-23	J. P. Buckley	Otto U. King	A. R. Melendy	1923	Cleveland
1923-24	W. A. Giffen	Otto U. King	A. R. Melendy	1924	Dallas
1924-25	C. N. Johnson	Otto U. King	A. R. Melendy	1925	Louisville
1925-26	Sheppard W. Foster	Otto U. King	A. R. Melendy	1926	Philadelphia
1926-27	Henry L. Banzhaf	Otto U. King	A. R. Melendy	1927	Detroit
1927-28	R. H. Volland	H. B. Pinney	A. R. Melendy	1928	Minneapolis
1928-29	Percy R. Howe	H. B. Pinney	R. H. Volland	1929	Washington, D.C.
1929-30	R. Boyd Bogle	H. B. Pinney	R. H. Volland	1930	Denver
1930-31	Robert T. Oliver	H. B. Pinney	R. H. Volland	1931	Memphis
1931-32	Martin Dewey	H. B. Pinney	R. H. Volland	1932	Buffalo
1932-33	G. Walter Dittmar	H. B. Pinney	R. H. Volland	1933	Chicago
1933-34	Arthur C. Wherry	H. B. Pinney	R. H. Volland	1934	St. Paul
1934-35	Frank M. Casto	H. B. Pinney	R. H. Volland	1935	New Orleans
1935-36	George B. Winter	H. B. Pinney	R. H. Volland	1936	San Francisco
1936-37	Leroy M. S. Miner	H. B. Pinney	R. H. Volland	1937	Atlantic City
1937-38	C. Willard Camalier	H. B. Pinney	R. H. Volland	1938	St. Louis
1938-39	Marcus L. Ward	H. B. Pinney	R. H. Volland	1939	Milwaukee
1939-40	Arthur H. Merritt	H. B. Pinney	R. H. Volland	1940	Cleveland
1940-41	Wilfred R. Robinson	H. B. Pinney	R. H. Volland	1941	Houston
1941-42	Oren A. Oliver	H. B. Pinney	R. H. Volland	1942	St.Louis (H. of D. only)
1942-43	J. Ben Robinson	H. B. Pinney	R. H. Volland	1943	Cincinnati (H. of D. only)

1943-44	C. Raymond Wells	H. B. Pinney	R. H. Volland	1944	Chicago (H. of D. only)
1944-45	Walter H. Scherer	H. B. Pinney	R. H. Volland		No meeting
1945-46	Walter H. Scherer	H. B. Pinney	R. H. Volland	1946	Miami (H. of D. only)
1946-47	Sterling V. Mead	H. Hillenbrand	R. H. Volland	1947	Boston
1947-48	H. B. Washburn	H. Hillenbrand	R. H. Volland	1948	Chicago
1948-49	C. E. Minges	H. Hillenbrand	H. B. Washburn	1949	San Francisco
1949-50	Philip E. Adams	H. Hillenbrand	H. B. Washburn	1950	Atlantic City
1950-51	Harold W. Oppice	H. Hillenbrand	H. B. Washburn	1951	Washington, D.C.
1951-52	LeRoy M. Ennis	H. Hillenbrand	H. B. Washburn	1952	St. Louis
1952-53	Otto W. Brandhorst	H. Hillenbrand	H. B. Washburn	1953	Cleveland
1953-54	Leslie M. FitzGerald	H. Hillenbrand	H. B. Washburn	1954	Miami
1954-55	Daniel F. Lynch	H. Hillenbrand	H. B. Washburn	1955	San Francisco
1955-56	Bernerd C. Kingsbury	H. Hillenbrand	H. B. Washburn	1956	Atlantic City
1956-57	Harry Lyons	H. Hillenbrand	H. B. Washburn	1957	Miami-Miami Beach
1957-58	William R. Alstadt	H. Hillenbrand	H. B. Washburn	1958	Dallas
1958-59	Percy T. Phillips	H. Hillenbrand	H. B. Washburn	1959	New York
1959-60	Paul H. Jeserich	H. Hillenbrand	H. B. Washburn	1960	Los Angeles
1960-61	Charles H. Patton	H. Hillenbrand	H. B. Washburn	1961	Philadelphia
1961-62	John R. Abel	H. Hillenbrand	P. H. Jeserich	1962	Miami Beach
1962-63	Gerald D. Timmons	H. Hillenbrand	P. H. Jeserich	1963	Atlantic City
1963-64	James P. Hollers	H. Hillenbrand	P. H. Jeserich	1964	San Francisco
1964-65	Fritz A. Pierson	H. Hillenbrand	E. Jeff Justis	1965	Las Vegas
1965-66	Maynard K. Hine	H. Hillenbrand	E. Jeff Justis	1966	Dallas
1966-67	William A. Garrett	H. Hillenbrand	E. Jeff Justis	1967	Washington, D.C.
1967-68	F. Darl Ostrander	H. Hillenbrand	R. K. Trueblood	1968	Miami Beach
1968-69	Hubert A. McGuirl	H. Hillenbrand	R. K. Trueblood	1969	New York
1969-70	Harry M. Klenda	C. G. Watson	R. K. Trueblood	1970	Las Vegas
1970-71	John M. Deines	C. G. Watson	H. S. Eberhardt	1971	Atlantic City
1971-72	Carl A. Laughlin	C. G. Watson	H. S. Eberhardt	1972	San Francisco
1972-73	Louis A. Saporito	C. G. Watson	H. S. Eberhardt	1973	Houston
1973-74	Carlton H. Williams	C. G. Watson	J. W. Etherington	1974	Washington, D.C.
1974-75	L. M. Kennedy	C. G. Watson	J. W. Etherington	1975	Chicago
1975-76	Robert B. Shira	C. G. Watson	J. W. Etherington	1976	Las Vegas

LIVING PAST PRESIDENTS AMERICAN DENTAL ASSOCIATION

J. Ben Robinson 1942-43
LeRoy M. Ennis 1951-52
Daniel F. Lynch 1954-55
Bernerd C. Kingsbury 1955-56
Harry Lyons 1956-57
William R. Alstadt 1957-58
Percy T. Phillips 1958-59
Gerald D. Timmons 1962-63
Fritz A. Pierson 1964-65
Maynard K. Hine 1965-66
William A. Garrett 1966-67
F. Darl Ostrander 1967-68
Hubert A. McGuirl 1968-69
John M. Deines 1970-71
Carl A. Laughlin 1971-72
Louis A. Saporito 1972-73
Carlton H. Williams 1973-74
Kennedy, L. M. 1974-75
Shira, Robert B. 1975-76

Attendance Record

Members of House of Delegates

	REGISTERED	MEETINGS 1	2	3	4
AIR FORCE 1,132 members, 1 delegate					
Delegate					
Thompson, Robert L., Jr., Washington, D.C.	•	•	•		
Alternate					
Archambault, Jean B., Washington, D.C.	•			•	•
ALABAMA 999 members, 5 delegates					
Delegates					
Mosteller, John H., Mobile	•	•	•	•	•
Lawson, William M., Birmingham	•	•	•	•	•
Coleman, O. A., Greensboro	•	•	•	•	•
Martin, Carlton S., Albertville	•		•	•	•
Dawson, Charles Paul, Scottsboro	•	•	•	•	•
Alternates					
Watson, George E., Mobile	•				•
Knight, L. A., Jr., Monroeville	•				
Moseley, Thomas P., Montgomery	•				
Lamar, W. D., Montgomery					
ALASKA 123 members, 1 delegate					
Delegate					
Fraley, George T., Juneau	•	•	•	•	•
Alternate					
Bline, Wilbur E., Anchorage	•				•
ARIZONA 850 members, 4 delegates					
Delegates					
Bradel, Thomas E., Tucson	•		•	•	•
Labadie, William L., Phoenix	•	•	•	•	•
Dalpiaz, Arthur, Flagstaff	•	•	•	•	•
Siroky, Charles L., Phoenix	•	•		•	•

Note:
*Delegate and Alternate attended portion of meeting

	REGISTERED	MEETINGS 1	2	3	4
Alternates					
Keaton, Bill F., Tucson	•				
Bills, Eldon, Flagstaff					
Purtymun, Charles S., Phoenix					
Matsuishi, Richard K., Glendale	•				
ARKANSAS 671 members, 3 delegates					
Delegates					
Cone, George M., Osceola	•	•	•	•	•
Kaldem, W. M., El Dorado	•	•	•	•	•
Chancey, J. P., Jr., Fort Smith	•	•	•	•	•
Alternates					
Roebuck, Tommy G., Arkadelphia	•				
Fike, R. A., Little Rock	•				
Abernathy, C. L., West Memphis	•				
ARMY 1,217 members, 1 delegate					
Delegate					
Bhaskar, S. N., Washington, D.C.	•	•	•	•	•
Alternate					
Pollock, Jack P., Fort Sam Houston, Texas	•				
CALIFORNIA 12,292 members, 44 delegates					
Delegates					
Taylor, Robert L., Los Angeles	•	•	•	•	•
Anderson, Stanley B., Jr., Pasadena	•	•	•	•	•
Saroyan, Jack M., San Francisco	•	•	•	•	•
Bishop, Lyall O., Walnut Creek	•	•	•	•	•
Cusenza, Anthony J., Modesto	•	•	•	•	•
Fat, Kenneth F., Sacramento	•	•	•	•	•
Francis, Sidney R., South San Francisco	•	•	•	•	•
Furstman, Edward F., Los Angeles	•	•	•	•	•
Holt, James A., Los Angeles	•	•			
John, Robert, Belmont	•	•	•	•	•
King, William R., Fullerton	•		•	•	•
Labelle, Arthur L., Fairfield	•	•	•	•	•
Marx, Gordon D., San Leandro	•	•	•	•	•
Opdahl, M. Darril, Stockton	•		•	•	•
Press, Burton H., Pittsburg	•	•	•	•	•
Riley, Lincoln L., San Fernando	•	•	•	•	•
Sander, Allan L., La Jolla	•	•	•	•	•
Schiefer, William E., San Diego	•	•	•	•	•
Scott, J. Vernon, Monrovia	•	•	•	•	•
Smithwick, R. Neil, Sunnyvale	•	•	•	•	•
Wagner, Eugene P., Monterey Park	•	•	•	•	•
Wilson, Charles E., Fairfield	•	•	•	•	•
Young, Leo E., Garden Grove	•	•	•	•	•
Allen, William E., Pasadena	•	•	•	•	•
Brucia, Frank A., San Francisco	•	•	•	•	•
Collinge, J. Walter, Santa Barbara	•	•	•	•	•
DeVincenzi, Ronald G., Monterey	•	•	•	•	•
Dugoni, Arthur A., South San Francisco	•	•	•	•	•
Franklin, Douglas R., San Leandro	•	•	•	•	•

	REGISTERED	MEETINGS 1	2	3	4
Garabedian, Henry C., Long Beach	•	•	•	•	•
Garrick, Richard M., Belvedere	•	•	•	•	•
Gaynor, J. David, Beverly Hills	•	•	•	•	•
Gordon, Daniel F., Santa Ana	•	•	•	•	•
Harada, Harold S., Culver City	•	•	•	•	•
Honig, Clarence D., Beverly Hills	•	•	•	•	•
Johnson, Francis S., Santa Barbara	•	•	•	•	•
Kingsbury, B. C., Jr., Vallejo	•	•	•		•
Moore, Dudley S., Santa Rosa	•	•	•	•	•
Redig, Dale F., San Francisco	•	•	•	•	•
Rogers, G. Robert, Riverside	•	•	•	•	•
Rouda, Robert E., San Francisco	•		•	•	•
Williams, Carlton H., San Diego	•	•	•	•	•
Yent, Donald R., Palo Alto	•	•	•	•	•
Yuen, Stephen S., Hayward	•	•	•	•	•
Alternates					
Young, Harold E., El Cerrito	•		•	•	•
Baker, George F., Fresno	•	•			
Garron, Martin D., Long Beach					
Brannon, Charles F., Santa Maria					
Lucas, Henry, Jr., San Francisco	•				
Lau, Carl C., Los Angeles	•				
Koch, George R., Sacramento					
Snow, Philip R., Camarillo	•				
Brown, Eugene M., Buena Park					
Senter, Alvin D., Oakland					
Abrahams, Norman N., Saratoga	•				
Annoni, Jerry, Vallejo					
Barbieri, Richard, Santa Rosa					
Berry, John, San Diego	•				
Binger, Nelson E., Corcoran					
Bock, Ernest E., Yuba City					
Booker, Jack R., Riverside	•				
Bromberg, Myron J., Reseda	•				
Conley, Jack F., Los Angeles	•				
DeFreece, Gerald, Glendora					
Falk, Theodore S., Frenso	•				
French, Robert E., Laguna Beach	•				
Humphreys, Harry W., San Rafael	•				
Kaumans, Dale, Berkeley					
Krajewski, Joseph J., San Francisco					
Lewis, Richard A., Long Beach					
Matlack, Robert E., Santa Cruz					
Odom, William M., San Mateo					
Orchard, John, Santa Maria	•				
Osser, H. Gordon, Castro Valley					
Panzer, Michael R., Stockton					
Perich, Michael J., Sacramento	•				
Sanda, John, Concord					
Simpson, Larry S., Oak View	•				
Sutro, Henry A., Oakland					
Teesdale, Arthur R., Bakersfield	•				
Tonge, William E., Modesto					
Tucker, Garrison, Arcata					
Walquist, Paul, Pacific Palisades	•				

	REGISTERED	MEETINGS 1	2	3	4
Webb, Ernest J., Menlo Park					
Young, Donald A., Red Bluff					
Zizza, Paul, Merced					
COLORADO 1,376 members, 6 delegates					
Delegates					
Wedum, Otis L., Denver	•	•	•	•	•
Schoemaker, D. Donald, Fort Morgan	•	•	•	•	•
Osburne, Jack M., Pueblo	•	•	•	•	•
Peters, William V., Golden	•	•	•	•	•
Nassimbene, Jack D., Denver	•	•	•	•	•
Slack, Thomas W., Colorado Springs	•	•	•	•	•
Alternates					
Ballard, Walter W., Pueblo	•				
Johnson, Dana J., Boulder	•				
Kletzky, Benjamin, Denver	•				
Hueston, James R., Denver	•				
Krauss, Thomas C., Grand Junction					
Reger, Roy H., Denver	•				
CONNECTICUT 1,998 members, 8 delegates					
Delegates					
Hornstein, Aaron, Hamden	•	•	•	•	•
Scinto, Lawrence, Bridgeport	•	•	•	•	•
Singer, Lawrence, Yalesville	•	•	•	•	•
Novey, Ernest E., Jr., Glastonbury	•	•	•	•	•
Barry, John F., Jr., Manchester	•	•	•	•	•
Showah, Henry J., Danbury	•	•	•	•	•
Slagle, Charles, Greenwich	•	•	•	•	•
Pearson, Lawrence, Stamford	•	•	•	•	•
Alternates					
Zeoli, Robert, Woodbridge	•		*	*	
Friedman, Howard, Torrington	•				
McLaughlin, A. Howard, Woodbury	•				
Pinto, Frank, Bridgeport	•				
Rubin, James E., Stamford	•				
Holzman, Stanley, West Hartford	•				
Hebert, Jean-Louis, Manchester	•				
Liscio, Paul P., Wilton	•				
DELAWARE 224 members, 2 delegates					
Delegates					
Truono, Eugene J., Wilmington	•	•	•	•	•
George, David A., Newark	•		•	•	•
Alternates					
Malinowski, Andrew S., Wilmington	•				
Miller, Phillip W., Wilmington					
DISTRICT OF COLUMBIA 544 members, 3 delegates					
Delegates					
Kerrigan, James P., Washington	•	•	•	•	•
Shulman, Israel, Washington	•	•		•	*
Chavoor, Ashur G., Washington	•	•	•	•	•

Note:
*Delegate and Alternate attended portion of meeting

	REGISTERED	MEETINGS 1	2	3	4
Alternates					
Salcetti, Joseph R., Washington	•				
Mattox, Balfour D., Washington	•				*
Shuford, Frank L., Jr., Washington	•				
FLORIDA **3,390 members, 13 delegates**					
Delegates					
Frey, Lawrence B., Jr., Pensacola	•	•	•	•	•
McDonald, Charles W., Jr., Jacksonville	•	•	•	•	*
Fryar, Ernest, Jr., Winter Park	•	•	•	•	*
Wegmann, G. William, Ft. Lauderdale	•	•	•	•	*
Sutnick, Stanley, Miami Beach	•	•	•	•	•
Stewart, John A., St. Petersburg	•	•	•	•	•
Cole, Robert J., St. Petersburg Beach	•	•	•	•	•
Dannheisser, Bertram V., Jr., Pensacola	•	•	•	•	•
Coleman, George J., Coral Gables	•	•	•		
Beattie, Jack R., Orlando	•	•	•		•
Watson, Walter J., Jacksonville	•	•	•	•	•
Williams, Robert W., Boca Raton	•	•	•	•	•
Schwartz, J. Leon, Tampa	•	•	•	•	•
Alternates					
McLeod, Donald S., Pensacola	•				
Baker, Joel W., Jacksonville	•				
Allen, Don L., Gainesville	•				
Detchon, Carl A., Ft. Lauderdale	•				*
Soutar, Jack H., Miami Shores	•				
Wood, Milton T., Tampa	•				
Earle, Lewis S., Winter Park	•			•	•
Ackel, Fred J., Ft. Lauderdale	•			•	*
Powell, Neil G., Orlando	•				
Hehn, Roger M., Jacksonville	•				*
Wright, David T., Lakeland	•				
Goodreau, George J., Panama City	•				
Sakrais, Leonard M., Miami Beach	•				
GEORGIA **1,618 members, 7 delegates**					
Delegates					
Cassidy, James L., Macon	•	•	•	•	•
Gamble, John A., LaGrange	•	•	•	•	•
Hicks, Thomas J., Jr., Atlanta	•	•	•	•	•
Jones, N. Buford, Cordele	•	•	•	•	•
Smith, Charles H., Atlanta	•	•	•	•	•
Smith, William T., Jr., Tifton	•	•	•	•	•
Williams, Alfred K., Atlanta	•	•	•	•	•
Alternates					
Carter, James E., Jr., Augusta	•				
Davis, Robert E., Rome	•				
Mallernee, Rollin E., Atlanta	•				
Rackley, R. Hunter, Millen	•				
Rainer, Robert A., Jr., McDonough	•				
Roberts, Thomas A., Brunswick	•				
Stegall, Jo H., Jr., Rome	•				

Note:
*Delegate and Alternote attended portion of meeting

	REGISTERED	MEETINGS 1	2	3	4
HAWAII	**528 members, 3 delegates**				
Delegates					
Fujioka, John M., Honolulu	•	•	•	•	•
Kobayashi, Herbert M., Honolulu	•	•	•	•	•
Wakai, Warren T., Honolulu	•	•	•	•	•
Alternates					
Oishi, Masaichi, Kailua	•				
Kanazawa, Kanemi, Honolulu					
Nishimura, Pete, Honolulu	•				
IDAHO	**351 members, 2 delegates**				
Delegates					
Toevs, Howard O., Rupert	•	•	•		•
Kern, Stanley M., Twin Falls	•	•	•	•	•
Alternates					
Nelson, Rex J., Idaho Falls	•			•	
Stones, John M., Boise	•				
ILLINOIS	**5,494 members, 20 delegates**				
Delegates					
Alzeno, Guerney E., Stockton	•	•	•	•	•
Brownfield, Richard H., Peoria	•	•	•	•	•
Catrambone, Dominic J., Chicago	•	•	•	•	•
Cory, Fred E., Quincy	•	•	•	•	•
Kaminski, Mitchell V., Chicago	•	•	•	•	•
Fourie, Louis V., Rockford	•	•	•	•	•
Lenzini, Arthur L., Herrin	•	•	•		
Levey, LeRoy D., Chicago	•	•	•	•	•
Long, Leslie E., Joliet	•	•	•	•	
MacLean, Grant A., Glenview	•	•	•	•	•
Martin, Harold L., Flora	•	•	•	•	•
Muller, Carl H., Villa Park	•	•	•	•	•
Ogata, Kenje, Sterling	•	•	•	•	•
Pelka, Francis X., Chicago	•	•	•	•	•
Prosser, Thomas J., III, Fairview Heights	•	•	•	•	•
Rus, Edward J., Jr., Cicero	•	•	•	•	•
Schroeder, Frank A., Arlington Heights	•	•	•	•	•
Troutt, Edwin A., Barrington	•	•	•	•	•
Unger, Robert M., Chicago	•	•	•	•	•
Wahl, James H., Jr., Champaign	•	•	•	•	•
Alternates					
DeWeerth, E. Orval, Rock Falls	•				
Rankin, Robert D., Gibson City	•				
Mathews, Henry J., Chicago	•				
Davison, Edgar N., East Alton					
Kolodziejczyk, Joseph, Chicago	•				†
Giannone, Leonard, Springfield	•			•	•
Lindenberg, William H., Centralia	•				
Grau, Gary W., Barrington	•				
Towner, F. William, Elgin	•				
Newkirk, Robert, Glenview	•				
Aikman, Eugene E., Mattoon	•				

Note:
*Delegate and Alternate attended portion of meeting
†Alternates attended portion of meeting

	REGISTERED	MEETINGS 1	2	3	4
Samuelson, Kenneth E., Glenview	•				
Dolezal, Wilbur F., Morris	•				†
Janson, Richard W., Highland Park	•				
Bloemer, William J., Belleville	•				
Williams, Thomas H., Chicago	•				
Sadowski, Francis X., Glenwood	•				
Shaner, Charles H., Mt. Prospect	•				
Russell, Cannutte, Chicago	•				
Stengel, Robert J., Decatur	•				
INDIANA 1,968 members, 8 delegates					
Delegates					
Stetzel, Robert M., Fort Wayne	•	•	•	•	•
Stevens, M. Gene, Columbus	•	•	•	•	•
Ricci, C. Robert, Kokomo	•	•	•	•	•
Schmidt, William G., Evansville	•	•	•	•	•
Lindquist, John T., Indianapolis	•	•	•	•	•
Carr, W. Kelley, Lafayette	•	•	•	•	•
McClure, David B., Anderson	•	•	•	•	*
Polizotto, Scott H., Valparaiso	•	•	•	•	•
Alternates					
Rohn, R. Dan, Alexandria	•				
Shellenberger, Robert E., Evansville	•		*		*
Frey, James D., Fort Wayne	•				*
Gorman, John C., Marion	•				
Michael, Jon S., West Lafayette	•				*
Compton, Duane E., Indianapolis	•				
Bayley, James W., Lafayette	•				
Rooksby, Lon L., Portage	•				
IOWA 1,347 members, 6 delegates					
Delegates					
Ray, D. Dean, Shenandoah	•	•	•	•	•
Lehman, Fredrick B., Cedar Rapids	•	•	•	•	•
Hollander, William, Sioux City	•	•	•	*	
Anderson, Truman J., Fort Dodge	•	•	•		*
Blaha, David D., Marshalltown	•	•	•	•	•
Degnan, Edward, Dubuque	•	•	•	•	•
Alternates					
Barrett, C. F., Davenport	•			*	•
Heath, James W., Des Moines	•				
Houk, Eugene, Jefferson	•				*
Kegler, A. G., Independence	•				
O'Meara, C. S., Des Moines	•				
Hugg, James, Burlington	•				
KANSAS 940 members, 4 delegates					
Delegates					
Danner, Clark D., Manhattan	•	•	•	•	•
Frazier, L. Thane, Lyons	•	•	•	*	•
Wells, Eugene R., Hutchinson	•	•	•	•	*
Hall, A. Edward, Wichita	•	•	•	•	•

Note:
*Delegate and Alternate attended portion of meeting
†Alternates attended portion of meeting

	REGISTERED	MEETINGS 1	2	3	4
Alternates					
Parsons, Ray E., Winfield	•		*	*	
Musser, Joseph E., Wichita	•				
Price, Ronald E., Topeka	•			*	*
Dryden, B. Richard, Dodge City	•				
KENTUCKY 1,304 members, 6 delegates					
Delegates					
Clines, J. L., Louisville	•	•	•	•	•
Evans, P. W., Ashland	•	•	•	•	•
Gernert, E. B., Middletown	•	•	•	•	•
Wagers, Lyman, Lexington	•	•	•	•	*
Francis, S. W., Hazard	•	•	•	•	•
Jones, Joe W., Jr., Madisonville	•	•	•	•	•
Alternates					
Keeling, R. W., Louisville	•				
Weddington, W. H., Louisville	•				
King, Duncan, Louisville	•				
Carpenter, William J., Lexington	•				*
Coxwell, A. B., Louisville					
Smythe, William H., Louisville	•				
LOUISIANA 1,272 members, 5 delegates					
Delegates					
Faget, E. Harold, New Orleans	•	•	•	•	•
Fortier, Eugene J., Jr., New Orleans	•	•	•	•	•
Walsh, William P., Houma	•	•	•	•	*
Monget, N. Gayle, Baton Rouge	•	•	•	•	•
Price, Mark A., Monroe	•	•	•	•	•
Alternates					
Charbonnet, Robert H., Metairie	•				
Corley, C. Richmond, Lake Charles	•				
Dauterive, F. Ralph, Arabi	•				
Single, Kenneth A., Alexandria	•				
Breaud, P. M., Baton Rouge	•				*
MAINE 411 members, 2 delegates					
Delegates					
Pulsifer, Earle W., Damariscotta	•	•	•	•	
McPhetres, Erwood E., Kennebunk	•	•	•	*	•
Alternates					
Hutchinson, Robert B., Cape Elizabeth	•			*	
Brookings, John W., Bangor	•				
MARYLAND 1,765 members, 7 delegates					
Delegates					
Rubenstein, Maurice, Baltimore	•	•	•	•	•
Ventura, Michael H., Baltimore	•	•	•	•	•
Coberly, Bernie O., Jr., Cumberland	•	•	•	•	•
Johns, Laurence E., Hagerstown	•	•		•	•
Wilson, Robert J., Gaithersburg	•	•	•	•	•
Dressel, Harry W. F., Jr., Ellicott City	•	•	•	•	•
Price, Joe N., Landover Hills	•	•	•	•	•

Note:
*Delegate and Alternate attended portion of meeting

	REGISTERED	MEETINGS 1	2	3	4
Alternates					
Brandenburg, Charles L., Jr., Rising Sun	•				
Strahan, William T., Silver Spring	•				
Ramsay, C. Baker, Towson	•				
Crouse, J. Richard, Frederick					
Phillips, Robert M., Baltimore	•				
Brotman, Don N., Baltimore	•				
Gibson, Jack T., Baltimore					
MASSACHUSETTS 3,482 members, 13 delegates					
Delegates					
Greenfeld, Elliot M., Pittsfield	•	•	•	•	•
Falla, William, Hyannis	•	•	•	•	•
Segal, Michael, Melrose	•	•	•	•	•
McKenna, William H., Wellesley Hills	•	•	•	•	•
Farrell, David J., Weston	•	•	•	•	•
DeRoche, Joseph, Belmont	•	•	•	•	•
DiStasio, Joseph G., Revere	•	•	•	•	•
Devaney, Thomas, Lynnfield	•	•	•	•	•
Scheinman, Solomon, New Bedford	•	•	•	•	•
Baker, William J., Braintree	•	•	•	•	
McKenna, Paul J., Springfield	•	•	•	•	•
LeBlanc, Romeo, Fitchburg	•	•	•	•	•
Kelly, Joseph M., Worcester	•		•	•	•
Alternates					
Leavitt, Jason, Pittsfield	•				
Clark, Harold L., Chatham	•				
Dinerman, Gerald E., Malden	•				
Mizner, Sidney S., Lowell					
Schilder, Herbert, Boston	•				
Tarullo, Ralph P., Waltham	•				
Bommer, Arno P., Revere	•				
Grzybinski, Stanley, Danvers	•				
Sicard, Paul C., New Bedford	•				
Pfeffer, Richard C., Quincy	•				•
Branch, Charles L., Northampton	•				
Fleming, John E., Pepperell	•				
Kentros, George, Worcester	•				
MICHIGAN 4,308 members, 16 delegates					
Delegates					
Shick, Richard A., Flint	•	•	•	•	•
Lyons, James R., Dearborn	•	•	•	•	•
Barone, James V., Birmingham	•	•	•	•	•
Cabot, Joseph, Lathrup Village	•	•	•	•	•
Homan, Henry L., Grand Rapids	•	•	•	•	•
Doerr, Robert E., Ann Arbor	•	•	•	•	•
Creason, William, Grand Haven	•	•		•	•
Travis, William, Dearborn	•	•	•	•	•
Atwood, Edward, Benton Harbor	•	•	•	•	•
Murray, Robert, Tecumseh	•	•	•	•	•
Cornwall, Robert, Southfield	•	•	•	•	•
Dietz, Anthony, Birmingham	•	•	•		
Love, William, Birmingham	•	•	•	•	•
Fletke, Wilbert, Lansing	•		•	•	•

	REGISTERED	MEETINGS 1	2	3	4
Reese, James, Ann Arbor	•	•	•	•	•
Stroud, Donald, Warren	•	•	•	•	•
Alternates					
Pierron, Daniel, Warren	•				
Krieg, Robert F., Bay City	•				
Weisenfeld, Michael D. L., Livonia	•				
Mann, William R., Ann Arbor					
Hart, Max S., Flint	•				
Fowler, H. William, St. Joseph	•				
Herschfus, Leon, Detroit	•				
MacKenzie, Alister M., Port Huron					
Nolen, John G., Lansing	•				
Mortimer, Wayne, Flint	•			•	•
Seibold, David H., Grand Haven	•				
Johnson, Vernon K., Escanaba	•				
Cartwright, Charles B., Ann Arbor	•				
Nedelman, Irving, Lansing	•				
Pittman, James L., Benton Harbor	•				
Washington, Kenneth B., Detroit					
MINNESOTA 2,474 members, 10 delegates					
Delegates					
Bentley, Donald E., Hawley	•	•	•	•	•
Keyworth, Bruce A., St. Paul	•	•	•	•	•
Johnson, Dennis A., Minneapolis	•	•	•	•	•
Swanstrom, Robert L., Duluth	•	•	•	•	*
Welter, Charles J., St. Paul	•	•	•	•	•
Corcoran, Bart E., Arlington	•	•	*		
Burke, Roger J., St. Paul	•	•	•	•	•
McGuiggan, Charles F., Marshall	•	•	•	•	•
Burrington, Spencer W., Rochester	•	•	•	•	•
Amundson, Gordon C., Duluth	•	•	•	•	•
Alternates					
McMillan, Donald G., Minneapolis	•				
Hill, Arnold J., Jr., Rochester	•		*	•	•
Farish, Robert W., Hopkins	•				
Rossi, Richard E., Rochester	•				*
Oltmans, Samuel J., Minneapolis					
Holland, Mellor R., Minneapolis	•				
Schulte, Bernard W., Minneapolis					
Dumke, Melvin P., Mankato					
Lingle, David T., Princeton	•				
MISSISSIPPI 552 members, 3 delegates					
Delegates					
Pettey, Claude V., Magnolia	•	•	•	•	•
Fortenberry, Marshall M., Jackson	•	•	•	•	•
Posey, Rudolph A., Philadelphia	•	•	•	•	•
Alternates					
Lefeve, Robert A., Gulfport	•				
Walker, Kirby P., Jr., Jackson					
Reynolds, R. J., Newton	•				

Note:
*Delegate and Alternate attended portion of meeting

	REGISTERED	MEETINGS 1	2	3	4
MISSOURI 2,036 members, 8 delegates					
Delegates					
Grana, Joseph M., St. Louis	•	•	•	•	•
Hagan, Joseph H., Crystal City	•	•	•	•	•
Haffner, Richard J., St. Louis	•	•	•	•	*
Stocker, William B., Springfield	•	•	•	*	*
Manning, Roy D., Columbia	•	•	•	•	•
McAllister, John E., Joplin	•	•		•	*
Bogert, John A., Kansas City	•	•	•	•	*
Kavanaugh, C. E., Kansas City	•	•	•	•	
Alternates					
Frost, W. Dale, St. Louis	•				
Brandhorst, William S., St. Louis	•			*	*
Schlattman, H. Richard, St. Louis	•			*	*
Ferrel, Richard, Hannibal	•				•
Cartwright, Robert W., Sweet Springs	•				*
Neal, John R., Chillicothe	•				*
O'Neil, Durl W., Kansas City	•				•
Woosley, Howard, Kansas City	•				*
MONTANA 381 members, 2 delegates					
Delegates					
Murphy, Joseph J., Great Falls	•	•	•	•	•
Cotner, Robert B., Columbia Falls	•		•	•	•
Alternates					
Lohman, John W., Butte	•				
Taylor, Robert N., Billings	•				
NAVY 1,160 members, 1 delegate					
Delegate					
Elliott, R. W., Jr., Washington, D.C.	•	•	•	•	•
Alternate					
Farrell, Paul E., Washington, D.C.	•				
NEBRASKA 808 members, 4 delegates					
Delegates					
Hunt, Duane M., Lincoln	•	•	•	•	•
Moran, Bernard J., Lincoln	•	•	•	•	*
Murphy, William E., Lincoln	•	•	•	*	•
Nelson, Herbert C. Q., Sidney	•	•	•	•	*
Alternates					
Edwards, Donald W., Lincoln	•				
Maschka, Philip J., Omaha	•			*	*
Person, Earle G., Omaha	•				*
Seberg, G. Herbert, Hastings	•				
NEVADA 269 members, 2 delegates					
Delegates					
Schaefer, William H., Reno	•	•	•	•	•
Morrison, Robert L., Las Vegas	•	•	•	•	•

Note:
*Delegate and Alternate attended portion of meeting

	REGISTERED	MEETINGS 1	2	3	4
Alternates					
Massoth, Harry P., Reno	•				
Lovaas, Leeland M., Las Vegas					
NEW HAMPSHIRE 398 members, 2 delegates					
Delegates					
Zumbrunnen, Charles E., Concord	•	•	•	•	•
Ash, Homer L., Keene	•	•	•	•	•
Alternates					
Stahl, David G., Manchester	•				
Comolli, Arthur E., Nashua	•				
NEW JERSEY 4,148 members, 15 delegates					
Delegates					
Doeringer, Clifford, Plainfield	•	•	•	•	•
Oxman, Jacob H., Union	•	•	•	•	•
Lewin, Jules N., Belmar	•	•	•	•	•
Pison, William, Clifton	•	•	•	•	•
Botkin, C. Kermit, Morristown	•	•		•	•
Schwartz, Philip, East Orange	•	•	•	•	•
McLean, L. Deckle, Jersey City	•	•	•	•	•
Sved, Edwin, New Brunswick	•	•	•	•	•
Mazzotta, Leon, Wildwood					
Sloan, Walter, Garfield	•	•	•	•	•
Henry, Charles T., Trenton	•	•	•	•	•
Zackon, Paul, Pennsauken	•	•	•	•	•
LiSooey, Harold, Westfield	•		•	•	•
Cahan, Herbert N. D., Atlantic City	•	•	•	•	•
Sengin, Norman F., Cherry Hill	•	•	•	•	•
Alternates					
Sage, Edmund M., Plainfield					
Mehr, Henry, Union	•	•	•	•	•
McKenna, Edward J., Red Bank	•				
Haddon, Wallace, Passaic	•				
Surdi, William, Bernardsville					
Hester, H. Curtiss, Upper Montclair					
Kantor, Harry, Union City	•				
Engle, Jerome, New Brunswick					
Millstein, Sidney, Margate City					
Forte, Robert Paul, Ridgewood					
Katin, Robert, Trenton					
Barbell, Philip, Pennsauken	•	•			
Krevsky, Alvin, Roselle					
Landry, Frank G., Denville					
Lazerwitz, Miles, Paterson	•				
NEW MEXICO 361 members, 2 delegates					
Delegates					
Simms, David E., Albuquerque	•	•	•	•	•
Spier, Thomas, Santa Fe	•	•	•	•	*
Alternates					
Frederick, William A., Las Cruces					
Lopez, Ralph R., Santa Fe	•				*

Note:
*Delegate and Alternate attended portion of meeting

	REGISTERED	MEETINGS 1	2	3	4
NEW YORK 13,202 members, 47 delegates					
Delegates					
Adelson, Henry, Brooklyn	•	•	•	•	•
Brink, Richard, Franklinville	•	•	•	•	•
Bruel, Paul J., New York	•	•	•	•	•
Burnett, Gorman L. D., Rochester	•	•	•	•	•
Coppola, Samuel J., Scotia	•	•	•	•	•
Davies, John D., Newburgh	•	•	•	•	•
DiMango, Anthony L., Brooklyn	•	•	•	•	•
Feltman, Nathan, Albany	•	•	•	•	•
Finnegan, John G., Rye	•	•	•	•	•
Gladziszewski, Richard, Syracuse	•	•	•	•	•
Golden, John E., Olean	•	•	•	•	•
Golomb, Ida M., New York	•	•	•	•	•
Halik, Frederick J., Rochester	•	•	•	•	•
Jacobson, Milton, Elmira	•	•		•	•
Jerrold, Theodore L., Hempstead	•	•	•	•	•
Kramer, Louis, Niagara Falls	•	•	•	•	•
Lasoff, Gustave, Flushing	•	•	•	•	•
Lentchner, Emil, Jamaica Estates	•	•	•	•	•
Lerner, Theodore R., Brooklyn	•	•	•	•	•
Loveland, Lawrence W., Endwell	•	•	•	•	•
Lusterman, Edward A., Rockville Centre	•		•	•	•
Maitland, Ronald I., New York	•	•	•	•	•
Menell, Howard B., New York	•	•	•	•	•
Mullen, George E., East Rockaway	•	•	•	•	•
Perlow, Jack, Flushing	•	•	•	•	•
Phillips, Percy T., New York	•	•			
Posteraro, Anthony F., New York	•	•	•	•	•
Prezzano, Wilbur J., Mt. Kisco	•	•	•	•	•
Quartararo, Ignatius N., Garden City	•	•	•	•	•
Queern, John B., Jr., Schenectady	•	•	•	•	•
Raskin, Robert, Lindenhurst	•	•	•	•	•
Rubin, Herman, Bronx	•	•	•	•	•
Sachs, Jeremiah, Kingston	•	•	•	•	•
Saladino, John C., Brooklyn	•	•	•	•	•
Salman, Lawrence, New York	•	•	•	•	•
Schachner, Joseph, Bronx	•	•	•	•	•
Schlein, Milton A., Center Moriches	•	•	•	•	•
Shuman, Irving, Brooklyn	•	•	•	•	•
Slavin, Sidney, Utica	•	•	•	•	•
Solomon, Alvin, Jamaica	•	•	•	•	•
Sorrel, Jerome M., New York	•	•	•	•	•
Spieske, Herbert G., Castleton-on-Hudson	•	•	•	•	•
Springer, Wilfred A., Jr., Rochester	•	•	•	•	•
Sweeney, Harry T., Syracuse	•	•	•	•	•
Roohan, Leo W., Jr., Saratoga Springs	•	•	•	•	•
Tanz, Norman P., Suffern	•	•	•	•	•
Timmermans, John J., New York	•	•	•	•	•
Alternates					
Berkey, L. Gordon, White Plains	•				
Smith, Robert A., Johnstown	•				
Cincotta, Francis, Fulton					
Canali, Guelfo, Niagara Falls	•				
DiCerbo, Alphonso E., Schenectady					

	REGISTERED	MEETINGS 1	2	3	4
Divack, Morton L., Jackson Heights	•				
Emerton, Donald, Watertown					
Folley, John Fred, Jr., New Hartford					
Greenberg, Saul, Flushing					
Gross, Gary D., New York					
Gruber, Joseph L., West Sayville					
Guttuso, James, Williamsville					
Jacobs, Alvin D., New York					
Jacobs, Henry, Kingston	•				
Joseph, Simon, Bronx					
Kaufman, Paul, Hollis	•				
Kirsch, Sanford, White Plains					
Kobren, Abraham, White Plains	•				
Koechley, Robert, Albany					
Lachnicht, Vitus J., Brooklyn					
Mascari, Charles, Geneva	•				
Montgomery, Robert L., Buffalo					
Nash, Seymour L., New York	•				
Nicklaus, Frank E., Bath					
Nicora, Walter B., New York					
Pardo, Gonzalo I., Rocky Point	•				
Pasternak, Richard, Hempstead					
Puglisi, Arthur W., Staten Island					
Purdy, Harold, Ithaca	•				
Quick, Herbert, Brooklyn					
Robertson, Alberto L., New York					
Rosencrans, Martin, Jackson Heights					
Rosenthal, Alfred A., New York					
Rothman, A. Allen, Flushing	•				
Valinoti, Joseph R., Manhasset					
Schlagel, Eugene, Brooklyn					
Seldin, Leslie W., New York					
Stark, A. Burton, Jr., Mt. Kisco					
Swart, Robert J., Rochester	•				
Taub, Herbert L., Rockville Centre	•				
Tillis, Bernard P., Brooklyn	•		•	•	•
Travin, Milton S., Brooklyn					
Triftshauser, Roger, Batavia	•				
Weil, Ralph B., Brooklyn	•				
Whalen, Edward F., Cooperstown	•				
Wolf, Merwin, Bronx	•				
NORTH CAROLINA 1,775 members, 7 delegates					
Delegates					
Barden, R. B., Wilmington	•	•		•	•
Austin, Edward U., Charlotte	•	•	•	•	•
Coffey, Ralph D., Morganton	•	•	•	•	•
Aldridge, M. W., Greenville	•	•			
Hand, William L., New Bern	•	•	•	•	
Harrell, James A., Elkin	•	•	•	•	•
Willis, Guy R., Durham	•	•	•	•	•
Alternates					
Litton, Robert B., Shelby	•		•	•	•
Spillman, J. Harry, Winston-Salem	•				

	REGISTERED	MEETINGS 1	2	3	4
Maxwell, Harold E., Fayetteville	•				
Wallace, Mitchell W., Spring Lake	•				
Shankle, Robert J., Chapel Hill	•				
Watson, Robert H., Charlotte	•				
Seifert, D. W., Raleigh	•				•
NORTH DAKOTA 265 members, 2 delegates					
Delegates					
Nutter, O. R., Minot	•	•	•	•	•
Larson, G. D., Langdon	•	•	•	•	•
Alternates					
Biel, E. F., Dickinson					
Ford, W. J., Jr., Fargo	•				
OHIO 4,588 members, 17 delegates					
Delegates					
Mercer, James F., Akron	•	•	•	•	•
Snyder, Bernard S., Columbus	•	•	•	•	•
Hardin, Rexford E., Toledo	•	•	*	•	•
Tapper, Irving B., Cleveland	•	•	•	*	•
Bitonte, Robert C., Youngstown	•	•	•	•	*
Fritz, Calvin O., Cleveland	•	•	•	•	•
Adams, James R., Toledo	•	•	•	•	•
Sherriff, Stanley D., Dayton	•	•	•	•	•
Bowen, Robert K., Columbus	•	•	•	•	•
Schroeder, Robert L., Elyria	•	•	•	•	•
Secrest, Brodie G., Jr., Cambridge	•	•	•	•	
Hughes, Thomas H., Hillsboro	•	•	•	*	•
Gottschalk, Jack W., Cincinnati	•	•		•	•
Barlow, Harold E., Akron	•	•	•	•	•
Lauer, Robert E., Columbus	•	•	•	•	•
Pearson, David B., Jr., Berea	•	•	•	•	•
Codispoti, Isidore B., Canton	•	•	•	•	•
Alternates					
Clemens, Kenneth M., Lima	•			*	•
McConnell, Bernie A., Canton	•				
Hooker, Joseph E., Tiffin	•				
Buchanan, Richard S., Spencerville	•				
White, Edward M., Painesville	•				
Buchsieb, Walter C., Dayton	•		*		
Hickey, Paul F., Dayton	•				*
Marshall, W. Frederick, Mansfield					
Dredge, Howard Z., Springfield	•				
Hiatt, N. Wayne, Grove City	•				
Scheingold, Sanford S., Cincinnati	•				
Broadbent, B. Holly, Jr., Beechwood					
Fisk, Marvin M., Cleveland	•			•	
Blodgette, Weldon G., Fairview Park	•				
Rose, M. William, Cleveland	•				
Feuer, Seymour I., Youngstown	•				
Parrish, Jack R., Columbus	•				

Note:
*Delegate and Alternate attended portion of meeting

	REGISTERED	MEETINGS 1	2	3	4
OKLAHOMA 956 members, 4 delegates					
Delegates					
Gardner, Gary D., Lawton	•	•	•	•	
Kouri, Charles M., Chelsea	•	•	•	•	•
Saddoris, James A., Tulsa	•	•	•	•	•
Benson, Ben H., Woodward	•	•	•	•	•
Alternates					
Barnes, Harry W., Ardmore	•				
Whiteneck, Otho, Enid	•				
Holt, Arvil B., Oklahoma City	•				
Sommer, Frank L., Tulsa	•				
OREGON 1,472 members, 6 delegates					
Delegates					
Bell, James J., Lake Oswego	•	•	•	•	•
Howard, Berne M., Portland	•	•	•	•	•
Over, Jack D., Portland	•	•	•	•	•
Manny, Vernon R., Portland	•	•	•	•	•
Howard, William W., Portland	•	•	•	•	•
Wold, Johan E., Salem	•	•	•	•	•
Alternates					
Wold, Charles R., Salem	•				
Norman, Theodore R., Portland	•				
Durham, Kenneth W., Eugene					
Kunkel, Paul W., Portland	•				
Darke, George J., Portland					
Terkla, Louis G., Portland	•				
PANAMA CANAL ZONE 26 members, 1 delegate					
Delegate					
.....					
Alternate					
.....					
PENNSYLVANIA 5,490 members, 20 delegates					
Delegates					
McKechnie, Alex J., Jr., Camp Hill	•	•	•	•	•
Bomba, John L., Havertown	•	•	•	•	•
McFeaters, Arthur C., Jr., Pittsburgh	•	•	•	•	•
Czarnecki, Eugene S., Flourtown	•	•	•	•	•
Roeck, Dale F., Philadelphia	•	•	•	•	•
Neff, Jack H., Philadelphia	•	•	•	•	•
Mihalski, Edmund R., Hellertown	•	•	•	•	•
Peters, Ray F., Jr., Allentown	•		•	•	•
Hartman, Paul G., Jr., Lansdale	•	•	•	•	•
Shemo, Robert J., Wilkes-Barre	•	•	•	•	•
Dougherty, Harry H., West Reading	•	•	•	•	•
Mazaheri, Mohammed V., Lancaster	•	•	•	•	•
Whittaker, John E., Williamsport	•	•	•	•	•
Haller, Joseph L., Hollidaysburg					
Probst, Robert A., Warren	•	•	•	•	•
Maruca, Anthony F., Erie	•	•	•	•	•
McDermott, Charles F., Pittsburgh	•	•	•	•	•

	REGISTERED	MEETINGS 1	2	3	4
Finder, Moses J., Pittsburgh	•	•	•	•	•
Perkins, Thomas L., Bradford Woods	•	•	•	•	•
Ewing, F. Eugene, Pittsburgh	•	•	•	•	•
Alternates					
Sniderman, Marvin, Pittsburgh	•				
Lathrop, Laurence L., Emporium					
Horkowitz, Simon A., Allentown	•	•			
Sammartino, Frank J., Philadelphia	•				
Alloy, Jack, Philadelphia	•				
Levin, Lester L., Aston					
Miller, Reuben E. V., Jr., Easton	•				
Gentile, Nicholas, West Chester	•				
Wagner, David S., Hazleton	•				
Willits, Harry K., Reading					
Tome, Mark S., Hanover	•				
Lopatofsky, George, Troy					
Wehrle, Herbert A., Jr., Altoona	•	•	•	•	•
Reichel, Richard L., Erie	•				
Dietz, Laurence E., Beaver	•				
Kondis, Stephen L., Munhall	•				
Ehrlich, David H., Pittsburgh					
Timko, Michael, Pittsburgh	•				
PUBLIC HEALTH SERVICE 358 members, 1 delegate					
Delegate					
Greene, John C., Rockville, Maryland	•	•	•	•	•
Alternate					
Robertson, Jack D., Rockville, Maryland	•				
PUERTO RICO 366 members, 2 delegates					
Delegates					
Pagan, William J., Santurce	•	•	•	•	•
Noya, Carlos J., Santurce	•	•	•	•	•
Alternates					
Suris, Jose A., Rio Piedras	•				
Rodriguez, Herman A., Hato Rey	•				
RHODE ISLAND 470 members, 3 delegates					
Delegates					
Sarcione, Felix, Providence	•	•	•	•	•
Romenski, Joseph R., Pawtucket					
Garber, Martin, Cranston	•	•	•	•	•
Alternates					
Pascone, John P., Greenville					
Caputi, Anthony A., Newport	•		•	•	•
SOUTH CAROLINA 753 members, 4 delegates					
Delegates					
Draffin, William C., Columbia	•	•	•	•	•
Hoffmann, George P., Greenville	•	•	•	•	•
Stalvey, A. Derrick, Georgetown	•	•	•	•	•
Parler, John W., Batesburg	•	•	•	•	•

Note:
*Delegate and Alternate attended portion of meeting

	REGISTERED	MEETINGS 1	2	3	4
Alternates					
Stukes, Ollie L., Hartsville	•				
Hamrick, Fitzhugh N., Charleston	•				
Dunkin, Millard L., Columbia	•				
Little, Henry T., Greenville	•				
SOUTH DAKOTA 250 members, 2 delegates					
Delegates					
Buechler, Alvin A., Gettysburg	•	•	•	•	•
Ray, Charles J., Rapid City	•	•	•	•	•
Alternates					
Schoessler, Richard J., Pierre	•				
Ackerman, Walter J., Rapid City	•				
TENNESSEE 1,559 members, 6 delegates					
Delegates					
Parker, L. Willard, Nashville	•	•	•	•	•
Lockett, W. L., Knoxville	•	•	•	•	•
Green, Frank A., Chattanooga	•	•	•	•	•
Graham, R. Parker, Nashville	•	•	•	•	•
Denney, Robert P., Milan	•	•	•	•	•
Overbey, R. Malcolm, Memphis	•	•	•	•	•
Alternates					
Montgomery, Robert H., Kingsport	•				
Phillips, James A., Chattanooga	•				
Walker, Joe Tom, Murfreesboro	•				
Sullivan, Richard J., Jr., Brentwood	•				
Williams, Robert M., Jackson	•				
Manning, H. R., Jr., Memphis	•				
TEXAS 4,667 members, 17 delegates					
Delegates					
Maberry, Robert T., Ft. Worth	•	•	•	•	•
Williams, Thomas R., Gatesville					
Sorrels, H. M., Houston	•	•	•	•	•
Milligan, William B., Victoria	•	•	•	•	•
Minton, Morris S., McKinney	•	•	•	•	•
Londeree, Robert D., Jr., Dallas	•	•	•	•	•
Weatherall, John T., Texas City	•	•	•	•	•
Harris, Jack H., Houston	•	•	•	•	•
Besch, Ernest H., San Antonio	•	•	•	•	•
Priess, Harry C., Brady	•	•	•	•	•
Gibbe, Carl A., Ft. Worth	•	•	•	•	•
Lewis, Charles G., Muleshoe	•	•	•	•	•
Slack, F. M., Ft. Worth	•	*	•	•	•
Smith, Harold L., Tyler	•	•	•	•	•
Kunik, Burton J., Houston	•	•	•	•	•
McWilliams, R. O., San Angelo	•	•	•	•	•
Trice, Frank B., Houston	•	•	•	•	•
Alternates					
Richardson, Lloyd W., Ft. Worth	•	*			
May, A. David, Abilene	•				
Vaughn, William J. H., Dallas	•				

Note:
*Delegate and Alternate attended portion of meeting

	REGISTERED	MEETINGS 1	2	3	4
Sampeck, Adrian J., Dallas	•				
Glenn, William L., Jr., Galveston	•				
Brown, James N., Port Arthur	•				
Schneidler, J. G., Laredo	•				
Woodside, Robert M., San Antonio	•				
Burnett, James V., Ft. Worth	•				
Johnson, Paul W., Lubbock	•				
Cartwright, O. V., Grand Prairie	•		†	•	•
Patterson, William R., Texarkana	•	•	†		
White, Wilbur S., Beaumont	•				
Clitheroe, William R., Houston	•				
Wilbanks, John D., El Paso	•				
Mayer, Tully A., Pharr	•				
Horne, Robert K., Ft. Worth	•				
UTAH 724 members, 4 delegates					
Delegates					
Warr, Newell E., Salt Lake City	•	•	•	•	•
Benton, Daniel W., Roy	•	•	•	•	•
Bingham, Sanford M., Provo	•	•	•	•	•
Foster, Charles E., Salt Lake City	•	•	•	•	•
Alternates					
Lunt, Paul R., Cedar City	•				
Stultz, Edgar H., Salt Lake City	•				
Woffinden, Robert G., Salt Lake City					
VERMONT 260 members, 2 delegates					
Delegates					
Perrin, Robert M., South Burlington	•	•	•	•	•
Johnson, Lyman W., Rutland	•	•	•	•	•
Alternates					
Barker, Robert L., Jr., St. Albans	•				
Montgomery, Dale B., Burlington	•				
VETERANS ADMINISTRATION 586 members, 1 delegate					
Delegate					
Aaronian, Albert J., Washington, D.C.	•	•	•	•	
Alternate					
Fischer, Eugene E., Washington, D.C.	•				•
VIRGINIA 1,953 members, 8 delegates					
Delegates					
Bradshaw, Thomas C., Blackstone	•	•	•	•	*
Clark, Lonnie O., Jr., Virginia Beach	•	•	•	*	•
Fisher, Elmer O., Jr., Hampton	•		*	*	•
Gregory, Carlton E., Arlington	•	•	•	•	*
Henderson, Myron E., Roanoke	•	•	*	*	*
Marshall, Virgil H., Charlottesville	•	•	•	•	•
Martone, Alexander L., Norfolk	•	•	•	•	*
Wendt, Douglas C., Arlington	•	•	•	•	•

Note:
*Delegate and Alternate attended portion of meeting
†Alternates attended portion of meeting

	REGISTERED	MEETINGS 1	2	3	4
Alternates					
Bruni, Rudolph H., Jr., Richmond	•		*	*	
Fleming, Harry B., Falls Church	•		*	*	*
Michaels, Emanuel W., Norfolk	•				*
FitzHugh, William B., Richmond	•			*	
Moore, French H., Jr., Abingdon	•				
Huff, Wallace L., Blacksburg	•			*	
Ames, J. Wilson, Jr., Smithfield	•				*
Pugh, Robert L., Roanoke	•				*
VIRGIN ISLANDS 14 members, 1 delegate					
Delegate					
Shrallow, Bruce, St. Thomas	•	•	•	•	•
Alternate					
Hertz, Sidney S., St. Thomas					
WASHINGTON 2,306 members, 9 delegates					
Delegates					
McNally, Joseph D., Tacoma	•	•	•	•	•
Zuck, Eugene M., Seattle	•	•	•	•	•
Ryan, A. Lynn, Vancouver	•	•	•	•	•
Stevens, Otto O., Spokane	•	•	•	•	•
Wood, George W., Walla Walla	•	•	•	•	•
Briscoe, DeWayne L., Bellevue	•	•	•	•	•
Craswell, Bruce A., Silverdale	•	•	•	•	*
Forsyth, Arthur H., Jr., Chehalis	•	•	•	•	•
Johnson, Ewing M., Spokane	•	•	•	•	•
Alternates					
Richards, John W., Seattle	•				*
Davidson, Ellwood F., Tacoma					
Dodge, John B., Tacoma	•				
Losh, J. Harvey, Seattle	•				
Scott, Jack T., Tacoma	•				
Compaan, Donald E., Seattle	•				
Barletti, Robert J., Yakima	•				
Hearon, Donald L., Tacoma	•				
WEST VIRGINIA 572 members, 3 delegates					
Delegates					
Bridgeman, Robert G., New Martinsville	•	•			
Campbell, John L., Morgantown	•	•	•	•	
Mendenhall, James D., Parkersburg	•	•	•	•	•
Alternates					
Stevens, Frank H., Bridgeport	•		•	•	•
Lake, Charles L., South Charleston	•				
Loflin, Paul H., Beckley	•				
WISCONSIN 2,405 members, 9 delegates					
Delegates					
Sabin, Norbert M., Elkhorn	•	•	•	•	•
Cohn, Perry P., Shorewood	•	•	•	•	•
Copoulos, Paul C., Milwaukee	•	•	•	•	•

Note:
*Delegate and Alternate attended portion of meeting

	REGISTERED	MEETINGS 1	2	3	4
English, Leon J., Arcadia	•	•	•	•	•
Green, H. Daniel, Beloit					
Larson, Gerald A., Brookfield	•	•	•	•	•
Leone, Edward F., West Allis	•	•	•	•	•
Shuler, Carliss B., Clinton	•	•	•	•	•
Simley, Donald O., Madison	•	•	•	•	•
Alternates					
Baumann, Charles J., Milwaukee	•				
Buckley, William G., Racine					
Groth, Gerald K., Appleton	•	•	•		
Hambuch, Carl A., Ashland	•			•	•
Kestly, James J., Milwaukee	•				
Larsen, Vernon A., Menasha	•				
Pawlisch, James T., Middleton	•				
Rech, Richard L., Milwaukee	•				
Strand, Richard J., La Crosse	•				
WYOMING 162 members, 2 delegates					
Delegates					
Ewan, George E., Sheridan	•	•	•	•	•
Devine, Joseph A., Cheyenne	•	•	•	•	•
Alternate					
Kildebeck, Orval C., Torrington	•				

List of Resolutions

Res. 1 Council on Dental Education—Eligibility for Board examination, 104; Board, 474, 673; House, 896

Res. 2 Council on Dental Education —Amendment of *Requirements for National Certifying Board for Special Areas of Dental Practice,* 104; Board, 474, 673; House, 896-8

Res. 3 Council on Dental Education—Establishment of voluntary national program for evaluation of continuing education sponsors, 105; Board, 474, 673; House, 896

Res. 4 Council on Dental Education—Education eligibility requirement for dental hygiene licensure examination, 105; Board, 474, 520, 674; House 896-9

Res. 4S-1 Fifth Trustee District—Amendment to Res. 4, 398; Board, 519, 757; House, 896

Res. 4S-2 Fifth Trustee District—Substitute for Res. 4RC, 402; House, 896

Res. 5 Council on Dental Health—Approval of *Suggestions for Dentists on Participating in the National High Blood Pressure Education and Screening Program,* 114; Board, 480, 661; House, 848

Res. 6 Council on Dental Health—Approval of *Statement on National Health Service Corps,* 114; Board, 480, 662; House, 848

Res. 7 Council on Federal Dental Services—Continuation pay eligibility for dental officers in uniformed services, 144; Board, 480, 717; House, 872

Res. 8 Council on Federal Dental Services—Productivity of present workforce of dentists, 144; Board, 480, 717; House, 872

Res. 8S-1 Fifth Trustee District—Amendment to Res. 8, 398; Board, 522, 774; House, 872

Res. 9 Council on International Relations—Amendment of *Bylaws* on membership in constituent societies and affiliate membership, 159; Board, 481, 693; House, 924

Res. 10 Council on International Relations—Amendment of criteria 2 for awarding Certificate of Recognition for Volunteer Service in a Foreign Country, 160; Board, 481, 693; House, 924

Res. 11 Council on Journalism—Approval of *Standards for Dental Publications,* 163; Board, 481, 694; House, 926

Res. 12 Council on Judicial Procedures, Constitution and Bylaws—Discontinuation of moratorium on announcement in more than one specialty under Section 18 of *Principles of Ethics,* 177; Board, 481, 718; House, 878

Res. 13 Council on Judicial Procedures, Constitution and Bylaws—Amendment of Section 7 of *Principles of Ethics* (patient visits or referrals), 178; Board, 481, 546, 718; House, 880

Res. 14 Council on Judicial Procedures, Constitution and Bylaws—Amendment of Section 18 of *Principles of Ethics* (specialty area of dentistry), 178; Board, 481, 719; House, 880

Res. 15 Council on Judicial Procedures, Constitution and Bylaws—Moratorium on disciplinary action, 178; Board, 482, 719; House, 882

Res. 16 Council on Judicial Procedures, Constitution and Bylaws—Amendment of *Bylaws* on nomination to councils, 179; Board, 481, 720; House, 883

Res. 17 Council on Judicial Procedures, Constitution and Bylaws—Amendment of *Bylaws* on admission of active members, 179; Board, 481, 720; House, 884

Res. 18 Council on Judicial Procedures, Constitution and Bylaws—Amendment of *Bylaws* on student membership and active member dues, 179; Board, 481, 720; House, 884, 933

Res. 19 Council on Judicial Procedures, Constitution and Bylaws—Amendment of *Bylaws* on appeals of disciplined members, 180; Board, 481, 720; House, 884, 933

Res. 20 Council on Judicial Procedures, Constitution and Bylaws—Amendment of *Bylaws* on privileges of active member under sentence of suspension, 181; Board, 481, 720; House, 884, 933

Res. 21 Council on Judicial Procedures, Constitution and Bylaws—Amendment of *Bylaws* on constituent societies, 181; Board, 481, 720; House, 884, 933

Res. 22 Council on Judicial Procedures, Constitution and Bylaws—Amendment of *Bylaws* on Council on Relief, 181; Board, 481, 721; House, 884, 933

Res. 23 Council on Relief—Amendment of Relief Fund *Indenture of Trust,* 201; Board, 483, 721; House 895

Res. 24 Council on Dental Education, Special Report—Approval of *Statement on Expanded Function Dental Auxiliary Utilization and Education,* 233; Board, 477, 680; House, 831-6

Res. 24S-1 Delegate Eugene J. Fortier, Jr., Louisiana—Substitute for Res. 24, 428; Board, 526, 762; House, 831-6

Res. 24S-2 Fifth Trustee District—Substitute for Res. 24, 403; Board, 522, 760; House, 831-6

Res. 24S-3 Tenth Trustee District—Substitute for Res. 24, 415; House, 831-6

Res. 25 Commission on Licensure—Licensure for protection of public, 255; Board, 483, 675; House, 915

Res. 25S-1 Fifth Trustee District—Amendment to Res. 25, 399; Board, 523, 759; House, 915

Res. 26 Commission on Licensure—State board review of application for licensure, 255; Board, 483, 675; House, 916

Res. 26S-1 Fifth Trustee District—Substitute for Res. 26, 404; Board, 523, 759; House, 916

Res. 27 Commission on Licensure—Verification of credentials and application data of licensure candidates, 255; Board, 483, 675; House, 916

Res. 28 Commission on Licensure—Approval of *Guidelines for Licensure,* 256; Board, 483, 676; House, 916-20

Res. 28S-1 Fifth Trustee District—Substitute for Res. 28, 404; Board, 523, 760; House, 916-20

Res. 28S-2 Fifth Trustee District—Substitute for Res. 28RC, 405; House, 916-20

Res. 29 Commission on Licensure—Mechanisms for licensure by credentials for specialists, 256; Board, 483, 676; House, 921

Res. 30 Commission on Licensure—Mechanism for issuing licenses, 256; Board, 483, 676; House, 915, 921

Res. 31 Commission on Licensure—State support for enforcement of state dental practice act, 256; Board, 483, 676; House, 915, 921

Res. 32 Commission on Licensure—Mechanisms of licensure by credentials for use as relicensure standards, 256; Board, 483, 676; House, 921

Res. 33 District of Columbia Dental Society—Complete utilization of dentists in treatment of patients, 367; Board, 488, 681; House, 836

Res. 34 New Jersey Dental Association—Amendment of *Bylaws* on scientific session, 378; Board, 492, 708; Withdrawn, 927

Res. 35 The Dental Society of the State of New York—Amendment of ADA *Standards for Dental Prepayment Programs,* 379; Board, 493, 670; House, 845

Res. 35S-1 Ninth Trustee District—Substitute for Res. 35RC, 412; House, 845-7

Res. 36 The Dental Society of the State of New York—Termination of TEAM programs, 380; Board, 493, 534, 682; House, 836

Res. 36(aB)S-1 Fifth Trustee District—Substitute for Res. 36aB, 405; Board, 524, 760; House, 836

Res. 36(bB)S-1 Fifth Trustee District—Substitute for Res. 36bB, 406; Board, 524, 760; House, 836
Res. 37 Oregon Dental Association—Engagement of actuary for ADA insurance programs, 384; Board, 494, 708; House, 818
Res. 37S-1 Fifth Trustee District—Substitute for Res. 37, 406; House, 818
Res. 38 Rhode Island Dental Association—Amendment of *Bylaws* on scientific session, 385; Board, 492, 708; House, 927
Res. 39 Washington State Dental Association—Introduction of new business in House of Delegates, 387; Board, 496, 709; House, 927
Res. 39S-1 Seventh Trustee District—Substitute for Res. 39RC, 410; House, 927
Res. 39S-2 Fifth Trustee District—Substitute for Res. 39RC, 407; House, 927
Res. 40 Washington State Dental Association—Policy on functions of dental auxiliaries, 388; Board, 496, 682; House, 838
Res. 41 Washington State Dental Association—Position statement on advertising, 389; Board, 496, 524, 709; House, 807, 887
Res. 41S-1 Fifth Trustee District—Substitute for Res. 41, 407; Board, 524, 534, 774; House, 887
Res. 42 Wisconsin Dental Association—Reconsideration of 1974 Wisconsin Res. 43 regarding modification of membership card, 390; Board, 497, 711; House, 820
Res. 43 Wisconsin Dental Association—Redevelopment of conference on expanded duties of dental auxiliaries, 390; Board, 498, 534, 683; House, 831-6
Res. 44 Council on Dental Care Programs, Supplemental Report 1—Amendment of *Standards for Dental Prepayment Programs*, 32; Board, 472, 659; House, 841
Res. 45 Florida Dental Association—Study of the dentist in all his relationships, 368; Board, 488, 516, 534, 669, 750; House, 852
Res. 46 Illinois State Dental Society—Amendment of Section 20 of *Principles of Ethics* (name), 369; Board, 489, 733; House, 885
Res. 47 Illinois State Dental Society—Classification of dental laboratory technicians, 369; Board, 489, 681, 771; House, 900
Res. 48 Illinois State Dental Society—Publication and distribution of fee surveys, 370; Board, 489, 669; House, 853
Res. 49 Indiana Dental Association—Commendation to Dr. Lloyd J. Phillips, 371; Board, 492, 708; House, 933
Res. 50 Louisiana Dental Association—Reaffirmation of Section 12 of *Principles of Ethics* (advertising), 374; Board, 492, 719, 734; House, 886
Res. 51 Pennsylvania Dental Association—Identification of dental procedures by scientific term, 385; Board, 495, 734; House, 937
Res. 52 Texas Dental Association—Involvement of ADA delegates with third party programs, 386; Board, 495, 670; House, 855
Res. 53 Texas Dental Association—Nomination for Offices of the American Dental Association, 386; Board, 496, 709; Withdrawn, 807
Res. 54 Arkansas State Dental Association—Amendment of ADA *Standards for Dental Prepayment Programs*, 361; Board, 487, 668; House, 851
Res. 55 California Dental Association—Guidelines for dental directories, 363; Board, 487, 534, 732; House, 885
Res. 56 California Dental Association—Clarification of terminology of pedodontics, 362; Board, 487, 515, 732, 772; House, 881
Res. 57 California Dental Association—Military dependent care, 364; Board, 487, 733; Withdrawn, 874
Res. 57S-1 Thirteenth Trustee District—Substitute for Res. 57 and Res. 139, 420; Withdrawn, 874
Res. 58 California Dental Association—Remote status designations for military installations, 366; Board, 488, 524, 733; House, 875
Res. 58S-1 Fifth Trustee District—Substitute for Res. 58, 399; Board, 524, 774; House, 875

Res. 58S-2 Fifth Trustee District—Substitute for Res. 58RC, 408; House (See Res. 58H, 876)
Res. 59 California Dental Association—Professional exemption from antitrust legislation, 365; Board, 488, 534, 719, 733; House, 890
Res. 60 Thirteenth Trustee District—Amendment of *Bylaws* on disciplinary penalties, 419; Board, 499, 734; House, 887
Res. 61 Delegate Paul J. McKenna, Massachusetts—Amendment of Section 15 of *Principles of Ethics* (professional titles and degrees), 434; Board, 499, 734; House, 889
Res. 62 House Standing Committee on Rules and Order—Approval of minutes of 1975 session of House of Delegates; House, 804
Res. 63 House Standing Committee on Rules and Order—Approval of agenda of House of Delegates; House, 804
Res. 64 House Standing Committee on Rules and Order—Amendment of *Manual of House of Delegates* on resolution on creation of new programs; House, 804
Res. 65 House Standing Committee on Rules and Order—Amendment of *Manual of House of Delegates* on conduct of hearings; House, 804
Res. 66 House Standing Committee on Rules and Order—Amendment of *Manual of House of Delegates* on nomination procedures, Board, 791; House, 805
Res. 66S-1 House Standing Committee on Rules and Order—Substitute for Res. 66; House, 805
Res. 67 House Standing Committee on Rules and Order—Approval of lists of referrals of resolutions; House, 806
Res. 68 House Standing Committee on Rules and Order—Omit reading of background material in reference committee reports; House, 806
Res. 69 House Standing Committee on Rules and Order—Special order of business for installation of officers and trustees; House, 806
Res. 70 Board of Trustees, Board Report 1 to House—Nominations to Honorary Membership, 464; House, 806
Res. 71 Board of Trustees, Board Report 1 to House—Nominations to councils, 468; House, 807, 811
Res. 72 Board of Trustees, Board Report 1 to House—Nominations to Commission on Accreditation of Dental and Dental Auxiliary Educational Programs, 469; House, 807, 811
Res. 73 Board of Trustees, Board Report 1 to House—Nominations to Appeal Board of Commission, 469; House, 807, 811
Res. 74 Board of Trustees, Board Report 1 to House—Nominations to Commission on Licensure, 470; House, 807, 923
Res. 75 Board of Trustees, Board Report 2 to House—Delta Dental Plans public and professional program, 473, 660; House, 843
Res. 76 Board of Trustees, Board Report 2 to House—Definition of cosmetic dentistry, 668; House, 850
Res. 77 Board of Trustees, Board Report 2 to House—Amendment of *Bylaws* on duties of Council on Dental Education, 477; Board, 535, 676; House, 922
Res. 77S-1 Fifth Trustee District—Substitute for Res. 77, 408; House, 922
Res. 78 Board of Trustees, Board Report 2 to House—Creation of office of immediate past president, 485, 699; House, 823
Res. 79 Board of Trustees, Board Report 2 to House—Elimination of office of second vice president, 485, 699; House, 815, 823
Res. 80 Board of Trustees, Board Report 2 to House—Changing of first vice president to vice president, 485, 699; House, 823
Res. 81 Board of Trustees, Board Report 2 to House—Amendment of *Bylaws* regarding officers and trustees not serving as council members or voting members of House, 485, 700; House, 823

Res. 82 Board of Trustees, Board Report 2 to House- -Amendment of *Bylaws* on composition of House (vote to student member) 500, 685; House, 824
Res. 83 Board of Trustees, Board Report 2 to House—Recision of House Res. 24-1972-H on publication of business referred to councils by House, 501, 689; House, 826
Res. 84 Board of Trustees, Board Report 2 to House—Veterans Administration reimbursement arrangements, 501, 716; House, 877
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"DENTURISM" (FOOTNOTE)
"Denturism" is the unqualified as well as the illegal practice of dentistry in any form on the public.
"DENTURIST" (FOOTNOTE)
A "denturist" is a person who is educationally unqualified and not licensed, for the necessary protection of the public, to practice dentistry in any form on the public.

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Abbreviations

COUNCILS

CDCP	Dental Care Programs, Council on
CDE	Dental Education, Council on
CDH	Dental Health, Council on
CDLR	Dental Laboratory Relations, Council on
CDMD	Dental Materials and Devices, Council on
CDR	Dental Research, Council on
CDT	Dental Therapeutics, Council on
CFDS	Federal Dental Services, Council on
CHDS	Hospital Dental Service, Council on
CI	Insurance, Council on
CIR	International Relations, Council on
CJ	Journalism, Council on
CJPCB	Judicial Procedures, Constitution and Bylaws, Council on
CL	Legislation, Council on
CNBDE	National Board of Dental Examiners, Council of
CR	Relief, Council on
CSS	Scientific Session, Council on

BUREAUS

BAS	Audiovisual Service, Bureau of
BCS	Convention Services, Bureau of
BDHE	Dental Health Education, Bureau of
BDPSMR	Data Processing Services and Membership Records, Bureau of
BDSS	Dental Society Services, Bureau of
BERS	Economic Research and Statistics, Bureau of
BLS	Library Services, Bureau of
BPI	Public Information, Bureau of

COMMISSIONS

CADDAEP	Accreditation of Dental and Dental Auxiliary Educational Programs, Commission on
CLic	Licensure, Commission on

COMMITTEES

CAP	Committee on Advance Planning

MISCELLANEOUS

AAALAC	American Association for the Accreditation of Laboratory Animal Care
ACCENT	ACtion CENTral (ADHA program)
ADA	American Dental Association
ADAHF	ADA Health Foundation
ADAHFRI	ADA Health Foundation Research Institute
ADAHFRU (NBS)	ADA Health Foundation Research Unit at National Bureau of Standards
ADHA	American Dental Hygienists' Association
ADPAC	American Dental Political Action Committee
AFDH	American Fund for Dental Health
AHA	American Hospital Association
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services (Army)
DDPA	Delta Dental Plans Association
DHEW	Department of Health, Education and Welfare
DOD	Department of Defense
FDA	Food and Drug Administration
FTC	Federal Trade Commission
HMO	Health Maintenance Organization
ICD	International College of Dentists
NADL	National Association of Dental Laboratories
NHF	National Health Federation
NIDR	National Institute of Dental Research
NIH	National Institutes of Health
PEP	Public Education Program
PHS	Public Health Service
RTI	Research Triangle Institute of North Carolina
STAR	Special Travel Arrangements Recognition
TEAM	Training in Expanded Auxiliary Management
UCR	Usual, customary, and reasonable
VA	Veterans Administration


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GEORGIA
FLORIDA
SOUTH CAROLINA
NORTH CAROLINA
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TENNESSEE
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ILLINOIS
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MICHIGAN
WISCONSIN
MINNESOTA
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NORTH DAKOTA
SOUTH DAKOTA
NEBRASKA
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