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ADA American Dental Association
211 East Chicago Avenue
Chicago, Illinois 60611
Pages 1-232

1990

Annual Reports and Resolutions

131st Annual Session

Boston, Massachusetts

October 13-18, 1990

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American Dental Association
211 East Chicago Ave.
Chicago, IL 60611

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Special Note

Copies of the 1990 *Annual Reports and Resolutions* have been mailed to both delegates and alternate delegates. Please bring your copy to the meetings of the House of Delegates.

Notes

Notes

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Notes

Reports of Councils, Commissions, Bureaus and Other Association Agencies

Divisions of Communications, Conference and Meeting Services, and Membership and Marketing Services

Council on ADA Sessions and International Relations

Division of Communications

Bureau of Library Services

Division of Membership and Marketing Services

Commission on the Young Professional

Notes

Council on ADA Sessions and International Relations

DiMango, Anthony L., New York, 1991, chairman
Brewster, James E., California, 1992
England, Fred A., Texas, 1990
Fujioka, John M., Hawaii, 1990
Goodman, William E., Oklahoma, 1993
Harrell, James A., Sr., North Carolina, 1992
Hunter, Robert E., Massachusetts, 1990, ex officio
Johnson, Johnny N., Washington, 1991, ex officio
McDermott, Bernard K., District of Columbia, 1993
Morawa, Arnold P., Michigan, 1992
Reinke, Paul H.H., South Dakota, 1991
Shankle, R.J., North Carolina, 1990
Smith, Robert J., Pennsylvania, 1991
Jeske, Edward T., secretary
Cherrett, Helen McK., assistant secretary
Stiegel, Marsha P., assistant secretary

Meetings: The Council met January 22-23, 1990 in Boston at the Westin Hotel Copley Place, and May 21-22, 1990 at the Headquarters Building in Chicago.

Activities: During 1989-90, the Council on ADA Sessions and International Relations continued serving as the program coordinating body for the annual session as well as acting as the committee to formulate and recommend policies related to the Association's role in international affairs and serving as its liaison to the world dental community. The Council's January meeting in Boston primarily dealt with planning for the 1990 and 1991 Annual Sessions, but it also included an update report on the status of the Council's new International Volunteer Service Program. Association president, Dr. R. Malcolm Overbey, and Dr. Bert Y. Hayashi, Fourteenth District trustee and the Board of Trustee's liaison to the Council, also attended that meeting.

At its May meeting, the Council finalized plans for the 1990 session and pursued plans for the 1991 meeting. The Council also considered international matters which fall under its responsibility.

1989 Annual Session: The 1989 Annual Session was the first time the meeting was held in Honolulu. While the lack of a convention center required creative alternatives be developed for the technical exhibits and scientific programs, the result was a highly successful meeting. Total registration was 27,648, including 10,739 dentists of which 750 were internationals. Although the exhibits were separated from the scientific programs, which were in various hotels along Waikiki Beach, both the exhibits and the programs were heavily attended.

1989 ADA/Dentsply Student Clinician Program: This student program, which celebrated its 31st anniversary in 1989, is conducted annually by the Council on ADA Sessions and International Relations and is financially supported by Dentsply International, Inc., York, Pennsylvania.

Outstanding student clinicians representing 56 accredited dental schools in the United States including Puerto Rico presented table clinics on Monday afternoon at the Hawaiian Regent Hotel. On Tuesday morning the winning students presented their clinics at the Sheraton Waikiki Hotel.

Winning students in the ADA/Dentsply Program Category I, Clinical Application and Technique, were: Lynne A. Brock, University of Texas Dental Branch at Houston, first place; Eric D. Johnson, University of Nebraska Medical Center College of Dentistry, second place; Mary S. Anderson, University of Missouri School of Dentistry, third place.

Winning students for Category II, Basic Science and Research, were: Charles R. Todd, Harvard School of Dental Medicine, first place; Mary A. Hanlon, Ohio State University College of Dentistry, second place; George A. Nail, Baylor College of Dentistry, third place.

The first place winners in each category were awarded a travel prize to present their winning table clinics at the Chicago Dental Society Midwinter Meeting. Second and third prize winners in each category received awards of $150 and $100, respectively.

Judges for Category I were: John Olmsted, Greensboro, North Carolina, chairman; Leslie A. Burstein, New York; Cordell S. Fisher, San Pedro, California; Brenda J. Harman, Chicago; Arthur D. Hunger, Jr., York, Pennsylvania; Daniel Middaugh, Seattle; and Jack Penhall, Jeanette, Pennsylvania.

Judges for Category II were: Jon B. Suzuki, Baltimore, chairman; Mario Andriolo, New York; Gordon Christensen, Provo, Utah; Thomas Emmering, Wheaton, Illinois; J. Terrell Hoffeld, Bethesda; Theresa Madden, Rochester, New York; Mirdza E. Neiders, Buffalo, New York; Roger Stambaugh, Los Angeles; and Richard C. Tatum, Columbus, Maryland.

1989 Technical Exhibits: The Sheraton Waikiki Hotel Ballroom and Exhibit Pavillion was the site for 383 technical exhibit booths representing 295 different companies. The latest in dental materials, instruments, equipment, therapeutics and services was displayed encompassing over 100 different classifications of products.

1989 Scientific and Educational Exhibits: Due to limitations of space, no scientific or educational exhibits were displayed in Hawaii.

1989 Scientific Program: Four days of registered clinics, lectures and workshops were offered at the annual session in Honolulu. The scientific programs, which were conducted in numerous properties, covered a variety of topics, including endodontics, oral pathology, orthodontics, prosthodontics, periodontics, implants, oral medicine, practice management, oral surgery, temporomandibular disorders, esthetics, restorative dentistry, AIDS and infection control, and other subjects pertaining to the art and science of dentistry and the health and well-being of the practitioner. A limited attendance clinic discussed meeting OSHA requirements. The eight registered clinics addressed periodontics, prosthodontics, esthetics, restorative techniques, dental materials, endodontics and practice management. Workshops addressed endodontic skills, prosthetic restorations for implants and temporomandibular disorders. The dental hygiene facility at the University of Hawaii was used for the endodontics workshop. There were more than 3,300 participants in the workshop and clinic programs. Programs of general interest included cooking, quality of life, photography and wine selection. With 63 programs scheduled in 1989, all attendees had a variety of topics from which to choose. The audience attendance, with standing room only in most courses, and program evaluations attested to the relevance of the courses offered and the success of the program. Eight videotapes were made of selected programs for continuing education and most courses were audiotaped. These tapes were available for purchase at the meeting and afterwards. In addition to the programs, the educational experience included over 100 clinicians presenting table clinics, and these demonstations were also well attended.

1989 Post-Annual Session Seminars: In addition to the scientific programs, three post session seminars were offered on November 9 and 10: bonding and esthetics was presented on Kauai, endodontics on Maui and practice management on the big island of Hawaii. There were more than 500 participants in the seminars and they were successful.

Certificate of Recognition for Volunteer Service in a Foreign Country: At its May meeting, the Council awarded 77 dentists in 18 states the Certificate of Recognition for Volunteer Service in a Foreign Country. Since the program was initiated in 1975, 1,189 Certificates have been awarded to individuals in 44 states and the District of Columbia. In March, an article about the program appeared in the *ADA News;* it was also mentioned in the February issue of *The Journal of the American Dental Association:* and a news release was included in the *Update for Dental Editors* which resulted in the processing of 82 applications. The discrepancy in the number of applications presented and the number of certificates actually awarded is generally because of lack of adequate documentation.

This program continues to be well-received throughout the profession, as evidenced by the number of nominations, publicity in dental journals and presentation of the Certificates at dental society meetings. It also assists the Council in locating the increasing number of volunteer programs that use dental personnel.

International Subscription Program: Since this program was revised in 1982, subscriptions have been sent to dental school libraries and dental organizations in Africa, Asia and Europe as well as Central America and South America. This year the Council registered 65 subscriptions to *Dental Abstracts* and one other U.S. dental periodical of choice; recipients are encouraged to select from Association publications for their additional periodical. The provision of current professional journals to dental school libraries in lesser developed countries has proven to be one of the most effective and least costly ways of helping to raise standards and improve the dental health of these countries' citizens. The many letters of appreciation received by the Council attest to the valuable contributions the journals make to dental educational programs.

National Council for International Health (NCIH): The purpose of the NCIH is to improve health worldwide by strengthening the U.S. response to international health needs. Its emphasis is on information, education/training, job opportunities, policy and technical cooperation. The NCIH is currently the only organization in the United States which functions as a coordinating council and provides information to leading private and voluntary health organizations. Established 19 years ago, this organization, of which the ADA is a founding member, is flourishing and serves a broad segment of the international health community. The Association participates actively through its representative, Dr. Paul H. H. Reinke, who is a member of the Governing Board.

The three major initiatives which the NCIH has undertaken this year are: first, a Public Policy Program; second, a Public Education Program funded by a challenge grant from The Carnegie Corporation of New York; and third, the 1990 International Health Conference, "Expanding Partnerships." This annual conference, which is held in Washington, D.C., acts as a forum to facilitate information sharing, identify trends and focus on future health programs.

ADA/HVO Voluntary Service Program: In 1989, the Board of Trustees adopted Resolution B-53-1989, (*Trans.* 1989:471), which established an ADA Voluntary Service Program under the auspices of Health Volunteers Overseas (HVO), and it included funds in the Council's 1990 budget request to initiate this program. They also determined that the program should be managed by a special steering committee, composed of five consultants and one member of the Council to act as the liaison. Dr. Anthony L. Di Mango, representing the Council, and Drs. Hugh Cooper, Raymond A. Flanders, Francis G. Serio, Michael J. Till and Richard G. Topazian were appointed to serve on the committee for terms ending with the 1990 annual session.

The committee met on January 11-12 in Chicago and

appointed Dr. Cooper as chairman. James Cobey M.D., chairman of HVO gave an overview of the organization and discussed the role of the steering committee and the logistics in setting up a program. The committee members considered an initial set of requests for assistance and were assigned specific countries to survey. On March 21, they met in Washington, D.C. to review these surveys and set up initial site visits to Belize, Grenada, Jamaica, St. Lucia and Trinidad. After making these site visits the committee met again in Washington, D.C. on June 6. They examined in detail the 'in country' reports on each site visit and determined that Greneda, St. Lucia and Trinidad were the most suitable for instigating the first ADA/HVO programs. Additionally, as part of the annual session scientific program, the ADA/HVO program "Dentistry Overseas" was introduced to the members and an educational forum was presented to help dentists prepare to volunteer overseas.

1990 Annual Session: Boston, Massachusetts is the site of the Association's 131st Annual Session. The theme of the meeting is "A Heritage of Progress." The Hynes Veterans Memorial Convention Center is the site of the House of Delegates, the technical exhibits, scientific programs, table clinics and other activities. The program offers a full range of topics related to dentistry including periodontics, endodontics, fixed and removable prosthodontics, temporomandibular disorders, implants, esthetics and bonding, oral medicine and pathology, dental materials and practice management. Nine registered clinics and eight workshops are offered as well as the open lectures.

1990 Post-Annual Session Seminars: Following the scientific session, two seminars are offered on October 18 and 19: practice management in Bermuda and esthetics and dental materials in Montreal.

Response to Assigment from the 1989 House of Delegates:

Expansion of Council Responsibilities. At the 1989 House of Delegates, the Fifteenth Trustee District introduced Resolution 82 which sought to revise the *Bylaws* to expand the responsibilities of the Council on ADA Sessions and International Relations. The House referred Resolution 82 to the Council and asked that it report back to the 1990 House with its recommendations on this matter. During its January 1990 meeting, the Council discussed the resolution and directed the preparation of a report to the 1990 House of Delegates which would recommend that Resolution 82 not be adopted. The Council took this action based on the following:

1. The ADA Annual Session is currently recognized as one of the premier dental meetings and routinely presents world renowned clinicians as speakers as well as the largest dental exhibition in the United States.
2. The Council in functioning as the program and coordinating body for the annual session does so under the guidelines outlined in the *Manual on Annual Session* which gives the Council a role in planning all major meeting activities.
3. The Council believes that final site selection should remain a function of the Board of Trustees and that the Council should provide advice to the Board deliberations about proposed sites.
4. On the matter noted in the background to Resolution 82 regarding the Council not having responsibility for "hotel negotiations," the Council feels that since the Association utilizes just about every major hotel in a given city and since many variables affect the room rates each of these proposes to charge, it would be impractical for the Council as a group to have such a role. In reviewing the listing of annual session hotels and the room rates, the Council has the opportunity for comment and it has generally felt that an excellent job has been done in negotiating reasonable hotel room rates for the annual session given the many variables involved in setting these. The Council will continue to review the hotel rates proposed for annual session to assure that aggressive action is taken to keep these room rates as low as possible.

In conclusion, the Council is proud of its having produced so many highly successful annual sessions and feels that there is no demonstrable need to change the bylaws authority under which it now operates in respect to the annual session.

Acknowledgments: The Council wishes to express its sincere appreciation to Dr. Robert E. Hunter, general chairman of the 1990 Committee on Local Arrangements, who leaves the Council after this year's annual session, and to his entire committee for their invaluable assistance in planning and producing this year's meeting. The Council also wishes to recognize the contributions of those members who will be leaving the Council after the 1990 session: Fred A. England; John M. Fujioka, who served as 1989 Council chairman; and R.J. Shankle.

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

Division of Communications

Lorna Mitchell, assistant executive director
Danielian, Jay, director, Department of Media and Audiovisual Services
Dawson, Marilyn, director, Department of Design Services
Hansen, Joan M., director, Department of Public Information and Education
Ranallo, Barry, director, Salable Materials Program
Thiersch, Ginny, director, Department of Professional Communications

Division activities in the 1989-90 reporting period focused on the first year of full implementation for the Smile, America program and on significant challenges in the media.

Smile, America, the Association's public outreach program, was introduced to the profession at the annual session in Honolulu with a video presentation to the House of Delegates. Shortly thereafter, each ADA member received the 1990 Smile, America Dental Health Events Calendar and dental office program planning guide. Dental societies and related dental groups received a similar introductory mailing of material that also included a dental society program planning guide. A February (1990) Public Relations Conference focused on the campaign and drew more than 60 volunteers and dental society staff to Chicago in the city's worst blizzard in a decade. Each department in the Division has contributed to the campaign's success to date and each has ongoing responsibilities for future activities, including an extensive agenda of corporate-sponsored activities. Details can be found in the departments' individual reports.

The second major influence on Division activities during this reporting period has been significant media interest in the safety of fluoride and dental amalgam. Prompted by the early release of raw data from a federal research program, intense media interest in the safety of community water fluoridation continued through April. The Division implemented an extensive media relations campaign to manage this, and also developed and distributed informational materials for state and local dental societies and dental leadership to help them respond to local media inquiries. The cooperation and assistance of the Division of Scientific Affairs and the Council on Community Health, Hospital, Institutional and Medical Affairs in this effort is gratefully acknowledged.

In early 1990, the Division tracked growing media attention to the safety of dental amalgam; legislative staff indicates increased activity by amalgam opponents to direct media attention to the alleged toxicity of dental amalgam through efforts to legislate patient "right to know" laws. Once again the scientific and clinical expertise of the staff of the Division of Scientific Affairs has been most helpful in the development of materials to answer this challenge and their cooperation is gratefully acknowledged.

Department of Design Services

The Design Services Department provides creative consultation and project management to Association agencies in the design and production of print materials. Other department responsibilities include implementation and use of the Association logo; development of other trademarks and guidelines for their use, in cooperation with the Division of Legal Affairs; and the purchase of goods and services in support of print material production.

In the year covered by this report, the Department produced approximately 330 new, revised or reprinted projects and campaigns. Included in these figures are collateral material developed for seven campaigns, two corporate sponsored promotions, approximately 55 new and revised brochures, booklets and projects, six quarterly newsletters, 11 specialty items and support materials for five conferences.

Division of Communications Projects: Most of the projects initiated in the Division during the year were developed in support of the Smile, America campaign or were revised to incorporate the Smile, America logo. Design department staff worked with the Division of Legal Affairs to trademark the logo and develop guidelines for its use by corporate sponsors, constituents and component societies.

The Design Services and Professional Communications Departments developed and produced the "Dental Health Events Calendar" and planning guides for dental societies and dental offices. All elements were designed to generate visibility for the new campaign and included community activities and promotional ideas. The poster and the dental office planning guide were sent to all member dentists.

The society planning guide and the poster were also included in the Smile, America Starter Kit sent to 720 constituent and component societies, national dental organizations, dental school deans and American Student Dental Association (ASDA) representatives. Other kit materials were a fact sheet, feature story or speech, and the *ADA Catalog.*

Department staff worked with the Department of Professional Communications to produce *Word of Mouth,* the ADA employee newsletter; *Mouthpiece,* a quarterly patient newsletter; and other publications for dental societies. Design, layout and production coordination were also provided for the annual session daily newspaper, *The Daily Bulletin.*

With the Department of Public Information and Education the design staff developed a Smile, America information kit for potential corporate sponsors and materials for National Children's Dental Health Month (NCDHM) and National Senior Smile Week (NSSW). The corporate kit, sent to approximately 360 dental manufacturers in February 1990, included "Guidelines for Participation in the Smile, America Campaign" and "Guidelines for Corporate Sponsorship of Health Education Materials."

All materials developed for the two national promotions,

National Children's Dental Health Month and National Senior Smile Week, were revised, conceptually and visually. The Smile, America logo and new slogans were integrated into these promotions; additional information on these campaigns is outlined in the report of the Department of Public Information and Education.

Smile, America promotional items (buttons, balloons, stickers and recall cards) were developed and featured in the catalog and direct mail promotions.

Corporate Projects: The Department is responsible for the design and production of print materials produced for corporate sponsors and works with the Department of Public Information and Education to develop these materials. Information about projects currently in development can be found in that department's report.

Assistance to Association Agencies: The Department works extensively with other Association agencies to develop and design or revise materials on an ongoing basis. Materials produced this year include three publcations for the Division of Scientific Affairs: the *ADA Regulatory Compliance Manual,* detailing OSHA and EPA regulations affecting the dental office; *Infection Control in the Dental Environment*, a comprehensive video training course produced by the ADA and several government agencies; and *Safety and Infection Control,* the first in a series of scientific monographs.

Other projects include annual session materials developed for the Division of Conference and Meeting Services; a direct mail campaign to 150,000 members in response to proposed OSHA regulations in conjunction with the ADA's Washington office; "Membership Matters," an employee communication program for ADA staff; and the Young Dentist Recruitment Campaign, a three-part direct mail campaign. These last two were programs of the Department of Membership Services. Other materials developed for the Division of Marketing and Membership Services include the second ADA Seminar Catalog; *Connections*, a reference guide to the WATS line and ADA member services; and *In Brief*, a reference guide for dental students produced in cooperation with the American Student Dental Association. Two new publications in the "Risk Management" series, revised versions of two "Dental Practice Library" publications, and a promotional logo and repro sheets for the American Dental Assistants Association's Dental Assistant Recognition Week were produced for the Division of Dental Practice.

The Association utilizes desktop publishing (DTP) to develop some publication formats and reduce project costs. Six newsletters for Association agencies are currently produced using the in-house DTP system. Several larger projects, such as manuals and brochures, have been produced using outside desktop publishing services.

Salable Materials Program: Thirteen revised brochures or patient education charts, four new brochures and numerous print orders were produced during the year. The Department also works with the Salable Materials Program staff on product promotions and the *ADA Catalog.*

Ongoing Activities: The Department reviews requests to reproduce illustrations, photographs and educational materials copyrighted by the Association. Permission is granted when the manuscript content is consistent with Association policy and scientifically accurate. The Department also handles requests for the Association logo and guidelines for its use and works closely with the Division of Legal Affairs to develop and register promotional trademarks and slogans for other Association programs.

Department of Media and Audiovisual Services

The Department of Media and Audiovisual Services supervises the Association's national media relations activities and provides creative consultation and program development for Association audiovisual productions. Ongoing responsibilities include placement of dental stories and spokespersons with print and broadcast outlets; production of radio and television public service announcements and video news releases; publicity and media activities for annual session, the Smile, America campaign, National Children's Dental Health Month and National Senior Smile Week; and the management of the ADA Video Library and Association audiovisual projects.

Magazine and Newspaper Publicity: More than 220 major articles on dentistry in over 110 national publications resulted from Department contact with national newspapers and magazines and through distribution of Association news releases. Topics included pain and anxiety control, dental implants, AIDS, pediatric and geriatric dental care and dental education, among others.

Several major daily newspapers carried dental health articles. Periodontal disease, plaque-control products, fluoridation and tooth decay were covered in *USA Today*; stories on older adults and tooth decay, and amalgam appeared in the *Washington Post*; dental adhesives, sealants, implants and the ADA Seal of Acceptance were topics of stories in the *New York Times*; glass ionomers, computer imagery and infection control were covered in the *Chicago Tribune*; and the *Wall Street Journal* featured new technologic advances in clinical and technical areas.

Coverage in national consumer magazines also increased, including articles on sealants in *Reader's Digest*; an overview of the profession, advances in cosmetic dentistry and pediatric dental care in *Fortune*; dental care for cancer patients in *American Health*; tooth bleaching in *Business Week*; periodontal disease in *New Woman*; cosmetic dentistry, dental implants, prevention, dental needs of pregnant women and nutrition in *Better Homes & Gardens*; the benefits of fluoride to older adults in the *Saturday Evening Post*; new techniques in *Gentlemen's Quarterly*; fluoride and infants in *Parade*; dental emergencies in *Parenting*; fluoride and tooth decay in *Family Circle*; and antiplaque products in *Consumer Reports*. The Association's combined print placements reached more than 145 million people in 1989-90.

In addition, the Association staff developed editorial copy for several national magazine supplements promoting dentistry and dental health. The November 1989 issue of

Vista, a national newspaper insert reaching 1.6 million Hispanic readers in 35 cities, carried a dental health supplement entitled "Brushing Up on Your Smile." The November 1989 issue of *U.S. News & World Report* (circulation 2.6 million) included the dental health supplement entitled "National Dental Check-Up." Ten thousand complimentary issues of the magazine were distributed at the Honolulu annual session, and an additional 50,000 reprints were made available to the ADA for distribution to the membership. The February 1989 *Ladies' Home Journal* (circulation 5.1 million) carried a dental health article on fluoride for children developed with input from ADA staff.

National Broadcast Publicity: Highlights of national broadcast coverage during the past year included an appearance by Dr. Arthur Dugoni on the NBC-TV *Today Show* discussing the role of the ADA Seal of Acceptance in consumer selection of anti-plaque products. NBC-TV's *On-Line* did a segment on the benefits of sealants, and the ABC-TV *Home Show* aired several segments with ADA Consumer Advisor Dr. Christine Dumas on the basics of diet and dental health, healthy Halloween snacks, new dental technologies and periodontal disease. ABC-TV's *The Health Show* also aired a segment on periodontal disease, and in February ADA Consumer Advisor and Trustee Dr. Heber Simmons, Jr., appeared on ABC-TV's *Good Morning America* to discuss dental care for children. ABC-TV's *World News Tonight* featured a segment on the oral health hazards of removing fluoride from community water supplies with ADA assistant executive director for scientific affairs, Dr. Enid Neidle.

CBS Evening News with Dan Rather aired a segment on the preliminary data from the National Toxicology Program (NTP) fluoridation study featuring Dr. Neidle. Financial News Network featured the ADA's position on the safety of amalgam, Cable News Network aired reports on the CAD/CAM, Sjogren's Syndrome (dry mouth), dental implants, dental school closings and adults wearing braces. *MediNews Television* taped a segment on the importance of dental care for patients with serious medical conditions. This segment, generated by an ADA press release, featured Dr. Dumas and was distributed to 90 ABC affiliates across the country.

On national radio, *Paul Harvey News*, a daily feature of ABC radio, broadcast reports on the future of dental school enrollments and on the positive state of the profession. CBS Network Radio broadcast a "Your Dollars" report by Marshall Loeb, managing editor of *Fortune* magazine, on the status of the profession, the benefits of fluoridation and sealants, procedures used in cosmetic dentistry and the problems of gum disease and root decay for older Americans. Based on an article in the September 11 issue of *Fortune* magazine in which Dr. Dugoni was featured, the story aired twice to an estimated audience of 500,000 listeners nationwide.

The combined audience reach for all network and nationally syndicated television and radio programs was an estimated 470 million people.

Annual Session Publicity: Media activities for the 130th Annual Session included press kit distribution to almost 300 print, broadcast and wire service outlets nationwide. On-site visits to Honolulu TV and radio stations, newspapers and magazines to distribute the press kit and encourage coverage resulted in more than 15 interviews by Honolulu newspapers, radio and TV stations. Topics included new technology, computer imaging and ADA policy on dentists treating HIV-infected patients. Pretaped radio interviews with annual session scientific presenters were broadcast by more than 830 national and regional stations, reaching an estimated 20.4 million people. During session, news releases based on scientific and educational sessions were distributed via the PR Newswire to 1,200 newsrooms nationwide.

USA Today covered the session with stories on new developments in periodontal disease detection and treatment, and anesthetics. Other national media coverage included an article in the *Wall Street Journal* and a segment on ABC-TV's *Home Show* on new technologies in dental care.

Assistance to Association Agencies: The Department provided video consulting and production services for ADA projects, including a 25-minute video on *Management Techniques for Endodontics Procedure*, part of the Council on Insurance Risk Management Series, and a film on dental care for seniors entitled *Keeping Your Smile a Lifetime*. A 30-second television public service announcement (PSA) for National Children's Dental Health Month, released to 650 stations nationwide, featured magician Harry Blackstone, Jr., on the protection of sealants. For the first time, the dental message was distributed to 117 cable networks across the country and fed via satellite to approximately 600 additional stations through a special news service known as the PSA Channel. For National Senior Smile Week, the Department produced a 30-second TV PSA featuring actor Cliff Robertson, on periodontal disease.

The Department also produced two synchronized slide-audio tape presentations on the hazards of smokeless tobacco, one set directed to adults and coaches and one for teens. Both are available through the *ADA Catalog*. In addition, various speaker support slides were produced for the Division of Membership and Marketing Services.

The Department also coordinated and produced several audiovisual presentations featured at annual session. These included eight video transcripts of selected scientific programs for the Council on ADA Sessions and International Relations, a 3-minute multi-image slide presentation for the Golden Apple Awards for the Department of Dental Society Services, speaker support slides for the Office of Finance and Business Affairs, and a 3-minute video promoting the Smile, America campaign.

Work in progress includes an animated film on a child's visit to the dentist, video programs on esthetic dentistry and implants, a public service announcement on mouthgards and another in the risk management series on the subject of prosthetics.

Video News Releases (VNRs): Prompted by a cover story in the August issue of *Consumer Reports* on dental plaque control products, a 2-minute VNR recommending consumers use the ADA Seal of Acceptance as their guide to product selection was transmitted to TV stations across the country in July 1989. In addition, ADA President Dr. Arthur Dugoni and secretary of the Council on Dental

Therapeutics, Dr. Kenneth Burrell, participated in a live, satellite media tour to 17 major cities. The VNR explained mechanical and chemical means of plaque reduction and encouraged consumers to look for the ADA Seal when choosing an antiplaque product. The project was funded by Warner Lambert. Interviews were also conducted with the Cable News Network and NBC-TV's *The Today Show.* The VNR, distributed to 264 stations, and the satellite media tour reached a total audience of 11.5 million viewers.

A satellite media tour on the benefits of sealants was conducted in conjunction with the forty-first celebration of NCDHM. Broadcast via satellite from Chicago, the live, 3-hour telecast reached TV outlets across the country and featured ADA Consumer Advisor and Fifth District Trustee Dr. Heber Simmons, Jr., and Acting Director of Research at the University of North Carolina School of Dentistry Dr. James W. Bawden. Portions of the tour interviews were edited, combined with sealant video footage and distributed via satellite the following day to approximately 700 stations nationwide for broadcast within local newscasts as a VNR. The VNR encouraged viewers to call a toll-free number to request an ADA brochure on sealants; Johnson & Johnson handled the fulfillment. The tour and video footage reached an estimated audience of 2.7 million viewers, and was underwritten by Johnson & Johnson.

In May 1990, a VNR on dentures was distributed as part of the Association's National Senior Smile Week promotion. The 2-minute video news release highlighted the need for denture wearers to have regular dental check-ups. The VNR contained interviews with ADA President Dr. R. Malcolm Overbey and denture wearers and was distributed to almost 700 TV stations. A press release dispelling the myths about dentures and recommending proper maintenance procedures was mailed as part of the NSSW press kit to approximately 250 print and broadcast outlets across the country; the release was also distributed to *Modern Maturity, Mature Outlook, Golden Years* and newspapers in cities with large senior populations. A prepared newspaper column was released through a distribution service to 3,800 suburban newspapers, including 1,000 dailies. The denture project was funded by Dentsply.

ADA Video Library: The ADA Video Library rents films, videotapes and slide sets to members and other dental professionals nationwide. The inventory includes clinical education videos for the profession and programs suitable for public audiences. More than 350 titles are available for rent at a nominal fee; the ADA Video Library catalog is available to all members.

ADA Video Continuing Education: The Association now has 14 video transcripts for sale to its members. Subjects include *Amalgam Restorative Dentistry, Current Concepts in Endodontic Therapy, The Art of Handling Ceramometal Failures, Current Concepts in Conservative Esthetic Bonding* and *Adhesion Monomers for Luting and Porcelain Repair* from scientific programs presented at the 129th and 130th Annual Sessions.

The Association's dental health films also are available on a rental basis in Canada, and contractual agreement with a British firm allows the reproduction and distribution of 11 selected educational films to nontheatrical audiences in the United Kingdom.

From April 1, 1989 to March 31, 1990, a total of 3,606 films and tapes were shipped from the rental library. Although the number of copies available for most popular titles was increased, 534 requests for rentals could not be accommodated because of excess demand.

Department of Professional Communications

The Department provides editorial assistance, communications counseling and public relations support to other agencies and senior staff of the Association, to state and local dental societies, to dental editors and to related groups.

Assistance to Association Agencies: The Department works extensively with other Association agencies in the development, writing, editing and production of various materials to assure that the ADA's internal and external communications accurately reflect organized dentistry's goals and positions.

The Department worked with the Division of Dental Practice in the review and development of current and future publications in the ADA's Success Library and developed editorial and support materials for the Smile, America campaign.

The Department prepares an annual speech kit for the use of Officers and Trustees with modules addressing topics of key professional impact. Department staff also provides individual speech-writing assistance to the President, President-elect and Executive Director on request, and work closely with the Office of the Executive Director in the preparation of Board and House reports. Department staff also provides training and briefing sessions for staff, Officers, Trustees and allied dental organizations.

Word of Mouth: The Department is responsible for publication of the employee newsletter, *Word of Mouth,* which is distributed bimonthly to all Association employees and provides news about ADA policies, staff activities and articles of employee interest.

In support of the annual session, the Department works closely with the Division of Conferences and Meeting Services and the Council on ADA Sessions and International Relations in the development of meeting materials and publicity; during the meeting, the Department produced four issues of the *ADA Daily Bulletin,* a daily publication covering the activities of the meeting. The 1989 *Bulletin* generated in excess of $120,000 in advertising revenue for the Association at the Honolulu meeting and the efforts of the Department of Advertising Sales are gratefully acknowledged.

Services and Programs for Dental Societies: The Department conducts spokesperson training seminars annually for state and local dental societies on a cost-shared

basis. In 1989-90, training sessions were conducted or are scheduled for the Montana Dental Association, Oklahoma Dental Association, Maryland State Dental Association, the Chicago Dental Society, the American Academy of Pediatric Dentists and the Pediatric Dentists of Florida. Training requests are pending for Connecticut Dental Association, the American Academy of Periodontology, the American Student Dental Association, the Academy of General Dentistry, Rhode Island Dental Association and the ADA Commission on the Young Professional. The sessions, conducted by staff members and professional trainers, include instruction and on-camera experience in media interviews and public speaking, and practical advice on media relations strategy and placement.

One-day public relations workshops provide training and program planning assistance to public relations volunteers and dental society staff members and are available on request to dental societies wishing to strengthen the expertise of their volunteers in this area. In 1990, Department staff also made presentations at the Texas Dental Association's annual meeting and the Auxiliary to the American Dental Association's Dental Health Education Leadership meeting in Wichita.

In 1990, the Department sponsored a two-day public relations conference at ADA Headquarters. More than 60 people registered for the meeting, which focused on the Smile, America program, related materials and outreach opportunities. Given the attendees' enthusiastic response to the conference, another will be scheduled in 1992.

A new activity in 1990 was the introduction of a monthly media materials service for state and local dental societies. A collection of newspaper columns, press releases, tip sheets and other materials for personalization cover dental topics tied to themes and events in the Smile, America Dental Health Calendar.

Other services for dental societies include dental health newspaper columns, a dental public relations manual for staff and volunteers and a Speakers Bureau Kit, to assist societies implementing an outreach program utilizing dental speakers for community groups. In 1990, the Department inaugurated two new communications vehicles for society staff and volunteers: "Smile, America Newsline" is published on an as-needed basis to advise all tiers of organized dentistry of developments in the Association's public outreach campaign. A quarterly newsletter, "Impressions," covers dental public relations activities and case studies of constituent and component outreach efforts.

Assistance to Dental Editors: The Department serves as the primary resource for dental editors in the U.S. Services and programs provided to dental editors allow the Association to broaden its distribution of information about the ADA and various issues affecting dentistry in this country.

In December 1989, the *ADA Editors List* was updated and distributed to approximately 1,000 dental editors in the U.S. and Canada. Maintenance of this list allows the ADA to stay in contact with virtually every dental publication on the North American continent.

A monthly mailing of materials appropriate for inclusion in dental publications reaches approximately 600 dental editors through the *ADA Update for Dental Editors.* Contents include editorials, news items and press releases. In 1989-90 clinical abstracts were deleted in response to results of a reader survey; press releases on research topics are now provided by the Princeton Dental Research Center, whose assistance is gratefully acknowledged. Department staff scan approximately 200 dental periodicals a month; continuous reprinting of *Update* materials indicates this service is highly valued by the editors at all levels of organized dentistry.

Dental editors continue to utilize the Department's publication critique service; the Department offers a dozen critiques a year, using the services of an independent consultant. Critiques include an audiotaped, one-hour commentary on content, style and design, and copies of the publication are annotated to illustrate suggested revisions and changes.

Publications for editors are distributed to new editors as they are identified, on request and at ADA-sponsored editorial workshops; these include *Brighter Writing for Dentistry, Publishing the Professional Journal or Newsletter* and a clip art book of illustrations for reproduction.

The Department sponsored two seminars for dental editors in 1990. In June, a two-day seminar for editors with advanced skills was held in Colorado Springs. In September, the Department hosted the annual ADA/ICD journalism workshop for new editors at ADA Headquarters. Faculty for the program are drawn from the prestigious Medill School of Journalism at Northwestern University in Evanston, Illinois, and the seminar is partially supported by a grant from the U.S. Section of the International College of Dentists.

In addition, Department staff presented an editorial workshop for auxiliary editors at the AADA Dental Health Education Conference in Wichita, Kansas. The profession shows a continuing level of interest in regional workshops, as well as the university-taught seminars.

American Association of Dental Editors (AADE): The Department of Professional Communications maintains a close working relationship with the AADE. Copies of the annual AADE journal and membership information are distributed through the *Update for Dental Editors.* Cooperative program management such as this assists the editors, the Association and the AADE.

Dental Health Promotion: The Association's quarterly patient newsletter for publication by dental offices, *Mouthpiece*, is written and produced by Department staff. The newsletter provides educational and motivational material for dental patients.

Interprofessional Relations: Department staff annually coordinates material for publication of a special July issue of *Pharmacy Times* featuring dentistry and dental health.

Department of Public Information and Education

National Children's Dental Health Month: The 1990 National Children's Dental Health Month (NCDHM)

marked the 41st annual celebration of the campaign, and the slogan, "Smile, America: There's Magic In Your Smile," kicked off the new ADA Smile, America campaign. Over 850,000 full-size posters with a dental theme and featuring dental facts were distributed to state and local dental societies nationwide. In October, each member dentist received a free poster in a promotional mailing.

To assist state and local NCDHM campaign planners, 4,000 free program planning kits were distributed. These included program ideas, publicity guidelines, presentation aids, resources and camera-ready reproduction sheets featuring games and information for use as handouts for children. For the 1990 campaign, two new activity sheets were developed. Produced in cooperation with the Department of Media and Audiovisual Services, an NCDHM television PSA, "The Magic of Sealants," featured magician Harry Blackstone, Jr., and was accepted by the ABC and CBS television networks for broadcast to approximately 600 stations nationwide; the spot was also distributed to 117 cable stations. In addition, radio versions of the PSA were sent to 3,000 radio stations across the nation. A station usage survey indicated that 81% of the responding television stations and 97% of the cable stations used the PSA, while approximately 89% of the radio stations responding aired the spot. In September 1990, the television spot will be made available with local tag lines to constituent and component societies for re-release to stations in their areas.

National Senior Smile Week: The fourth National Senior Smile Week campaign, held May 13-19, 1990 marked its first observance under the new Smile, America umbrella theme. Featuring the slogan, "Smile, America: A Healthy Smile is Ageless," NSSW offered state and local program planners all new materials, including a revised planning kit, press releases, feature articles, program ideas and reproducible artwork. Each state and local dental society and dental auxiliary also received a complimentary supply of NSSW posters and brochures for distribution to senior centers and nursing homes.

New to this year's NSSW program was a promotional mailing to every dental office in the country offering program planning tips for the office and the community and including a list of appropriate support materials. A television PSA entitled "Save Your Smile," featuring Academy Award-winning actor Cliff Robertson was developed for NSSW. The 30-second spot was accepted for broadcast by the ABC and CBS television networks and three versions of the PSA were distributed to 3,000 radio stations throughout the country. "Save Your Smile" will be made available to state and local dental societies for localization by January 1991.

TV/Radio Public Service Announcements: Noncampaign-specific public service announcements produced by the American Dental Association continue to be well-received by both television and radio public service programmers. Station usage reports indicate consistent utilization of the ADA's dental health spots.

The 1990 celebrity radio PSA series was sent to 3,000 stations in mid-April. Personalities included Dom DeLuise, Dixie Carter, Michael Landon and Judd Hirsch speaking on topics ranging from periodontal disease to dental sealants. Three Spanish PSAs were recorded by actor Edward James Olmos and actress Maria Conchita Alonso and mailed to 225 Spanish-speaking stations. The topics were brushing and flossing, baby bottle tooth decay and periodontal disease.

Film Distribution Program: The Association-sponsored distribution of dental health education films and videos is a highly effective way to reach television and theatrical audiences, as well as school and adult community groups. In early 1990, the ADA released "Keeping Your Smile a Lifetime," focusing on the lifestyle and oral health needs of today's older adult. The film highlights oral health care options for seniors and emphasizes the importance of daily oral hygiene and regular dental check-ups. Making this dental health material available through the film distribution program allows the ADA Video (rental) Library to devote a major part of its resources to technical and continuing education subjects for professional audiences.

A report of the film distribution program, made possible by the Association through the services of Modern Talking Picture Services, Inc., is indicated in the following summaries in Tables 1, 2 and 3 on page 22.

Complimentary Materials: The Department fulfills requests for information from patients, educators, students, health organizations, dental professionals and health-related industries. Telephone contacts average 600-775 calls per month and written correspondence exceeds 1,100 requests monthly. Consumer inquiries cover virtually all dental subjects; topics of recent interest include infection control, periodontal disease, peer review, choosing a dentist, implants, amalgam and children's dental health. Requests from educators and health professionals concern basic dental education in the areas of functions of teeth, restorations, periodontal diseases, baby bottle tooth decay and diet and dental health.

Printed Materials Program: A total of 12 health education brochures and statement stuffers have been developed, revised or updated since May 1989. Topics covered include bleaching, third molars, professional cleanings, children's dental activities book, children's oral hygiene book, gingivitis, x-rays, endodontics and a series of materials printed in Spanish on gum disease, baby bottle tooth decay and basic oral hygiene.

Community Outreach Activities: The Department also counsels dental societies, individual practitioners, institutions and health organizations regarding community outreach programs. Inquiries come from groups such as schools, hospitals, health fairs, employers, museums and associations.

Dental Health Education Statement: On request, the Department reviews articles, books, scripts and other materials produced by outside sources. Staff of the Division of Scientific Affairs assist in reviewing scientific information and their cooperation is gratefully acknowledged.

In early 1990, the Department consulted with the National Dairy Council in the development of "That's A Mouthful," a brochure on snacking and dental health.

Table 1

AMERICAN DENTAL ASSOCIATION
NON-THEATRICAL PERFORMANCE (SCHOOL AND LAY AUDIENCES)
4/1/89 - 3/31/90

TITLE	BOOKINGS	SHOWINGS	AUDIENCE
A WORD TO THE WISE	3,000	3,617	99,918
THE BEST IS YET TO BE[a]	175	318	8,605
MERLIN'S MAGICAL MESSAGE	2,821	4,837	160,899
THE MUNCHERS: A FABLE	3,180	5,977	203,721
TOOTHBRUSHING WITH CHARLIE BROWN	4,516	6,961	224,537
PORTRAIT OF THE ENEMY[a]	167	378	13,293
OPTIONS: DENTAL HEALTH IN THE LATER YEARS[a]	623	991	21,782
SOME CHILDREN NEED SPECIAL CARE[a]	18	19	440
FLOSSING WITH CHARLIE BROWN	5,085	8,487	288,502
BARNYARD SNACKER[a]	367	566	22,611
FLASH THAT SMILE[a]	287	570	17,429
TOOTHBRUSHING[a]	92	178	6,827
FLOSSING[a]	105	203	7,239
SMOKELESS TOBACCO (CHECK IT OUT!)	8,575	16,024	485,291
FLUORIDATION: THE FACTS	2,777	3,986	112,120
THE HAUNTED MOUTH[b]	6,670	13,226	458,701
KEEPING YOUR SMILE A LIFETIME[c]	62	95	2,300
TOTALS	38,520	66,433	2,134,215

[a]These titles are no longer in circulation.
[b]Includes closed captioned videocassette showings.
[c]New title added in 1990.
17 titles - 2,144 films and videos.

Table 2

AMERICAN DENTAL ASSOCIATION
PSA PERFORMANCE VIA SATELLITE
4/1/89 - 3/31/90

TITLE	TOTAL TRANSMISSIONS	TOTAL PLAYS	TOTAL POTENTIAL HOMES (000)
SMOKELESS TOBACCO	20	24,000	360,000
NURSING BOTTLE MOUTH	24	28,800	432,000
GRAVEYARD OF NEGLECT	25	30,000	450,000
PAINT ON PROTECTION	26	31,200	468,000
SOLEIL: CHILDREN'S DENTAL HEALTH	20	24,000	360,000
TEETH CAN LAST A LIFETIME	25	30,000	450,000
WISDOM OF YOUTH	25	30,000	450,000
TOTAL	165	198,000	2,970,000

The following short videos were booked as cameos at the PSA rate.

TITLE	TOTAL TRANSMISSIONS	TOTAL PLAYS	TOTAL POTENTIAL HOMES (000)
FLOSSING	13	15,600	234,000
SEALANTS	9	10,800	162,000
BONDING	14	16,800	252,000
TOOTHBRUSHING	9	10,800	162,000
TOTAL	45	54,000	810,000

Each satellite transmission realizes approximately 1,200 systems with a cumulative audience base of over 18 million households.

Table 3

AMERICAN DENTAL ASSOCIATION
TELEVISION PERFORMANCE
4/1/89 - 3/31/90

TITLE	TELECASTS	ESTIMATED AUDIENCE
THE HAUNTED MOUTH[ab]	49	362,233
SMOKELESS TOBACCO (CHECK IT OUT!)	4,605	7,315,780
KEEPING YOUR SMILE A LIFETIME[c]	1,200	1,980,000
TOTALS	5,854	9,658,013

[a]This title is no longer in television circulation.
[b]Includes closed captioned telecasts.
[c]New title added in 1990.

Totals include broadcast, cable and satellite to cable and closed captioned telecasts.

Foreign Requests: In cooperation with the Council on ADA Sessions and International Relations, the Department provided information on dental health materials and resources in response to inquiries from Saudi Arabia, Israel, Mexico, Australia, Canada, New Zealand, Ireland, Brazil, Zambia and Spain.

Corporate Projects

Denture Awareness Program: With the generous support of Dentsply, the ADA sponsored a consumer/professional denture awareness program in conjunction with National Senior Smile Week in May. Project components included a video news release, press release and consumer brochure emphasizing the need for regular dental check-ups and denture maintenance for the long-term denture wearer. A direct mail campaign to 75,000 dentists offered complimentary copies of the brochure.

Sealant Promotion: In conjunction with National Children's Dental Health Month, a satellite media tour focused on the benefits of dental sealants. Broadcast via satellite from Chicago, the live, three-hour telecast was a cooperative effort with Johnson & Johnson, and was followed by a direct mail promotion to 15,000 pediatric dentists and general dentists with large pediatric practices.

Readers' Digest Insert: In May 1990, the ADA and Chesebrough-Pond's cooperatively produced an insert in Readers' Digest, (circulation 16.3 million) as part of the "Full Life" Program of the American Academy of Family Physicians. Editorial material focused on oral hygiene and the importance of regular professional care. A copy of the issue was sent to 65,000 ADA-member dentists.

Save the Children Project: This family-centered oral health and dental education program targeted 25,000 underprivileged children in the United States. A collaborative effort of Proctor & Gamble (P&G), the ADA and Save the Children, the program recognized the thirtieth anniversary of Crest toothpaste's acceptance under the ADA Seal Program, and can generate a redemption donation by Crest to Save the Children, up to $250,000. The promotion was featured in free-standing coupon inserts, national print ads and in-store displays.

"Dental Outlook" Brochure: The Division collaborated with Proctor & Gamble on a second "Dental Outlook" brochure distributed through Whittle Communications to more than 30,000 dental offices nationwide. The booklet, entitled "Making Your Smile a Winner: Tips for Teens," fits the pamphlet racks Whittle provides for dental reception areas and was distributed in July.

Salable Materials Program

Background: The Salable Material Program produces and sells professional, patient education and school-related print

and audiovisual materials. Program objectives include enhanced public knowledge and understanding of dental health, provision of key reference materials to the dental profession, development and marketing of products to support practicing dentists, and generation of nondues revenue.

1989 Sales Analysis: Revenue from the sale of materials in all product categories exceeded $2.9 million in 1989. Among the most profitable items were: *Infection Control in the Dental Environment* video package; *Periodontal Disease: Don't Wait 'Til It Hurts; The Chairside Instructor; 1989 American Dental Directory; The Index to Dental Literature;* and the 1990 Single and Double-Column Appointment Books. Additionally, the market showed increased activity in practice management publications with the introduction of the first three volumes of the Council on Dental Practice's new "Success Library": *The Successful Dental Practice: An Introduction, Building Successful Associateships,* and *Successful Valuation of a Dental Practice.*

ADA Catalog: The Association's most visible and profitable promotional activity is the annual *ADA Catalog,* listing more than 250 products. Nearly 195,000 copies of the catalog are mailed annually to members of the ADA, American Dental Hygienists Associaton, American Student Dental Association, constituent and component dental societies, affiliated organizations, foreign dental groups and other interested parties. The catalog is also distributed at the major dental meetings at which the Association exhibits. In a test marketing effort to expand the customer base to include the educational market, approximately 20,000 catalogs were mailed to elementary level educators in January.

For 1990, the catalog was reorganized to add emphasis to seven main product catagories: infection control, patient education, community education, office records, plaques and posters, professional books and audiovisual materials. Product category color coding in each main section allowed improved product location and selection and forty-four products highlighted in the 1990 catalog are new, revised or best sellers. A mailing date of September is anticipated for the new 1990-91 catalog. Expanded distribution of the catalog is planned to test frequency mailing response.

Exhibit Program: The ADA's exhibit program is displayed at selected national, regional and state dental meetings throughout the year to increase the ADA's visibility to the membership and dental community and to evaluate product and purchasing trends. During the period covered by this report, the meetings included: Yankee Dental Congress (Boston); Chicago Mid-Winter Dental Meeting (Chicago); Hinman Dental Meeting (Atlanta); California Spring Scientific Session (Anaheim); ADA Annual Session in Honolulu; and the Greater New York Dental Meeting (New York City). In 1990, the exhibit schedule will add a meeting in Canada each year. The total number of dentists reached through this exhibit program exceeds 55,000 per year.

A table display of school curriculum material was provided at the American School Health Association's annual convention to develop additional audiences for this material. This meeting offers access to key decision makers and health care providers in the field of school health.

Direct Mail Promotion Activities: Throughout the year, direct mail promotions highlight new or revised products and products targeted to specific audiences. Major direct mail promotions from April 1989 through April 1990 included: National Children's Dental Health Month material; National Senior Smile Week material; ADA Appointment Books; ADA Directory, Infection Control Video/Manual; Regulatory Compliance Manual and infection control resources; cosmetic dentistry brochures; ADA membership plaque; and ADA medical history and insurance claims processing forms.

Other Cooperative Ventures: To increase member awareness of ADA products, several cooperative ventures included an ad in *Special Care In Dentistry* to support the introduction of ADA's new protocol series for medically compromised patients; an exhibit and product display at the February 1990 Public Relations Conference featuring Smile, America materials; a mailing to fifteen national dental organizations announcing the availability of the *Infection Control In the Dental Environment* video package, jointly developed by the Department of Veteran Affairs, the Department of Health and Human Services, and the ADA; brochure mailing on "Seal Out Decay" in cooperation with Johnson & Johnson to 15,000 pediatric dentists and dentists with large pediatric practices; and wholesale distribution of ADA products to the Anatomical Chart Company and National Biological Laboratories.

Product Development: New or revised products produced include: *Brighten Your Smile With Bleaching; Ask Your Dentist About Veneers; Facts About AIDS for the Dental Team; Infection Control in the Dental Environment* video package; the *ADA Regulatory Compliance Manual; Safety and Infection Control Monograph; Baby Bottle Tooth Decay;* smokeless tobacco slide sets; Smile, America promotional items; NCDHM promotional items; *Referral to a Dental Specialist;* and a recall card series.

Products planned in 1990 include four new publications in the Council on Dental Practice Success Library; scientific monographs on dental restorative materials and pain and anxiety control; a manual on current dental terminology relating to claims processing; a new children's video and workbook featuring "Dudley the Dinosaur"; and patient education brochures on implants, third molar extractions, and orthodontics. A new mini-series of patient education brochures in Spanish is also planned.

Research/Evaluation: Advisory committees of ADA-member dentists in private practice who regularly purchase ADA catalog material convened in August and December 1989 at the Headquarters Building. The objective of these meetings was to solicit feedback from frequent buyers for upcoming publication revisions and new product development. The meetings provided valuable input, particularly in the area of patient education materials. In 1990, increased marketing research through survey mailings

and split promotional testing will take place and an additional advisory group will convene in the fall.

Order and Subscription Activity: A new computerized order entry system was implemented in September 1989 that allows quick and efficient inquiries by customer name or invoice number. It will also permit the Association to learn more about the buyers of ADA products and services, monitor outstanding debt and coordinate information into one general system. In 1989, use of the WATS lines for ordering and use of credit cards for payment continued to grow. In the month of February, during the observance of National Children's Dental Health Month, over 8,500 telephone calls were handled.

The Department also processes subscriptions and renewals for all Association periodicals. Subscription levels for 1989-90 are listed as follows:

Title	Subscribers
The Journal of The American Dental Association (Life Members)	4,956
The Journal of The American Dental Association (Other)	5,270
ADA News	615
Mouthpiece (patient newsletter)	448
Index to Dental Literature	1,042
*Dynamic Dental Strategies**	430

*Discontinued publication in March 1990.

Two periodicals previously handled by the Association were transferred to new publishers in 1989; *Dental Abstracts* was sold to Mosby-Yearbook Publishers, and *Special Care in Dentistry* is now produced by the Federation of Special Care Organizations in Dentistry.

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

Bureau of Library Services

Kowitz, Aletha A., director and librarian
Schultz, Ruth D., assistant director

The general collection, package library collection, archives collection and historical collection continue to grow with acquisition of materials by purchase, gift or exchange.

Cancellations, delinquencies of publication, and cessation of publication resulted in deletion of 14 titles during this year while 63 serial titles were added resulting in a net gain of 49.

The card catalog has been maintained again in state-of-the-art form by use of the OCLC on-line data base for cataloging and card production. Technical services staff are saved many hours of repetitive typing and proof-reading by this data base.

The mail continues to bring some requests for information or material to the Bureau, but the bulk of the requests come by the WATS line. In order to speed service when time is critical, the Bureau acquired a FAX terminal early in 1990. FAX service is new enough that statistics on its use are not available but will be reported for the next fiscal year.This new service was publicized in the *ADA News*.

Service Activities: These activities are summarized in Table 1. For the fourth year in a row, the circulation of books, journals and package libraries to Bureau users has decreased appreciably—this year in the amount of 21%. This apparently reflects the decreasing numbers of foreign dentists, dental students, dental hygiene students, dental assisting students, and more importantly, the amount of reading being done by dentists, and partly due to the decreasing numbers of dental books being published. This decrease is also reflected in fewer books being purchased by members. Reserve lists are being maintained at the four month level because of the economics of book and periodical prices. Despite the decrease in the numbers of requests, the amount of copying has changed less than 1%. All copying still is done within the U.S. Copyright Law of 1976.

It should be noted, however, that the reference questions which are presented to Bureau staff continue to increase in difficulty, requiring much knowledge of not only dentistry, but also related health fields. This change means that Bureau functions are becoming more information oriented and more time and knowledge are required per request than in the past.

Interlibrary Projects: Memberships are maintained by the Bureau in the John Crerar Library, OCLC Network, the Chicago Library System (a network of public, academic and special libraries in the Chicago Metropolitan area), the Illinois Library and Information Network (ILLINET), the

Table 1

Comparison of 1988-89 and 1989-90 Circulation Figures, Service Fees and Book Sales.

		1988-1989	1989-1990			1988-1989	1989-1990
Books	Mail	3,894	2,713	Microfilms	Mail	0	0
	Local	1,719	1,383		Local	0	0
Journals	Mail	1,293	1,035	Renewals	Books	504	628
	Local	754	669		Journals	58	34
					Packages	89	79
Package Libraries	Mail	2,107	1,494	Reserves	Books	1,905	2,076
	Local	318	186		Journals	71	255
					Packages	13	145
Interlibrary Loans:				Overdues	Books	2,645	2,082
(Outgoing)	Books	10	35		Journals	69	374
	Journals	611[1]	408[3]		Packages	805	797
Interlibrary Loans:							
(Incoming)	Books	7	11[4]	Copies Ordered:	Mail	11,286	11,735
	Journals	24[2]	18		Local	447	188
					Complimentary	3,855	3,596
Service Fees:		$40,620.06	$41,563.04				
Book Sales:		3,968.65	2,465.65				

1 Includes 609 copies (4,193 pages).
2 Includes 24 copies (150 pages).
3 Includes 408 copies (2,898 pages).
4 Includes 18 copies (169 pages).

Greater Midwest Regional Medical Library Network (GMRMLN), and other cooperative activities are entered into when opportunities arise. The Bureau is one of the resource libraries for GMRMLN and the National Library of Medicine, and has its serial holdings listed in the DOCLINE and SERHOLD data bases for use by libraries around the world.

Book Lists: *Books and Package Libraries For Dentists*, an annual publication of the Bureau for about the last 40 years, is still one of the most popular items to be distributed by the Bureau. It is used to answer many reference questions and also to provide the reader with capsule information on the extent of the Bureau's collections. Four hundred eighteen copies were distributed by mail and hundreds of copies to persons using collections within the Bureau. Fifty-two copies of *Basic Dental Reference Works* were mailed in answer to specific requests.

Additions To The Collection was distributed to Headquarters staff and also to many libraries and individuals who use it for purchasing suggestions. The Publication Reviews Section, prepared by Bureau staff, of *The Journal Of The American Dental Association* appeared three times during the year.

Bureau Collections: Table 2 summarizes the current collections of the Bureau.

Table 2

Bureau Collections:		
Present Holdings	30,160	Books
	16,140	Bound Journals
	46,300	Accessioned items
Volumes added during year (including volumes received as gifts or on exchange)		
Volumes withdrawn	55	
Titles published outside U.S.	275	
Catalog cards prepared	3,937	
Volumes commercially bound	452	
Vertical File	885	folders
Microfilms	370	items
Periodicals received	1,194	titles
Newsletters included	283	titles
Subscriptions purchased	495	titles
Dental periodicals published abroad, 54 countries	382	titles

Indexing Services: The 1989 annual volume of the *Index To Dental Literature* was the 59th volume in the series, and the 25th produced in cooperation with the National Library of Medicine. It was the fourth issue for the year and appeared in print in February 1990. A total of 19,306 articles were included in the *Index* and were taken from periodicals in 41 languages for an increase of about 17.6% over last year. This increase reflects a full complement of experienced indexers working at top production for the major portion of the year. Volume indexes were also prepared for *The Journal Of The American Dental Association, Dental Abstracts, Special Care In Dentistry, Dental Teamwork,* and the *Transactions Of The American Dental Association.* The index for the *Digest Of Official Actions* was also prepared for the Executive Director's Office.

Archives: A total of about 2,000 titles (consisting of one or many items) was added to the various archival collections. Especially large amounts of material were received for, sorted, and added to the American Dental Association and American Association of Women Dentists collections. Thirty items added to the museum collection included dental instruments and equipment and art work. Many of the museum items were used for exhibit purposes in the Headquarters Building. A large number of requests for background information and/or information to be used in the preparation of formal papers and speeches were answered from the archives collection.

Gifts and Exchange Programs: Four hundred eighty-nine items were received as gifts to the Bureau collections, and many were presented to other libraries to assist them in filling gaps in their collections.

Other Staff Activities: Staff members participated in the activities of OCLC Conferences, the Society of American Archivists, MEDLINE and GRATEFUL MED search strategy clinics, the United States Archives Modern Archives Institute, the History Section of the Federation Dentaire Internationale, The Quintessenz Symposium in Berlin, and a number of continuing education courses. The Director continues to serve as Secretary-Treasurer of the American Academy of the History of Dentistry and as Circulation Manager of the *Bulletin Of The History Of Dentistry.* The Director also is the co-author of the book, *Dentistry On Stamps*, published early in 1990.

Fifteen visitors from eight foreign countries signed the guest book as did many other visitors from the United States. Some of the visitors were Association members and many were doing research in Association collections for papers, speeches, clinical dentistry and general information.

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

Division of Membership and Marketing Services

Perich, Paula J., assistant executive director
Branz, Kay A., director, Marketing and Seminar Services
Hoyt, Karen M., director, Membership Development and Services
Jarr, Paul W., director, Membership
Newton, Patricia M., director, Dental Society Services

Department of Marketing and Seminar Services

Introduction: The Department of Marketing and Seminar Services has two primary objectives: (1) to provide assistance to members who seek to market their practices in an efficient and ethical manner and (2) to offer quality continuing education seminars to components, constituents, specialty organizations and study groups.

Marketing Assistance: Committed to providing members with up-to-date information, the Department gathers data from multiple sources on the attitudes of dentists and consumers and provides analysis and planning based on this information. The Department assists members in understanding the dental marketplace, assessing the effectiveness of their present internal and external marketing efforts and developing cost-effective strategies and tactics to enhance practice visibility and increase patient referrals from staff, patients and other professionals. Information is made available to the membership through written materials, seminars and phone consultations.

Marketing Materials: When members call the Department of Marketing and Seminar Services on the toll-free line, they are invited to consult with Department staff. Depending on each member's needs, information packets on a variety of topics are available to members by mail at no charge. In response to numerous inquiries from members who have no specific request for information on a particular marketing topic but instead ask for a potpourri of material, the Department sends a "core marketing packet." This packet contains information on popular topics such as promotional ideas, guidelines for generating additional referrals, training scripts to improve telephone techniques and target marketing plans. Members are provided with the core marketing packet and other information based on the nature of the request, and they are invited to call back with questions after they receive the material in the mail.

The Department annually revises the manuals used in ADA marketing seminars. These revisions consist of a complete updating of all statistics, editing and reorganizing discursive material, identifying citations more clearly and writing new sections. To support ADA marketing seminars presented internationally, the Department customized the ADA seminar marketing manual for use in New Zealand, Great Britain and Sweden. Dental and consumer statistics are collected on each of these countries, and a section entitled "The Dental Marketplace" is written incorporating each country's statistics. This customized section is then appended to the U.S. version of the ADA marketing manual. In order to be consistent with revised and customized manuals, new slides are created each year. These slides contain the latest information, and are formatted in a consistent manner to produce a professional-looking presentation. Virtually all new slides are produced on in-house computers representing a 65% cost savings.

Market Research: Department staff conducts consumer research through the Gallup Organization's monthly omnibus surveys to determine motivation and utilization patterns for dental services. When the research is concluded at the end of 1990, reports summarizing the findings will be made available to the membership in 1991.

To guide development of marketing products and services for members, the Department conducted two practitioner surveys. The first completed survey investigated the health and lifestyle issues facing today's practitioner.

Stress—resulting from financial concerns, third party payers, and government regulations—and infection control were found to be the leading health concerns of today's dentist. In response to these identified health needs, a one-day seminar on stress management is being offered as part of the 1991 Seminar Series.

The second survey was conducted with members of Young Dentist Committees regarding the marketing challenges they faced in building their practices, and the tools they needed to help them better meet these opportunities. As of May 1990, the research findings indicated need for development of a marketing resource series to address the daily marketing needs of practitioners. Creation and promotion of these materials will occur by the end of 1990.

Presentations: Department staff assist the Council on Dental Practice by presenting the staffing and marketing sections of the OPTIONS program at 11 dental schools across the U.S. Department staff also presented lectures to dental students at Northwestern University and Marquette University at the request of the respective practice management faculty. In addition, Department staff prepared and presented a presentation entitled "The Age of the Grumpies" at Baylor College of Dentistry in April 1990. Marketing seminars are the most frequently booked programs of the ADA Seminar Series in 1990. Fifty-two presentations have been scheduled, accounting for nearly 50% of all the seminar programs given in 1990.

ADA Seminar Series: Since 1986, the Association has served as a seminar broker, approving and packaging seminars for sponsorship by state and local dental societies, study clubs and other dental organizations. The dental societies, in turn, make the seminars available to individual members by setting the date, place, time and registration fee.

Building on past success, the ADA Seminar Series has continued to expand. The number of dental society-sponsored seminars increased from 16 in 1986, to 81 in 1988, and then to 100 in 1990. An average of 50 members attend each seminar. In 1989, approximately 5,500 members attended ADA seminars. Also in 1989, the composite average evalution of all Association seminars by attendees was 4.7 on a 5 point scale. In terms of direct costs, the seminar program in 1989 was self supporting.

One of the most popular features of the seminar program is the availability of a ready-to-print brochure for the sponsor at no additional cost. This service is especially attractive to small societies that lack staff or sufficient budget to write and design their own brochures. Approximately 80% of sponsors avail themselves of this service.

With the aid of a grant from Colwell Systems, Inc. the ADA Seminar Series is able to make available the "Dental Practice Financing and Debt Management" and the "Do's and Don'ts of Associateships and Practice Valuation" seminars to eight dental society sponsors around the country at a reduced rate. Member dentists are able to attend these seminars at a nominal cost because of the corporate support. The corporate sponsorship affords universities the opportunity of sponsoring these seminars for their students and residents.

"The Team Approach to Periodontal Therapy" seminar adds a new clinical direction to the 1990 Seminar Series. This program, developed in cooperation with the American Academy of Periodontology, has been sponsored in eight locations around the country. With the aid of a grant from Chesebrough-Pond's, Inc., member dentists are able to attend this seminar at a reduced rate.

All seminar attendees receive spiral-bound books as an adjunct to the presentation. These materials are produced by the Department and shipped to each seminar location, providing a high quality, affordable workbook for use during and after the seminar.

Young professionals and specialists are two special target groups of the Seminar Series. Prior to all ADA seminars, sponsors are surveyed regarding projected audience characteristics. Speakers are advised when it is anticipated that young dentists will comprise a substantial portion of the audience and material relevant to their needs can then be stressed in the seminar. The Seminar Series served the needs of specialists by offering the course entitled "Professional Marketing for the Specialty Practice." This course has been customized for orthodontics, endodontics, periodontists, oral and maxillofacial surgeons and pediatric dentists.

In 1989-90, the Association offered the following seminar programs:

—Treating the Chemically Dependent Dental Patient
—The Team Approach to Periodontal Therapy
—Effective Marketing Without Advertising
—Help Wanted: Sound Solutions to the Personnel Shortage
—Just Say Yes: Increasing Treatment Acceptance
—Getting It Right the First Time: Communicating Effectively with Third-Party Payers
—Team Building Through Personality Profiles
—Planning Today for Tomorrow's Retirement
—Service with a Smile: Delivering Excellence in Dentistry
—Risk Management: Protect Yourself Against Malpractice
—Do's and Don'ts of Associateships and Practice Valuation
—Winning Financial Management Strategies for Dentists
—AIDS Update: What Every Dentist Should Know About Infection Control
—Beyond the Baby Boom: Target Marketing in the '90s
—Professional Marketing for the Specialty Practice
—Financial Planning for the Young Professional
—Dental Practice Financing and Debt Management
—Pros and Cons of Alternative Benefits Plans
—Smart Marketing: A Management Approach

The ADA Seminar Series is expected to continue its expansion of topics and program bookings in the year ahead.

Department of Membership Development and Services

Introduction: The Department of Membership Development and Services is engaged in implementing the activities related to the Association's Recruitment and Retention Business Plan. This plan was first implemented in 1987 (*Trans.*1986:472) after an analysis of member records revealed that membership market share had been declining by an average of 0.5% per year since 1980 and after comprehensive membership opinion research was conducted. Implementation of the second phase of the plan (1990-92) has begun and is based on the results of implementing the more than 100 strategies and tactics comprised in the plan's first three years as well as the results of the 1989 opinion research project.

The purpose of the strategies and tactics in the Recruitment and Retention Business Plan is to move the Association toward a more viable future by reversing the decline in membership market share while educating dentists on the value of membership. Target marketing serves as the backbone of the plan. Given the nature of the Association's tripartite structure, the majority of the Association's strategies involve providing the resources, materials and training for constituents and components to do an effective job in recruitment and retention.

1987-89 Business Plan Accomplishments and Market Share: The tactics of the Recruitment and Retention Business Plan have had mixed results. Market share increased by 0.6% in 1988, primarily due to success in faculty recruitment, young dentist recruitment and updating of the Association's data base. During 1989 the Association's national market share decreased by 0.5%. The Emphasis Program, however, which concentrates efforts at the local level, showed an average market share increase of

1.1% in the seven participating component societies during 1989.

The national market share decline is an improvement over decreases experienced since 1984, however, it falls below business plan expectations. Table 1 shows the Association's membership numbers, market share and market size since 1984.

Target Markets: Table 2 shows the results of the Association's recruitment and retention activities by the ten target groups currently tracked. Improvements can be seen in all but two of the target groups since 1987.

These results indicate that the Association's recruitment and retention efforts are producing some positive results in certain target markets.

Target markets are subgroups of the total national market (all U.S. dentists). It is important to note that a very small change (in hundreds) in either membership or market size in a target market can result in a seemingly large market share change. Conversely, a very significant fluctuation must occur (in the thousands) in the total national membership or national market to have an overall impact on the national market share. For example, only 68 additional members are needed to increase market share by one percent in the Federal Dental Services, whereas a total of 1,832 additional members are necessary to increase the national market share by one percent. Market size has changed most dramatically in the under 40 target group because the number of dentists turning 40 far exceeded the number of new graduates in 1989.

R&R Workshops: More than 50 workshops designed to teach proper planning and effective communication skills have been conducted for constituent and component dental societies.

Data Base Maintenance: In 1988, more than 2,500 records were suspended as a result of a major project to update nonmember records. A wealth of information was collected from a variety of sources. A major source of information was obtained from the returns of the *Distribution of Dentists Survey,* which was completed in 1988 for the first time in six years. This clean-up contributed significantly to the improvement in market share in 1988. The Association's records are more accurate than at any time in the past.

Maintaining an accurate data base is critical to recruitment and retention efforts. The addition or deletion of approximately 200 dentists to the data base affects market share by either plus or minus 0.1%. Again in 1989, substantial efforts were made to update the U.S. dentist masterfile. Major changes which impacted the masterfile were:

Table 1

National Market Share 1984-1989

National	1984	1985	1986	1987	1988	1989
Market Share	77.7%	76.8%	76.2%	75.5%	76.1%	75.6%
Membership	130,271	131,627	133,611	134,498	136,415	138,481
Total Market	167,630	171,471	175,242	178,072	179,142	183,179
Change from Prior Year		-0.9%	-0.6%	-0.7%	+0.6%	-0.5%

—1,068 dentists were deceased
—43,664 address changes were made
—3,475 dentists moved to another state
—821 newly licensed foreign trained dentists were added to the U.S. masterfile

Emphasis: The Emphasis Program represents the Association's major recruitment and retention success of the past three years. Begun in 1988, thirteen component dental societies have participated in the Association's pilot project to determine whether Association staff assistance at the component level can have a positive net effect on retention. In five of the first seven sites market share improved, sometimes dramatically. Although results vary by site, indications are that Emphasis can pay for itself within a year of implementation. Emphasis has proven itself a success in both numbers and in cost-effectiveness. Unlike the national market share decrease of 0.5%, the average overall market share change in the first seven Emphasis sites was a positive 1.1%, and young dentist market share had an average increase of 2.9%. New members recruited in the seven test sites almost doubled from 287 to 526. These increases generated more overall dues revenue than was invested in this program in a one-year period alone.

1989 Opinion Surveys: To update an understanding of Association members' needs and perceptions of Association services and activities, three separate questionnaires were developed and mailed in 1989: The 1989 *Membership Needs and Opinion Survey;* the 1989 *Past Member Opinion Survey;* and the 1989 *Nonmember Opinion Survey.* These surveys succeed the 1986 opinion survey series. Some selected results from the Membership Needs and Opinion Survey follow:

Table 2

1987/1989 Target Market Report
End of the Year Comparisons

	12/87	12/88	12/89	Change since 1987
National	75.5%	76%	75.6%	+ .1%
Members	134,498	136,415	138,481	+3,983
All	178,072	179,142	183,179	+5,107
Young Dentists	69.4%	70.4%	70.2%	+ .8%
Members	47,705	47,396	46,974	- 731
All	68,691	67,309	66,892	-1,799
Women	64.1%	65.9%	66%	+ 1.9%
Members	7,011	7,652	8,418	+1,407
All	10,947	11,607	12,749	+1,802
Faculty (All)	76.5%	77.2%	77.4%	+ .9%
Members	7,351	7,412	7,277	- 74
All	9,612	9,607	9,403	- 209
Faculty (Full Time)	68.3%	70.7%	70%	+ 1.7%
Members	2,590	3,069	2,882	+ 292
All	3,791	4,341	4,117	+ 326
Specialists	87.1%	87.1%	86.8%	- .3%
Members	23,024	25,317	25,968	+2,944
All	26,422	29,062	29,906	+3,484
General Practice	73.6%	74.0%	73.4%	- .2%
Members	111,474	111,098	112,513	+1,039
All	151,650	150,080	153,273	+1,623
FDS	67.7%	69.7%	73.3%	+ 5.6%
Members	4,735	4,647	4,968	+ 233
All	6,998	6,667	6,780	- 218
Graduate Students	79.3%	85.1%	84.2%	+ 4.9%
Members	2,774	3,825	3,829	+1,055
All	3,497	4,495	4,547	+1,050
Non-Renews	4.2%	3.9%	3.5%	- .7%
(1988 Actives Only)	4,484	4,183	3,629	- 855

1. Why Join the American Dental Association?

More than 50% of members indicated that the following were reasons why they initially joined:

—colleagues were members
—it seemed the right thing to do at the time
—access to scientific journals/dental publications
—began as a dental student
—wanted to join local or state society

The five primary reasons given by members for joining the Association were indicated as follows:

—began as a dental student (21%)
—seemed the right thing to do at the time (19.1%)
—wanted to join state and local societies (15.6%)
—colleagues were members (8.8%)
—to get involved in organized dentistry (7.1%)

2. Why Continue Membership in the American Dental Association?

More then 50% of members indicated the following were reasons for their continued membership:

—interests are represented at the national level
—membership benefits
—personal belief in belonging to my professional association
—access to news of the dental professional
—united voice in dentistry
—maintain insurance coverage
—access to scientific journals and papers

When asked to indicate a single primary reason for continued membership in the Association, members indicated the following five reasons:

—personal belief in belonging to my professional association (35.1%)
—maintain insurance coverage (13.8%)
—membership benefits (8.7%)
—representation of interests at the national level (8.4%)
—participation in local society actitivies (7.1%)

3. Value and Awareness of American Dental Association Services

More than 75% of members indicated the following Association services or activities were of value to them:

—materials and treatment/product research (81%)
—legal and legislative services (80%)
—insurance (83%)
—product, material, and equipment approval/standards (86%)
—editorial (84%)
—education and accreditation (82%)
—patient education materials (83%)
—preventive dentistry promotion (81%)
—information about AIDS, infection control and hazardous waste materials (88%)

In addition to the activities listed above, the following services were identified as important to at least 50% of Association members:

—dental practice management (59%)
—library services (68%)
—public relations activities (71%)
—meetings and conference services (70%)
—health education programs for school and community groups (65%)
—information about quality assurance (67%)
—peer review (70%)
—financial services (50%)

Overall, 89% of members rate the quality of services of the Association as good (50%) or excellent (39%).

4. Personal Opinions of Member Dentists

Members were asked to express their opinion about several Association activities or statements about the American Dental Association. Dentists were asked to indicate their opinion by choosing only one of four responses representing: (1) Strongly Disagree, (2) Disagree, (3) Agree and (4) Strongly Agree. Respondents were asked to consider a list of 34 statements about the Association or Association activities. More than 50% of dentists Agreed or Strongly Agreed with all the statements except for the following six:

—I regularly buy products from the Association catalog (31%)
—Alternative delivery systems should be encouraged by the Association (31%)
—I have a voice in how the Association policies and positions are developed (41%)
—The Association member dentist does not have an advantage over nonmember dentists (45%)
—The Association should encourage members to increase their practice of cosmetic dentistry (49%)
—I would pay a registration fee to attend Annual Session (47%)

At least 75% of members Agreed or Strongly Agreed with the following statements about the ADA:

—The Association should lobby for licensure by credentials (75%)
—New research information is adequately covered by *JADA* (72%)
—*ADA News* keeps me updated on important issues concerning the profession (89%)
—The Association should develop treatment guidelines to help dentists deliver the highest quality of dental care (78%)
—The Association should provide more continuing education seminars (76%)
—The Association should do joint promotion with dental manufacturers to educate the public on oral health (79%)
—I am proud of my ADA membership (90%)
—The Association should maintain its involvement in public service programs such as access and community preventive dentistry activities (95%)
—The Association's annual session provides educational opportunities at a reasonable price (78%)

—Teaching dentists how to avoid malpractice is an important activity of the Association (89%)
—The Association should develop practice guidelines to help evaluate risks associated with particular treatments (89%)
—The Association should actively promote community water fluoridation where it is not available (91%)
—The Association should do more to inform the public about the value of oral health (96%)
—The Association should establish guidelines for diagnosis and treatment of TMJ disorders (84%)
—The Association has provided useful information on infection control (88%)
—The Association has provided useful information on hazardous waste disposal (77%)

5. **Use of the ADA WATS Line**
Member callers to the Association rated the WATS operators Good or Excellent on knowledge (86%), efficiency (90%), and friendliness (88%). Association secretaries were rated Good to Excellent by 87%, 89%, and 91% of members on knowledge, efficiency and friendliness respectively. On knowledge, efficiency and friendliness, the Association management staff was rated Good to Excellent by 91%, 90%, and 91% respectively by member callers.

Both past members and nonmembers indicated their primary reason for not renewing or joining was for economic reasons. Two of every three past members (67%) indicated they would be receptive to joining the Association again; 45% of nonmembers indicated an interest in joining.

Young Dentists Recruitment: In addition to priority being placed on young dentist recruitment in the Emphasis Program, in 1989 the Association conducted its second annual multi-contact campaign targeted to the 17,000 nonmember dentists under 40. The campaign had three phases and featured the messages, "You Need Us," "Here's What We're Doing for You," and "We Need You." More than 1,400 dentists (8%) indicated they would join the Association by returning response cards.

These cards were forwarded to the respective constituent society for action and referral to the correct component. Young dentist market share increased 0.8% since 1987. More than 4,000 dentists responded to both the 1988 and 1989 campaigns. Another young dentist campaign is planned for the fall of 1990 and is based on a lead tracking analysis completed between the 1988 and 1989 campaigns. This lead tracking system is enabling the Association to invest its program resources where it can obtain the greatest results.

Office of Student Affairs: The Office of Student Affairs (OSA) contacted each of the approximately 13,000 undergraduate dental student members at least once during the 1989/90 school year. In its capacity as American Dental Association liaison to the American Student Dental Association (ASDA), the OSA assisted in the development of a marketing package for ASDA which facilitated ASDA's support of Dues Equity. Also, the Office of Student Affairs hosted and assisted ASDA leaders throughout the year.

Internal Marketing Campaign: Membership Awareness Month, September 1989, was the Association's first internal membership marketing campaign. Materials, training and incentives were provided to all Association employees for the purpose of assisting them in providing superior service to all members with whom they come in contact. An inside services telephone directory and membership benefits portfolio were two of the publications developed for this campaign.

***ADA News* Inserts:** In 1989, the April 3, October 9 and November 11 issues of the *ADA News* went to all dentists (31,000 nonmembers each issue) and included a postage-paid Intent to Join Response card. Only 108 positive response cards were returned. To date, thirteen have joined the Association. Because of the lack of responsiveness, this program was not repeated in 1990.

Home Mortgage Program: The American Dental Association Sponsored Home Mortgage Program, provided by the Prudential Home Mortgage Company, was announced as a new membership service in June 1989. Since that time 15,000 inquiry calls have been processed. As of May 1990, 73 members had closed on loans totaling more than $5,000,000. As an added incentive to this program, all members closing on mortgages receive $200 worth of coupons redeemable for Association dues, products or services.

Department of Membership

Introduction: The Department of Membership is responsible for maintaining accurate membership, occupational and demographic data on over 200,000 U.S. dentists and dental students. In 1989, the Department was successful in obtaining new sources for this data which greatly improved the accuracy of the member and nonmember records. The refinement of the data in the Association's masterfile was instrumental in the development of a variety of reports that were utilized by the Association, constituent dental societies and specialty organizations to monitor and direct their membership recruitment and retention activities.

The Department serves, on a continuing basis, as the primary liaison between the Association and its 54 constituent societies in all matters pertaining to ADA membership policies and dues processing. Additionally, the Department serves as the Association's link with nearly 10,000 direct members.

Data Base Management: In 1989, the Department of Membership completed a data base protocol on the ADA Dentist Masterfile. As a result of this protocol 1,257 foreign

trained dentists were identified as being licensed in the United States, but were not on the masterfile. A special survey was mailed to these dentists to verify practice location and collect biographical data. As a result of this data collection, a total of 821 foreign trained dentists were added to the masterfile that were not previously known to be in the United States. The completion of this final phase of the masterfile protocol now provides the Association with a reliable representation of all dentists in the United States. At the end of 1989, the American Dental Association represented 75.6% of all dentists in the United States, 86.8% of all specialists, 70.2% of all young dentists and 66.0% of all women dentists.

Last year, over 400 custom management reports were prepared for constituent, component and related dental societies. Several new resources were developed to aid with recruitment and retention efforts. Among these were the ADA *Leadership Statistics Resource Book,* recruiter cards and special message postcards.

Over 1,400 management information reports were prepared for internal staff use to monitor membership and revenue trends. Reports included: dues equity study revenue forecasting; short- and long-range dues revenue forecasts for the Division of Finance; national and Emphasis program membership market forecasts; and assistance with demographic studies for constituent societies.

Direct Members: The most successful targeted efforts to increase ADA membership have been accomplished with direct members, specifically the Federal Dental Services. Overall market share for federally employed dentists increased 3.6% in 1989. Total dues revenue—for the first time—exceeded the $1 million mark. The 1989 Federal Dental Services market share is 73.3%. Market share by branch of service is:

Navy Dental Corps	76.9%
Veterans Affairs	75.1%
Air Force Dental Corps	75.5%
Army Dental Corps	68.2%
Public Health Service	66.9%

These positive results can be attributed to: effective direct mail campaigns; timely and accurate lists of active duty dentists being provided by individual service branches; and enthusiastic support from the military, Public Health Service and Department of Veterans Affairs dental chiefs.

Additionally, the Department produces a new publication just for federally employed dentists, *Federal Dental News,* which has increased awareness of ADA policies, programs and services. The first issue was mailed in June 1989 to nearly 5,000 federally employed members. The second issue was mailed in October 1989 to members as well as 1,800 nonmembers. The issue to nonmembers included a letter from Dr. R. Malcom Overbey and a special membership application. The second issue also included a reader survey, which received over 200 responses. The majority of respondents found the contents of the first two issues very relevant, and over 100 took the time to write comments and offer suggestions for future topics.

Dues Processing: The Department continues to improve the dues collection process with constituent societies. The majority of the Department's efforts involve providing resources, materials and training to constituent and component staff to assist them in their dues collection and billing efforts. Additionally, communication with constituents utilizing the micromembership system was increased by providing specialized procedures and non-technical assistance to allow accurate and efficient maintenance of member records. For the first time, all payment discrepancies were settled by year end and no constituent owed additional dues dollars to the ADA.

A pilot program was launched by the Department to further enhance member and constituent society relations. Frequently, the membership election process can take six months to one year to complete. New members receive no ADA benefits until they have actually been elected by the constituent and their dues remitted to the ADA. Since the majority of constituents collect dues when the application is submitted, new procedures were implemented to allow dentists with provisional or applicant status in a constituent society to begin utilizing their ADA benefits at the time of initial application, rather than at the time of final approval. Currently, California, Pennsylvania and Florida are participating. The pilot program has been successful thus far and will be evaluated in December 1990 to determine continuation and expansion.

Member Communications: Last year, the Department received approximately 20,000 telephone inquiries and approximately 7,000 written inquiries concerning a variety of membership issues. The Department responded by telephone to most of the membership inquiries received and mailed letters to over 6,000 individuals in response to their inquiries.

Membership Publications and Recognition Awards: During the past year, the Department of Membership produced a variety of publications and awards for the membership and for dental societies including:

- —1990 ADA resource guide *Making the Right Connections*
- —1990 Membership Renewal Kit: certificate date seal, brochure detailing ADA resources and benefits, *ADA Code on Dental Procedures and Nomenclature,* informational brochure on ADA's 131st annual session, and brochure detailing the permanent membership plaque
- —Life member gold pins and life membership cards
- —1990 plastic membership cards
- —*Membership Manual of Policies and Procedures* for constituent and component membership staff
- —Monthly *Membership Statement*
- —Senior Roster: listing dental school seniors who will be eligible for active membership
- —1990 *American Dental Directory*

Response to Assignments from the 1989 House of Delegates:

Membership Dues Equity. In response to Resolution 28H-1989 (*Trans.*1989:507) constituent dental societies were notified by certified mail of the *Bylaws* amendments which will be effective January 1, 1991. The Association has developed a two-year business plan for implementing the various changes to the dues structure and membership categories. The two-year plan is designed to accomplish four specific objectives:

—To communicate the rationale of the Dues Equity Plan to constituent and component staff and leadership
—To provide constituents and components appropriate guidelines and materials to ensure administrative compliance
—To encourage constituents and components to amend their bylaws to conform with the ADA *Bylaws* provisions
—To develop and implement an effective recruitment and retention program for active life members, recent graduates and undergraduates

Additionally, the Executive Director has designated several staff members to assist dental societies in the implementation process. Staff is available upon request to conduct workshops and a slide presentation to communicate the importance and rationale of the Dues Equity Plan. Assistance is available from the Legal Department to draft bylaw amendments.

Eligibility for Direct Membership. In response to Resolution 71H-1989 (*Trans.*1989:539) an annual protocol has been established to provide constituent dental societies with a listing of federally employed dentists who maintain direct membership with the Association. Constituent societies are requested to assist in the verification of employment status of direct members within their jurisdiction and are encouraged to promote tripartite membership to federally employed dentists where appropriate.

Amendment of ADA Bylaws to Allow Constituent Society Membership for Federally Employed Dentists. In response to Resolution 57H-1989 (*Trans.*1989:537) constituent and component societies have been notified that the *Bylaws* were amended to clarify that federally employed dentists who reside outside the jurisdiction of a constituent society in which the federal dentist is licensed, may be a member of the Association and that constituent society without maintaining membership in a component society.

Department of Dental Society Services

Introduction: The Department continues to serve as primary liaison between the Association and its 54 constituent, 513 component and 107 national dental organizations. The Department's primary goals are to provide tangible support to dental society leaders and management staff, to promote the value of organized dentistry and to simplify access to Association resources.

Orientation Programs: The Department conducted the Administrative Orientation Program for five new dental society executives, September 6-8, 1989. The program provided an in-depth look at Association agency programs, structure and resources, as well as policy development and implementation. Participants represented constituent, component and specialty dental organizations. Evaluations indicated that this program continues to meet the needs of both new and experienced dental society executives.

The Board Orientation was held November 30-December 1, 1989 for new Association Officers and Trustees. The six new members of the Board of Trustees met with representatives of each Association Division for a thorough overview of its activities. It was determined that this orientation was useful, and it was suggested that it be repeated in 1990.

In addition, special orientations were held as needed: for the new executive director of the American Association of Orthodontists, Mr. Ronald S. Moen; and for the Colegio de Cirujanos Dentistas de Puerto Rico leadership and staff. Results of both day-long meetings included positive and increased communications and growing cooperation.

State Society Officers' Conference and Presentation of Golden Apple Awards: Following a legislative forum chaired by the Association's Washington Office, the first annual Golden Apple Awards were presented by then-president Arthur A. Dugoni on Saturday, November 4, 1989 during the annual session in Honolulu.

These awards were designed to recognize dental society achievements in membership recruitment campaigns, legislative activities and dental meetings.

In addition, an individual Golden Apple Award to recognize an outstanding young dental leader was presented by the Association's Commission on the Young Professional to Dr. Mark J. Reynolds of Maine.

The state society membership recruitment excellence award was presented to the Oregon Dental Association (ODA) (Mr. Barry Rice, executive director). Ranked first in ADA market share, the ODA recruited 193 new members on a limited budget. The local society Golden Apple was awarded to Tri-County (CA) Dental Society (Ms. Penny Gage, executive director).

In the category of legislative achievement, the Massachusetts Dental Society (Mr. Matthew Boylan, executive director) won the first Golden Apple for a successful grassroots lobbying effort. A second legislative award went to the Nebraska Dental Association (Mr. Tom Bassett, executive director), which used a coalition-building strategy to halt free distribution of smokeless tobacco in that state.

The Washington State Dental Society (Ms. Anne Hecker, executive director) won the Golden Apple in Dental Meeting Excellence for its well-attended conference. The West Coast Dental Society in Florida (Ms. Patty Laws, executive director) received the award for component society meeting excellence.

Winning societies designed goals, met their objectives within a specified time frame, and provided proof of

winning results. The second annual awards will be presented during the 1990 State Society Officers' Conference in Boston.

Specialty Organization Forum: On August 17, 1989, the Department coordinated a meeting between the leadership and executive directors of the eight recognized dental specialties and their Association counterparts. The meeting was chaired by Dr. Arthur A. Dugoni, then president. All specialties were represented. The purpose was to continue ongoing dialogue on policy issues and cooperative projects. Participants concluded that the forum served their needs and that it should be continued to enhance intraprofessional relations.

Meeting with the Presidents of the American Society of Constituent Dental Executives (ASCDE) and the Association of Component Society Executives (ACSE): On December 7, 1989, the Department met with Dr. Dale F. Redig, president of ASCDE and executive director, California Dental Association, and Mr. Joseph Lory, president of ACSE and executive director of the Metropolitan Denver Dental Society. The purpose was to identify constituent and component society concerns and to provide input into the agenda for the ADA Management Conference. The meeting was held at Association Headquarters.

President-elect's Conference: Dr. Eugene J. Truono, president-elect and treasurer, hosted his constituent dental society counterparts, January 29-30, 1990 at Association Headquarters. Presidents-elect from 51 constituents discussed future trends, membership statistics, dues equity, dental care issues, legislation, dental team recruitment, licensure and communications. A segment on leadership development was presented by Dr. Arnold C. Bacigalupo. Dr. Truono emphasized the value of the mentor concept for the profession. Participants indicated that they highly valued the program.

Management Conference: The 1990 Management Conference was held July 23-24 at Association Headquarters. The program was designed for the staff of constituent, component and national dental organizations.

The theme of the conference, "Plain Talk," framed the two-day interactive sessions with emphasis on negotiation, clarity of communication, public speaking, legislative strategy and board/staff relations. Other topics included meetings management and employment practices. The format encouraged peer-to-peer exchange on mutual concerns and program development suggestions.

Related activity included meetings of the American Society of Constituent Dental Executives, the Association of Component Society Executives, the Microcomputer Users' Group and the For-Profit Subsidiary Forum.

Leadership Workshops: The Department presented the "Goals and Roles" workshop to the leadership of constituent and component dental societies upon request. The workshop is designed to facilitate the development of dental society goals and objectives, and to identify the strengths of the board as a planning team.

Workshops offered in 1989-1990 included presentations for the Hawaii Dental Association, The Dental Society of the State of New York, the Nevada Dental Association, the Alaska State Dental Society, the West Virginia Dental Association, the Dental Society of Western Pennsylvania, the Minneapolis District Dental Society, the Greater Houston Dental Society, the Queens County (NY) Dental Society and the Tri-County Dental Society in California.

Reviews have been consistently positive and the program will be available to constituent and component societies on a regular basis.

Dental Society Update: The bimonthly publication of the Department expanded readership to include 70 staff and officers of national dental organizations. The newsletter featured articles on constituent, component and national dental organization programs; recruitment and retention of members; Association resources; and services for dental society administration.

Emphasis Program: The Department participated in the division-wide Emphasis Program, providing membership development support to the Greater St. Louis Dental Society.

Resource Development: Three surveys, for purposes of dental organization profile research, needs assessment and corresponding resource development, were completed to audiences served by this Department: constituent societies, component societies and national dental organizations.

The Executive Resource Kit: This orientation package was developed to help constituent and component dental societies access existing ADA services and resources. Four sections on "Administrative Overview," "ADA Member Benefits," "ADA Resources," and "Dental Society Leadership" comprise the kit, which includes phone numbers, an order form and a questionnaire for resource fulfillment.

For unstaffed component societies, a special "Dental Society Leadership" packet was developed to suggest resources to help local leaders enhance their success.

Constituent Auxiliary Membership Category: In response to Resolution 29H-1987 (*Trans.*1987:498), the Department conducted a survey in 1990 to fulfill its duty to report periodically to the House of Delegates on the auxiliary membership category.

Surveys were mailed during the month of February to 54 constituent dental societies. Responses were received from 51 societies.

Of those who responded, six states (Alabama, Arizona, Florida, Maryland, Tennessee and West Virginia) reported that they have a category of membership which is open to dental auxiliaries and/or staff.

Annual dues range from $15 to $50, at an average of $29. None of these states reported a start-up cost except

Tennessee which spent approximately $2,000 to implement this new category.

Florida Dental Association has the largest total number of members in the auxiliary category, reporting 510 dental hygienists and 631 chairside assistants for their two eligible types of dental personnel. The other five states (Alabama, Arizona, Maryland, Tennessee and West Virginia) have a combined total membership in the auxiliary category of only 284. Alabama has such a category, theoretically, but does not presently have any auxiliary members. Auxiliary membership in these five states averages between 50-100.

Dental personnel eligible for auxiliary membership vary from state to state. As mentioned above, Florida admits only hygienists and chairside assistants. The other five states admit lab technicians into membership also. West Virginia and Maryland also admit dental suppliers; and Tennessee welcomes other auxiliary staff of ADA member dentists.

Services offered to auxiliary members were reported as follows: continuing education, 5 states; insurance, 5 states; publication, 5 states; credit union, 1 state; credit cards, 1 state; and discount at meetings, 1 state.

The five states who currently have members in the auxiliary category plan to continue recruitment. Alabama Dental Association is undecided about the future of this category of membership. Comments regarding implementation of this category noted the inactivity or nonmembership of most auxiliary personnel in both their own associations, American Dental Hygienists' Association (ADHA) and American Dental Assistants' Association (ADAA). Without intruding on or competing with ADHA or ADAA membership, constituent societies could recruit from a large, but possibly uninterested, pool of auxiliary personnel.

Three states responded that the category of auxiliary membership is in the planning stage now. Illinois State Dental Society will bring it before its 1990 House of Delegates meeting in September. Missouri Dental Association notes that high interest has been shown by eligible auxiliary personnel but that there is concern about the future of the state assistants' organization. Wyoming Dental Association may implement the auxiliary category this year as a way of "serving the unserved" unless opposition from dental hygienists prevails.

The remaining 42 constituent societies have decided not to open a category of auxiliary membership at this time, although responses include: disinterest/opposition of constituent leadership and state dental auxiliary associations; fear of fragmentation within the Association, if non-dental personnel are included; maintenance of good rapport with state dental auxiliary associations.

Overall, constituent dental societies are moving slowly in implementing the auxiliary category of membership. In their considerations, careful thought is being given to all possible ramifications of this proposed category.

Response to Assignments from the 1989 House of Delegates:

Support of Membership Recruitment Activities. Resolution 41H-1989 (*Trans.*1989:540) reinforced the Association's goal to urge allied dental organizations to support membership recruitment and retention activities of organized dentistry. In addition, the resolution encourages those organizations that require Association membership to annually exchange membership and specialty status with the ADA. In March, the Department contacted the chief administrative officers of all national dental organizations to promote the ADA membership requirement, and to offer the membership reconciliation report.

Membership Benefits to Attendees of Constituent and Component Dental Meetings. Resolution 48H-1989 (*Trans.*1989:537) requested that the Association urge dental meeting planners to charge a lesser registration fee to ADA members than to nonmembers. In March, the Department contacted chief administrative officers of constituent and component societies, as well as the dental meeting planners for 61 dental meetings to acknowledge Association members by offering less expensive registration fees to them than to nonmembers. The Department featured an article in *Dental Society Update* reinforcing this message.

Support of ADA Membership by the American College of Dentists, the USA Section of the International College of Dentists and the Pierre Fauchard Academy. Resolution 79H-1989 (*Trans.*1989:538) requests that when feasible, these organizations require continuing membership in the ADA for members in good standing. The Department offered to provide an annual list of dropped members to directors of both Colleges and the Pierre Fauchard Academy. Additionally, a membership reconciliation report was offered to each organization. It was suggested that each organization periodically provide a list of its new members for the ADA to update its masterfile. Each organization has indicated its willingness and interest in this project.

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

Commission on the Young Professional

Crete, Michael J., Michigan, 1992, chair
Koufos, Michael J., Indiana, 1991, vice-chair
Bigelow, Tod A., Colorado, 1993
Castagna, Daniel F., California, 1990, *ad interim*
Doerfler, Andrew C., Texas 1992
Feinberg, Edward, New York, 1993
Higgins, Philip W., Jr., Maine, 1991
Hinkle, R. Alan, Virginia, 1993
Isaacson, Richard, New Jersey, 1990
Kell, Kathryn A., Iowa, 1992
Kennedy, Scott C., Kansas, 1991
Kiesling, Roger L., Montana, 1990
Outlaw, James F., Florida, 1991
Selcher, Samuel E., Pennsylvania, 1990
Thompson, Wm. Roy, Tennessee, 1992
Unger, Joseph G., Illinois, 1993
Shuck, J. Vincent, director
Peebles, John N., manager

Meetings: The Commission met on August 2-3, 1989 in Boston at the Boston Park Plaza Hotel and Towers and on February 15-17, 1990 at the Headquarters Building in Chicago. It is scheduled to meet again on August 8 and 9, 1990.

Dr. Charles E. Wilson, second vice-president, attended the August 1989 meeting and served as Board liaison. Dr. James N. Clark, Tenth District Trustee, is currently serving as Board liaison to the Commission.

Acknowledgments: The Commission acknowledges with appreciation the many contributions made by Drs. Roger L. Kiesling and Samuel E. Selcher upon completion of their tenure of service as Commission members. The 1990 annual session will also mark the completion of the ad interim appointments of Drs. Daniel F. Castagna and Richard Isaacson. The Commission extends its gratitude for their participation.

Election of Chair and Vice-Chair: In accordance with the authority contained in the Association's *Bylaws* (Chapter XIII, Section 40, Paragraph D), the Commission elected Dr. Michael J. Crete to serve as Chair. Dr. Michael J. Koufos was elected as vice-chairman. The election for the 1990-91 terms is scheduled to occur during the Commission's August 1990 meeting.

Recruitment and Retention of Young Dentists: As of December 31, 1989, the young dentist market share was 70.3%. This represents an increase of 0.8% since 1987, although a 0.2% decline was experienced over the last year. However, significant increases were demonstrated in the market share of women dentists, faculty and dentists in the Federal Dental Services. Even with these overall gains, the young dentist market share remains substantially below the market share for dentists over 40. In reviewing summary reports of the 1989 *Membership Needs and Opinion Survey,* the Commission noted that 45% of nonmembers and 67% of past members indicated an interest in joining if asked. This highlights the importance of the recruitment efforts undertaken by the Commission's network of young dentist committees and reaffirms the Commission's emphasis of encouraging the one-on-one recruitment approach among young dentists.

The Commission continues its efforts in developing recruitment and retention activities in cooperation with other Association agencies and provides information and assistance to young dentist committees in addressing potential objections from young dentists regarding the revised dues classification, as well as the dues increase. During the past year, activities have included the following: articles in the Commission's *Leadership Focus* newsletter; participation in the development of promotional materials for the Young Dentist Recruitment Campaign and the Young Dentist Transition Kit; participation in meetings and conferences to convey the importance of young dentist involvement and to respond to their specific concerns; development of a special campaign designed to increase the involvement of young dentists in their dental societies; dissemination of articles on Commission activities to constituent and component society dental editors; support of activities conducted by the American Student Dental Association; and promotion of successful young dentist committee activities.

Special Dues Payment Program: The Commission has developed a marketing plan for the ADA/MBNA Dues Payment Program implemented on July 1, 1990 for payment of 1991 dues. The program offers young dentists graduating within the previous five years from dental school or advance training the option to charge tripartite dues. The program will allow eligible members to use a special dues check issued by MBNA and permit repayment of the total tripartite dues amount interest-free over a six month period. The Commission determined that this option should serve as a valuable recruitment and retention tool by relieving the financial burden of a single dues payment for many young dentists.

Liaison with Component and Constituent Dental Societies: The Commission's network of young dentist committees currently includes 38 constituent and 46 component groups. This dramatic growth represents a unique commitment among young dentists to support their profession and

develop skills to assume additional leadership positions. The Commission continues to provide information to young dentist committees on a regular basis and individual assistance upon request. The Commission also agreed to offer a workshop for young dentist committees that will address organizational issues, special programs and activities, committee finances, short- and long-range planning, leadership skills and policy development. This workshop is scheduled to be pilot-tested in the fall of 1990.

The Commission also conducted legislative alerts to encourage young dentist committee members to contact their Congressional representatives to support restoration of the tax deduction for interest on student loans. The Commission Chair testified at a Congressional hearing in support of the issue. A statement on the status of this pending legislation is included in the annual report of the Council on Governmental Affairs and Federal Dental Services (*Reports*:153).

In view of the projected changes in the gender mix of dentists and the demographics of practice patterns (i.e., more employed and part-time dentists), the Commission developed a new Subcommittee on Emerging Trends in Dentistry to address the concerns of women dentists, employee dentists and various transitional modes associated with employed young dentists. The Subcommittee is undertaking a review of current Association publications and available survey data on female practitioners in an effort to suggest programs and activities to address these issues.

In view of its ongoing efforts to facilitate the transition of dental school graduates from academia to practice, the Commission suggested that a new seminar be developed for recent graduates who wish to move from employee/associate status to an ownership situation. The Commission offered the following content outline to the Council on Dental Practice for its consideration:

a. establishing a practice philosophy
b. managing and controlling overhead
c. staffing the new practice
d. marketing the new practice
e. implementing a business system

The Commission offered to promote the new seminar through its network of over 80 young dentist committees.

The Commission also developed a protocol for an activity designed to link young dentists seeking an associateship position with dentists seeking an associate and decided to pilot-test its implementation at a limited number of schools, in concert with the OPTIONS program when appropriate.

The Commission also determined that the OPTIONS program could be enhanced by the inclusion of a 30-45 minute segment presented by a young dentist who relates personal experiences of transitioning from dental school to dental practice. The Commisssion provided the Council on Dental Practice a detailed outline of the segment for its consideration.

Conference on the Young Dentist: Through the continuing support of Chesebrough-Pond's, Inc., the Commission will sponsor the Fourth National Conference on the Young Dentist in Chicago on August 9-11, 1990. The Conference will again offer a full day devoted to leadership issues, where representatives from young dentist committees and other young dentist leaders will address activities development, organizational change and leadership skills enhancement. The remainder of the Conference will focus on dental office related issues, such as practice management, office staffing, diagnosis and treatment planning, infection control and marketing.

Dates and locations are under consideration for a fifth national conference to be conducted in 1991.

Leadership Opportunities: The Commission continues to assess young dentist participation in leadership positions and pursues additional opportunites, in keeping with its bylaw responsibilities. Some significant increases have occurred at the component level where 205 (41.2%) of the society presidents are under age 40. The average age of ADA council/commission members remains at 54.1 years. Of the 170 ADA appointed council/commission members, only 20 (11.8%) are under age 40, the vast majority of which are Commission on the Young Professional members. In addition, only 2.4% of the delegates to the 1989 House were young dentists. These data do not adequately reflect the 33.9% of total Association members who are under age 40.

To address this issue the Commission is conducting a study of the delegate election/appointment process in each state, in order to formulate appropriate recommendations where necessary. The Commission also conducts the following activities to foster leadership growth among young dentists: annual Young Dentist Leadership Award; state, regional and national conferences on leadership skills development; quarterly publication of *Leadership Focus;* and circulation of its *Guidelines for Young Dentist Committees*. The Commission recognizes, however, that all segments of organized dentistry must commit to the process in order for young dentists to assume sufficient experience in leadership roles.

Licensure Issues: The Commission continued to address issues related to freedom of movement and licensure by credentials. The Commission has agreed to collect available information on licensure by credentials in order to consider the development of resolutions at the August 1990 meeting. The Commission also decided to consult with other Association agencies and licensing jurisdictions to determine whether the unique peer review, continuing education and supervision requirements of the federal dental services could be used as one mechanism to increase the acceptance of licensure by credentials by more licensing jurisdictions. Based upon actions taken during the August 1990 meeting, the Commission may forward a supplemental report to the 1990 House of Delegates.

Responses to Assignments from the 1989 House of Delegates:

Licensure Exam Assistance Program. The 1989 House of Delegates adopted Resolution 37H (*Trans.*1989:527) which calls for appropriate agencies of the Association to develop assistance programs for candidates for licensure examinations which will minimize factors unrelated to the candidates' clinical competence. The Commission has developed a protocol that will provide information to licensure candidates upon request. The protocol includes information on the following: (1) examination dates and requirements, (2) patient resources, (3) chairside assistance personnel and laboratory support resources and (4) clinic equipment requirements. The program will be pilot-tested in selected sites. Additional information on the licensure issue and comparability of licensure examination is contained in the special report of the Council on Dental Education (*Reports:*117).

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

Division of Dental Practice and Health

Council on Community Health, Hospital, Institutional and Medical Affairs

Council on Dental Care Programs

Council on Dental Practice

Bureau of Economic and Behavioral Research

Council on Insurance

Office of Quality Assurance

Commission on Relief Fund Activities

ADA Endowment and Assistance Fund, Inc.

Notes

Council on Community Health, Hospital, Institutional and Medical Affairs

Whiston, David A., Virginia, 1990, chairman
Newman, Gary J., Kansas, 1990, vice-chairman
Allen, J. David, Georgia, 1992
Bisch, Walter E., Missouri, 1990
Bonofiglo, Eugene L., Michigan, 1993
Boyd, William F., New York, 1991
Calderone, James J., New Mexico, 1993
Daniel, Thomas M., Florida, 1990, American Medical Association
Donlon, William C., California, 1993
Dumont, Thomas, Oregon, 1991
Hanson, Paul W., New York, 1990, American Hospital Association
Harris, David J., Indiana, 1992
Melnick, Harry J., Illinois, 1992
Neff, Jack H., Pennsylvania, 1991
Reid, Loy C., Texas, 1990
Romeo, Frank J., Maryland, 1992
Schilder, Herbert, Massachusetts, 1991
Tempero, Richard M., Nebraska, 1993
Klyop, John S., secretary
Marshall, James Y., manager

Organization: The Council works to broaden the scope of oral health care within the total health care system and to advance preventive dentistry and the delivery of oral health care in the community. Areas of program activity include (1) medical and dental interface, (2) access and community health and (3) dental disease prevention and health promotion. The Council recommends policy and directs programs in the aforementioned areas.

Meetings: The Council met in the Headquarters Building, Chicago, on October 6-7, 1989 and February 9-10, 1990. It is scheduled to meet again September 14-15, 1990. Three subcommittees of the Council facilitate its work activities. These subcommittees, Access to Dental Care, Preventive Dentistry and Institutional Dental Care meet in conjunction with regularly scheduled Council meetings.

Personnel: At the February meeting of the Council, Dr. Gary J. Newman was unanimously elected vice-chairman.

Council staff positions were completely reorganized in 1989. Mr. James Y. Marshall assumed the position of manager which includes responsibilities for the Council's interprofessional and institutional affairs. The new position of coordinator, Fluoridation and Preventive Health Activities, was assumed by Ms. Barbara Z. Park. Ms. Marianne E. LaVeille assumed the new position of coordinator, Access and Community Health Affairs.

Liaison Activities: In addition to other activities described in this report, Council members and staff maintain liaison with various health associations and governmental agencies. These liaison activities provide opportunities to present the profession's perspective on matters of interest and to monitor and report on related activities. Of particular note was an Association-hosted reception for members of the American Public Health Association's (APHA) Dental Health Section. The new APHA president, Dr. Myron Allukian, was honored at this reception.

National Conference on Special Care: A major element of the Council's access programming has always been sponsorship of conferences or scientific programs on access issues and special patient care. In cooperation with the Federation of Special Care Organizations in Dentistry, the Council presented the Second Annual National Conference on Special Care Issues in Dentistry, March 30-April 1, 1990, at the Association's Headquarters Building. Over 260 clinicians, researchers, educators and public health dentists attended. The program addressed special patient care issues from several perspectives including diagnostic and treatment modalities, delivery options, financial considerations, and legal and ethical issues. Mr. Walter J. McNerney, Herman Smith Professor of Health Policy at the J.L. Kellogg Graduate School of Management, Northwestern University, and Mr. Frank Jones, executive director, Associated Medical Schools of New York, presented the keynote addresses. Welcoming remarks were given by Association president, Dr. R. Malcolm Overbey. The Conference also featured four preconference symposia and workshops on March 30 which provided in-depth consideration of special care issues. Among them was a Council-sponsored Hospital Dental Directors Workshop which is discussed later in this report (see page 43). The Council appreciates the corporate contributions received from the Burroughs Wellcome Company, Marion Laboratories, the Warner-Lambert Company and Laclede Professional Products.

National Foundation of Dentistry for the Handicapped: The Council continues to function as the Association's primary liaison with the National Foundation of Dentistry for the Handicapped (NFDH). The Foundation's executive director, Dr. Larry Coffee, is a Council consultant and participates in the meetings of the Council. In addition to the Foundation's ongoing Campaign of Concern and Dental House Calls programs, the Donated Dental Services (DDS) program was expanded further this year. The Foundation reports that DDS programs have begun or are in the

developmental stages in several states and one major city. The Foundation is in the last year of a three-year affiliation agreement with the Association. This agreement affords improved visibility and recognition of Foundation programs while enhancing the Association's support of the Foundation. The Foundation is pursuing several fundraising activities to obtain stable financing to cover operational costs.

AIDS and Infection Control: The Council continues to monitor various issues surrounding the Human Immunodeficiency Virus (HIV) infection and infection control. In this regard, the Council is concerned with access issues, public health policy issues and issues related to institutional care. The Council's biennial survey of access programs seeks to measure the availability of dental society-sponsored access programs for AIDS patients. The Council also monitors the actions taken by the American Medical Association and American Hospital Association in this regard as part of its liaison function. The Council and its consultants review the Joint Commission on Accreditation of Healthcare Organizations' standards for infection control for the Association.

Institutional and Interprofessional Affairs

Related Activities of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO): As a corporate member of JCAHO, the Association maintains one seat on the Board of Commissioners and is represented on various committees.

Dr. Charles A. McCallum represents the Association on the JCAHO Board of Commissioners. Other Association representatives to the Joint Commission are Dr. John F. Helfrick, chairman of the Hospital Accreditation Program Professional and Technical Advisory Committee (PTAC); Dr. Paul Van Ostenberg, chairman of the Ambulatory Health Care PTAC and a member of the Home Care PTAC; and Dr. Terrance J. Thines, a member of the Long Term Care PTAC. Dr. James J. Crall serves on the Joint Commission's Quality Improvement Task Force, Dr. John A. Yagiela serves on the Medication Use Task Force and John A. Molinari, Ph. D., serves on the Infection Control Task Force.

Council staff attend all meetings of the Board, its standing committees, PTACS and task forces or special committees on which the Association has representation. The following summarizes the Joint Commission's most significant undertakings.

Agenda for Change. The Joint Commission is beginning to test the clinical indicators of quality care that were identified for use under the Agenda for Change program. The program's fundamental purpose is to establish an ongoing dedication to improve quality care. Initial hospital testing of indicators for monitoring obstetrical and anesthesia care was completed in November 1989. Large scale testing in 400 hospitals will begin in 1990. Additional indicators scheduled for development over the next 3-4 years include: oncology care, cardiovascular care, trauma care, medications use, infection surveillance and control, homecare, perioperative care, managed care, laboratory services, mental health, diagnostic imaging and unspecified hospital care.

An additional activity of interest includes a continuing review of the *Accreditation Manual for Hospitals'* chapter on leadership. This chapter addresses examination of medical staff bylaws issues and problems, the interpretation of practice acts and the role of the hospital leadership in assuring attention to quality patient care. The Joint Commission is considering an accreditation standard to prohibit smoking in hospitals, as well as a revised standard on emergency back up when anesthesia is used for procedures in the hospital.

JCAHO Surveyor Training. During the year the Council conducts three surveyor training sessions for new Joint Commission surveyors. Sessions are for physicians, nurses and administrators. Dr. Peter Hurst, of Northwestern Memorial Hospital, and Dr. Malcolm Lynch, of the University of Pennsylvania School of Dental Medicine, serve as faculty for the half-day program. They explain the role of dentistry and dentists in the accredited facility and discuss pertinent accreditation standards.

Hospital Chief of Staff Restriction: At the Council's request, the Association's Washington Office successfully effected a legislative change in federal eligibility regulations which previously prohibited dentists from serving as chief of staff in Medicare/Medicaid eligible hospitals. The original regulation limited this position to M.D.s or D.O.s only.

Hospital Bylaws Issues: The Council serves as the Association's resource for members who are experiencing problems with a hospital's bylaws or privileging policies. When necessary, the Association's Division of Legal Affairs plays a role in representing the rights of dentists and helps respond to local problems. The Council is developing a file of sample hospital bylaws. Language in these bylaws varies greatly and has been used to restrict or deny hospital privileges of dentists.

Liaison with National Organizations: Council staff maintains liaison with various health care organizations in an effort to present and promote the interests of the profession. Council staff attends both the Annual and Interim Meetings of the American Medical Association's House of Delegates and Hospital Medical Staff Section. Dr. Bernard S. Snyder serves as an official observer at these meetings. Council staff also attends the American Association of Oral and Maxillofacial Surgeons (AAOMS) annual meeting and the American Hospital Association's (AHA) annual convention. Dr. David A. Whiston, Council chairman, officially represents the Association at the AHA House of Delegates meeting.

The Council also plans activities with national health care organizations. Council staff works closely with the AAOMS and the American Association of Hospital Dentists.

Development of Oral Healthcare Guidelines: In 1990, the Council published several oral healthcare guidelines for the dental management of medically compromised patients. The first four sets of care guidelines, published in October 1989, include: Cancer Chemotherapy, Cardiovascular

Disease, Head and Neck Cancer and End-Stage Renal Disease. It is anticipated that guidelines on HIV Infection and AIDS, Hepatic Diseases, Pulmonary Disease and Endocrine Disorders will be published in 1990. The Council published these guidelines in cooperation with the Association's Salable Materials Program. The guidelines are available for purchase through the Association's Order Department.

Hospital Dental Directors Workshop: On March 30, 1990, the Council sponsored the Third Annual Hospital Dental Directors Workshop in conjunction with the National Conference on Special Care Issues in Dentistry. Dr. Joel Boriskin former chairman of the Council and William Jessee, M.D., vice-president of the Joint Commission on Accreditation of Healthcare Organizations were featured speakers. The workshop participants reviewed and suggested changes in the Council's *Standards for Hospital Dental Departments*. The Council will use the results of the Workshop's review of the *Standards* to develop new guidelines for hospital dental departments.

Access and Community Health

Access Program Promotion: New materials were developed and existing access related materials were revised this year. New materials include a videotape presentation, "Keeping Your Smile for a Lifetime," that focuses on preventive oral health care and new restorative procedures for the aging population. The Council responds to numerous requests for access related information reflecting increased interest by individual members and dental societies for information on special patient care.

Access Recognition Program: In 1989, the Council launched an ongoing program designed to honor individuals who have shown particular leadership and inspiration in the establishment of local access programs. Initial award recipients were: Dr. Roger Eldrige, Maryland; Dr. Charles M. Goldstein, California; Dr. Robert D. Gross, Washington; Dr. Joseph Kalil, Massachusetts; Dr. Benedict B. Kimmelman, Pennsylvania; Dr. Frank Romeo, Maryland; and Dr. Clark Sammartino, Rhode Island. These individuals received a certificate from the Association and have been mentioned in various Association publications. The Council has once again asked constituent dental societies to recommend names of outstanding individuals to be recognized in the future.

Nursing Home Regulations: The Council participated in the development of dental elements of a survey form to be used by the U.S. Department of Health and Human Services' Health Care Financing Administration (HCFA) to evaluate Medicare eligible nursing home and long-term care facilities. The Council, in cooperation with the Washington Office, continues to monitor the implementation of new federal home regulations which will go into effect October 1, 1990. The Council continues to ask HCFA to interpret these regulations.

Rare Disease Coalition: The Council is helping to organize a coalition of groups representing rare disease conditions. The group will identify oral health related problems experienced by individuals with rare medical conditions. The group will also suggest solutions to common problems such as specialized dental care, basic research and financing. Other organizations involved include the National Institute of Dental Research, American Association of Dental Schools and the Federation of Special Care Organizations in Dentistry.

National Special Patient Care Information Resource Center: The Council began the first phases of establishing an information resource center on special patient care. Initially the project, being coordinated with the Federation of Special Care Organizations in Dentistry, will seek to identify, catalog and computerize a comprehensive file of special patient care training, education and informational materials related to oral health. Subsequent phases may incorporate: bibliographical, drug and legal information; a technical assistance network; a program file and a bulletin board.

1990 Access Program Survey: The Council is conducting the biennial survey of constituent and component dental society-sponsored access programs. The survey instrument was revised and redesigned in order to collect more comprehensive information about access programs in dentistry nationwide. The survey was mailed in April 1990 with results expected later this year. The Council expresses its appreciation to the Bureau of Economic and Behavioral Research for technical administration and evaluation services.

Access Program Manual: The Council revised and updated the "Manual on Comprehensive Dental Care Access Programs: A Guide for Dental Societies," which was first published in 1981. The manual provides dental societies with suggested guidelines and program ideas for developing comprehensive dental care access programs.

Annual Session Program: The Council will sponsor a scientific program, "The Developmentally Disabled Patient in Your Practice," at the Association's 1990 annual session in cooperation with the Federation of Special Care Organizations in Dentistry. The program will discuss legal, ethical, social, diagnostic and treatment issues faced by private practitioners serving the developmentally disabled population.

Nonclinical Dental Careers: The Council provides background information and assistance to member dentists considering a nonclinical dental career. Initial guidance includes issues to consider when making such a change. Information and contacts within various fields that tend to employ dentists in nonclinical positions are also provided. The value of the service is being assessed in a follow-up survey of users.

Foreign Language Translations: Foreign language translations of commonly used dental phrases may aid in improved diagnosis and treatment of non-English speaking patients. The Council is investigating the development of such translations.

Liaison with National Advocacy Organizations: The Council is in the middle of a third two-year term on the executive committee of the National Volunteer Organizations for Independent Living of the Aging, a membership unit of the National Council on the Aging. This unit is composed of over 200 voluntary organizations nationwide that have an interest in the well being of the aging. As an executive committee member, the Association gains valuable insight, input and visibility on geriatric issues.

Council staff continues to communicate with the American Association of Retired Persons (AARP) in an effort to promote oral health awareness among its vast membership. The Council sponsored an exhibit at the biennial meeting of AARP held in June 1990.

The Association, through the Council, has maintained liaison with the National Commission on Correctional Health Care (NCCHC) and is one of its supporting organizations. Dr. William J. Byland is the Association's representative to the Board of Directors of the NCCHC. The NCCHC provides a health care accreditation service for interested correctional facilities nationwide.

Fluoridation and Preventive Health

Fluoridation Activities: The Council continues to support community water fluoridation and acts as a resource to the profession and the public on this issue. During the past year, the Council provided educational materials and assisted active campaigns in the following communities: Los Angeles and Sacramento, California; Lafayette and New Orleans, Louisiana; Iron Mountain, Michigan; Northfield, New Jersey; Massena, New York and Evert and Tacoma, Washington. The Council supported Alaska's successful effort in Anchorage. Technical assistance, a letter of endorsement and expert testimony were provided. The Council continues to work with the state of Pennsylvania to pass House Bill 507 which calls for mandated statewide fluoridation. Technical assistance was provided to this campaign to assist with lobbying efforts in the state senate.

In summary, over the past year, as a result of city government action, fluoridation was retained in Anchorage and public referenda were successful in three communities, while five communities voted against fluoridation.

National Fluoridation Advisory Committee: The National Fluoridation Advisory Committee (NFAC), composed of consultants to the Council, met on June 1, 1990. The Association appointed the following members to serve a one-year term on the NFAC: Dr. Herbert Schilder, chairman, Dr. Joel M. Boriskin, Dr. Gregory N. Connolly, Dr. Stephen Corbin, Dr. Robert Faine, Dr. P. Jean Frazier, Dr. Lawrence Furman, Dr. Herschel Horowitz, Dr. Elaine Neenan, Dr. Ernest Newbrun and Mr. John Small. A major focus this year has been implementation of the remaining NFAC recommendations for Association activities with regard to promoting community support for local fluoridation initiatives. Staff is developing a community assessment tool to complement the Association's Fluoridation Campaign Manual. Technical assistance will also be provided to local campaigns.

National Toxicology Program: Unevaluated data from a sodium fluoride bioassay performed on rodents, conducted by the National Toxicology Program (NTP), an agency within the National Institute of Environmental Health Sciences, were released prematurely. This release generated a national-level interest in fluoridation. The potential link suggested by this study between the ingestion of sodium fluoride and the occurrence of osteosarcoma, a rare form of bone cancer, renewed public debate regarding the issue of fluoridation. The Council, along with four divisions within the Association, quickly became involved and provided information on this issue to the members, the media and the public. The Council played a major role in this effort by assisting with the coordination, collection and dissemination of scientific information to the membership and the public.

Through the joint efforts of the Council and the Council on Dental Research, scientific documentation on the safety and effectiveness of water fluoridation in humans was provided to both the National Toxicology Program and the United States Public Health Service for internal peer review. Council staff participated in numerous Association strategy planning sessions and worked closely with the Centers for Disease Control to assimilate accurate, up-to-date information on this issue which was subsequently shared with the membership. At its June 1990 meeting, the National Fluoridation Advisory Committee recommended several possible strategies, for consideration by the Council, to assist in countering anticipated challenges to local fluoridation campaigns and current fluoridation ordinances. Concentrated support efforts will be required at the local level to offset these projected challenges.

A January 3, 1990 *Federal Register* notice from the Environmental Protection Agency (EPA) requested comments on the Primary and Secondary Drinking Water Regulations. In response, joint comments were prepared and submitted by the Council and the Council on Dental Research addressing the safety, effectiveness and cost of community water fluoridation. Photocopies of relevant peer-reviewed scientific publications were forwarded to EPA as part of this review process.

Fluoridation Commemorative Stamp: At its February meeting, the Council acted to support the efforts of the West Michigan Dental Society to procure a National Fluoridation Commemorative Stamp to coincide with the 50th anniversary celebration of community water fluoridation in the city of Grand Rapids, Michigan. The Council prepared the following resolution on this matter and recommends its adoption by the 1990 House of Delegates.

1. Resolved, that the American Dental Association support efforts to procure a National Fluoridation Commemorative Stamp to recognize the contribution community water fluoridation has made toward improving the oral health of United States citizens.

Caries Prevention Guide for Dental Practitioners: In February 1990, at the recommendation of the National Fluoridation Advisory Committee, the Council approved the development of a Caries Prevention Technical Assistance Guide for dental practitioners. This resource document, which covers a broad spectrum of caries prevention modalities, their rationale and appropriateness, was developed by an ad hoc committee that consisted of the following members: Dr. James Calderone, chairman; Dr. Joel Boriskin, Dr. Durward R. Collier, Dr. Richard C. Graves, Ms. Alice Horowitz, RDH, MPH, Dr. David Johnsen, Dr. James Jones and Dr. Mark Siegal. The Council is seeking outside funding to produce the guide.

Management Conference Program: The Council continues to enhance the working relationship between constituent and component dental societies and the states' dental public health offices. During the 1989 ADA Management Conference, the Council sponsored a special roundtable discussion. State dental directors from Tennessee and Indiana were invited to the conference to talk with dental society representatives. The Council expresses thanks to Dr. Durward Collier and Dr. Victor Mercer for their time and effort.

Healthy Mothers/Healthy Babies Coalition: The Council continues to represent the Association as a member of the Healthy Mothers/Healthy Babies Coalition (HMHB) which consists of more than 90 national organizations. The Council is also a member of the Coalition's Oral Health Subcommittee. The problem of "Baby Bottle Tooth Decay" (BBTD) continues to be a priority for the Subcommittee. Methods for increasing the effectiveness of educational materials on BBTD for low socio-economic populations are being explored.

Maternal and Child Oral Health: The Council continues to monitor the activities associated with the September 1989 Maternal and Child Oral Health Conference, sponsored by the Bureau of Maternal and Child Health and Resource Development. The Council will consider appropriate opportunities for Association involvement with the recommendations for action that emerged from this national workshop as these opportunities emerge.

Sports Dentistry: The Council remains committed to promoting a greater awareness of sports dentistry issues and encourages widespread use of oral/facial protectors. Council staff represented the Association at the Academy of Sports Dentistry meeting in June 1989. The United States Olympic Committee Division of Sports Medicine and Science has a Dental Advisory Committee composed of Dr. Robert Biddington, chairman, Dr. Jack Nichols and Mr. Nicholai Petrovic. Although the Committee was not funded to meet in 1989, it is expected to be active in 1990. Since the inception of the Committee nearly a decade ago, the Council has maintained a line of communication with the Committee Chairman and has reported its activities to the Board of Trustees.

Hypertension: Dr. Brodie Secrest, Jr., Council consultant, maintains liaison with the National High Blood Pressure Education Program. In 1990, the Council publicized to the constituent and component dental societies the availability of the National Heart, Lung and Blood Institute's "NHLBI Kit '90," which contains ideas and materials for preventing heart disease, lung disease and stroke. The Council continues to monitor the issue of hypertension and its relevance to dentistry.

Liaison with National Agencies: Liaison with national organizations continues to be an integral part of the Council's preventive health activity. Staff represented the Council at two major public health meetings in 1990: the annual meeting of the American Public Health Association and the American Association of Public Health Dentistry.

Staff also attended the National Oral Health Conference on March 31-April 4, 1990. The conference is cosponsored by the Centers for Disease Control and the Association of State and Territorial Dental Directors. A major focus of the conference was the future impact of the National Toxicology Program study on fluoridation activities at the state and local levels.

Pit and Fissure Sealants: The Council continues to promote the availability of the "Dental Sealant Resource Kit," a joint effort with the Council on Dental Materials, Instruments and Equipment. This kit is available on request. The Council also provided consultation to the Johnson & Johnson Dental Care Company regarding its nationwide dental sealant public awareness campaign, promoted in conjunction with the Children's Miracle Network telethon in June 1990.

Smokeless Tobacco: The Council believes that appropriate federal regulation of this product and its advertising are needed. Monitoring of this issue at various levels and providing public and professional information have increased over the past year. The Council is exploring opportunities for increased involvement by the Association in promoting the hazards associated with use of smokeless tobacco.

Tobacco Use: In cooperation with the American Student Dental Association (ASDA), the Council conducted a survey to ascertain the prevalence of tobacco use (cigarettes, smokeless tobacco, cigars and pipes) among dental students in the United States. The survey indicated a use rate of 16% compared to the U.S. adult population rate of 29%. This preliminary data has been shared with ASDA and the American Association of Dental Schools.

At its February 1990 meeting, the Council considered revising existing American Dental Association policy on tobacco use to include urging constituent and component dental societies, individual dentists, and related dental groups and dental schools to adopt smoke free policies. The Council prepared the following amendment to existing policy and recommends its adoption by the 1990 House of Delegates.

2. Resolved, that the following statements be added to the Association's current policy on smoking and tobacco use (*Trans.* 1988:489).

> The American Dental Association urges its individual members, dental societies, dental schools and related dental organizations to adopt antismoking policies for their offices and meetings, where such policies are not already in place.

Smoking Cessation: The Council continues to monitor two smoking cessation projects being sponsored by the National Cancer Institute (NCI). Both of these projects, the Community Intervention Project for Smoking Cessation (COMMIT) and the American Stop Smoking Intervention Study (ASSIST), will train and utilize dentists in smoking and intervention techniques.

Over the past year, the Council has been working with NCI to consider opportunities for Association involvement in the development of strategies and coordination of initiatives.

National Objectives for the Year 2000: The Association has been an active member of the consortium of organizations participating in the development of the National Objectives since 1987. In October 1989, draft copies of the Year 2000 Oral Health Objectives were distributed to constituent and component dental societies for review and comment. The Council encouraged letters to the U.S. Department of Health and Human Services supportive of the content of the objectives. In addition, the Council forwarded comments on this draft, on behalf of the Association, reiterating the American Dental Association's strong support for the national health objectives process. The final document will be released to the public in September 1990 in Washington, D.C. The Council Chairman will attend on behalf of the Association.

Community Preventive Dentistry Award: The Community Preventive Dentistry Award, funded by the Johnson & Johnson Dental Care Company and administered by the Council, recognizes those who have created and implemented significant preventive dentistry programs. Four programs were recognized for outstanding achievement in 1989, the 17th year of the program. An award of $2,000 was given to Dr. Stephen M. Feldman and Ms. Darlene E. Novak for the project "Louisville Celebrates National Children's Dental Health Month." Through the efforts of the Kentucky Dental Association, the University of Louisville School of Dentistry and 37 affiliated community sponsors, Louisville marked the 40th observance of National Children's Dental Health Month by organizing several educational activities throughout the month of February. It is estimated that 500,000 people throughout Kentucky and southern Indiana were reached by these programs.

Awards of merit were granted to the Ohio Department of Public Health for its entry "Sealing the Future," a statewide program to increase the awareness of the general public, insurance carriers and purchasers of dental benefit plans about the benefits of sealants; to the Public Dental Service Society, Cincinnati, for a public and private sector training/intervention project "Training and Technical Assistance: Project Head Start," and to the Texas Society of Periodontists for its state-wide media information program "Periodontics—On the Verge of a New Era," designed to increase the periodontal awareness of dental professionals.

Geriatric Dental Health Care Award: The Geriatric Dental Health Care Award, funded through a grant from the Warner-Lambert Company Consumer Health Products Group, recognizes those individuals and organizations that have improved the oral health care of the elderly through innovative research and health care delivery projects. The 1989 Geriatric Dental Health Care Award was presented to Dr. Stanley R. Saxe, University of Kentucky College of Dentistry, for the entry "Oral Health Care Strategies for Caregivers of Dependent Homebound Elderly in Appalachia." The aim of this project was to improve the oral health of dependent homebound elderly by providing oral health care workshops for caregivers. Innovative educational materials were developed on Alzheimer's disease, arthritis, Parkinson's disease and stroke for use by volunteer health educators.

Merit awards were granted to Dr. Henrietta Logan, University of Iowa, College of Dentistry for a comprehensive project, "Oral Health Training and Referral Program for the Frail Elderly," designed to improve the oral health of Iowans by educating home health caregivers; to the Alameda County Dental Health Bureau in Oakland, California for its geriatric dental care program, cosponsored by the Alameda County Dental Society, "Alameda County Geriatric Dental Care Program," developed to bring dental care to 7,000 non-ambulatory elderly residents in 85 nursing homes, regardless of their ability to pay; and to the Eastman Dental Center in Rochester, New York for its entry, "Workshops on Geriatric Dentistry," an annual activity begun in 1983 and scheduled to continue indefinitely.

National Fluoridation Award: Three National Fluoridation Awards for Outstanding Achievement in Water Fluoridation were presented by the Centers for Disease Control in cooperation with the American Dental Association and the Association of State and Territorial Dental Directors for the second time at the National Oral Health Conference in San Diego on April 2, 1990. The Florida Fluoridation Program was recognized for the addition of two large cities, Tampa and Tallahassee, with a combined population of 500,000. Dr. Melvin Ringleberg, state dental director, accepted the award on behalf of that program. Dr. William Gross, chairman, Pennsylvania Partners for Better Oral Health, received an award of recognition for his years of dedication to the Pennsylvania fluoridation movement. If Pennsylvania's fluoridation legislation is passed, five million additional people will receive fluoridated water. The third award recognized C. Everett Koop, M.D. for the outstanding support he gave fluoridation while he was Surgeon General of the United States. This annual award will continue to be presented during this National Conference to recognize the efforts of states and/or individuals in promoting community water fluoridation.

Response to Assignments from the 1989 House of Delegates

Oral Health Care Guidelines: Resolution 1H-1989 (*Trans.* 1989:541) urged constituent dental societies to meet with licensed home care agencies in their states to stress the need for attention to the oral health needs of home care patients. Further, the resolution encouraged national accrediting bodies to adopt meaningful oral health care standards within their accrediting standards for home care agencies. Lastly, the resolution directed the Council to develop and distribute guidelines to be used as a basis for recommendations to home care agencies and accrediting bodies. Subsequently, the Council developed and distributed guidelines and stressed the need for better attention to the oral health care needs of the homebound.

Oral/Facial Protectors in Sports Programs: Resolution 60H-1989 (*Trans.* 1989:541) formally consolidated several existing policies on oral/facial protectors. It was noted that several aspects of the essence of this resolution will require additional study and that the Council on Community Health, Hospital, Institutional and Medical Affairs will continue its review of this issue. In this regard, at its February 1990 meeting, the Council recommended that additional educational materials on oral/facial protectors be considered for distribution primarily to junior high and high school students. The Division of Communications is planning a public service announcement on mouth protectors to be released in the fall 1990 and a summary report on this issue is being considered for publication in *The Journal of the American Dental Association* or the *ADA News*.

American Association of Retired Persons (AARP) Health Agenda: Resolution 61H-1989 (*Trans.* 1989:568) directed agencies of the Association to continue efforts to educate the leadership of AARP on the benefits of an acceptable oral health agenda for older Americans, together with appropriate financing mechanisms. The responsibility for this resolution was assigned jointly to CCHHIMA and Council on Dental Care Programs. The Councils are working together to gain support from AARP for a dental benefits program either for its members or within the Medicare and Medicaid programs. Additionally, the Council has sought to have AARP include a dental health education component within its library of subjects available to its membership.

Summary of Resolutions

New Policy/Directive:

1. Resolved, that the American Dental Association support efforts to procure a National Fluoridation Commemorative Stamp to recognize the contribution community water fluoridation has made toward improving the oral health of United States citizens.

Amendment/Rescission of Current Policy/Directive:

2. Resolved, that the following statements be added to the Association's current policy on smoking and tobacco use (*Trans.* 1988:489):

> The American Dental Association urges its individual members, dental societies, dental schools and related dental organizations to adopt antismoking policies for their offices and meetings, where such policies are not already in place.

Council on Dental Care Programs

Fountain, Stuart B., North Carolina, 1990, chairman
Killinger, James B., Wisconsin, 1991, vice-chairman
Ansted, Richard A., Ohio, 1991
Dubowsky, Scott M., New Jersey, 1992
Eyre, Vern B., Utah, 1991
Georges, Ramon P., Illinois, 1993
Geraci, Timothy F., California, 1993
Halik, Frederick J., New York, 1990
Hickman, French E., Oklahoma, 1990
Hill, Arnold J., Jr., Minnesota, 1990
Kirchner, George A., Pennsylvania, 1992
Klein, H. Raymond, Florida, 1991
LaCoste, Roger R., Massachusetts, 1992
Lippert, Jacob J., Missouri, 1993
McClure, G. Terry, Texas, 1993
Straka, Edward A., Jr., Oregon, 1992
Feldman, Marye C., secretary
Hoffmann, Rita M., assistant secretary
Tice, David D., assistant secretary
Todd, Kathleen M., manager, Contract Analysis Service

Meetings: The Council met on December 15-17, 1989 and April 20-22, 1990. It is scheduled to meet again on November 30-December 2, 1990. The Council's liaison from the Board of Trustees, Dr. Douglas R. Franklin, Thirteenth District trustee, attended the December 1989 and April 1990 meetings of the Council.

The Chairman appointed five subcommittees of the Council to focus on major areas of activity. These subcommittees met, or are scheduled to meet, as follows:

Purchaser Information Service	January 26-27, 1990
	July 14-15, 1990
Peer Review	February 2-3, 1990
Individual Practice Associations	February 7-8, 1990
Reporting and Reimbursement	December 14, 1989
Practices	March 16-17, 1990
Utilization Management	June 1-2, 1990

Representatives of the American Association of Dental Consultants, American Association of Preferred Provider Organizations, Blue Cross and Blue Shield Association, Delta Dental Plans Association (DDPA), the Health Insurance Association of America (HIAA), and the National Association of Prepaid Dental Plans (NAPDP), met with the Council on April 20, 1990.

The Council also met with representatives of national dental organizations on April 20, 1990. In attendance were representatives of the Academy of General Dentistry, American Academy of Pediatric Dentistry, American Academy of Periodontology, American Association of Endodontists, American Association of Oral and Maxillofacial Surgeons, American Association of Orthodontists, American Association of Public Health Dentistry and the Federation of Prosthodontic Organizations.

Personnel: At the December 1989 meeting, the Council elected Dr. James B. Killinger as vice-chairman for the 1989-90 year.

The close of the 1990 annual session brings to an end the terms of four valued members of the Council: Dr. Stuart B. Fountain who has served as chairman of the Council for 1988-89 and 1989-90; Dr. Frederick J. Halik who has served as chairman of the Council's Advisory Committee on the *Code* from 1987-1990; Dr. French E. Hickman and Dr. Arnold J. Hill. These members have made great contributions to the work of the Council and have given unselfishly of their time and energy on behalf of the profession. Their efforts are acknowledged by the Council with great appreciation.

Dental Benefits Conferences: The Council's annual *Dental Benefits Conference* was held on July 28-29, 1989 in Chicago and was attended by 185 individuals including representatives of constituent and component dental societies, national dental organizations and the dental benefits industry.

The 1989 Conference consisted of concurrent workshops that were open only to Association members representing their constituent or component dental societies, national dental organizations and organization staff. Topics included:

—constituent society initiatives in addressing third-party claim problems;
—dental office claim submission issues;
—dentist contracting and other legal issues;
—first-hand experiences in alternative benefits plans;
—legislative remedies to third party issues;
—utilization review programs in dentistry; and
—effective purchaser communication and patient education programs.

The keynote speaker was The Honorable John E. Porter (R), U.S. Congressman, 10th District, Illinois, who discussed health care strategies and decisions under the Bush administration.

Dr. James H. Gaines, trustee, Sixteenth District, and 1988-89 Board liaison to the Council, made a presentation entitled "Where Dentistry Differs," that set the tone for the presentations and panel discussions which followed.

The 1990 Conference is scheduled for July 27-28, 1990 in Chicago. The format will be similar to the 1989 Conference;

however, programs scheduled for both days will be open to all participants.

The first day of the program will include: John Burns, M.D., vice president, Health Management, Honeywell, Inc., keynote speaker; a panel entitled "Trends in Health Care," with Ms. Lynn Gruber, vice president, Managed Care Research, Interstudy; Dr. William Hoffman, director, Social Security Department, United Auto Workers of America; Mr. Bill Crumley, senior account executive, Provident Life and Accident, and chairman of the Dental Relations Committee of the Health Insurance Association of America; Mr. Earl Pomeroy, president, National Association of Insurance Commissioners; and Dr. Quentin Young, president, Health and Medicine Policy Research Group.

The concurrent sessions to be held in the afternoon are as follows:

—utilization management, a basic overview;
—developing a purchaser contact program;
—electronic claims processing;
—reporting and reimbursement practices;
—mediation and dispute resolution; and
—individual practice associations (IPAs).

The second day of the program will include a report on the Council's activities, a special presentation on the ADA's *Code of Dental Procedures and Nomenclature* and a panel on Electronic Claims Processing that will include presentations on major facets of this developing industry.

An open forum will be held in the afternoon for those participants who wish to informally discuss issues with the Council.

Peer Review Conference: The Council held a National Conference on Peer Review on September 23-24, 1989, at Association Headquarters. It was attended by 179 individuals representing constituent and component dental societies, state dental boards, national dental organizations, federal dental services, and third-party payers. The Conference offered the attendees several panel discussions and the opportunity to attend two of six concurrent workshops. Topics included:

—perspectives on peer review from third parties, employer groups, state boards, and a peer review committee chairman;
—the National Practitioner Data Bank;
—legal and liability issues;
—mediation training and the arbitration process;
—confidentiality and immunity issues;
—peer review procedures; and
—matters for review.

Based on the evaluation forms received, the majority of the sessions received a rating of "excellent." In fact, no session received less than a rating of "good." The highest rated program was the concurrent session, "Mediation Training and the Arbitration Process." Many Conference attendees suggested that an entire conference be devoted to that topic. The Council has responded to this interest in mediation in several specific ways (See section of this report entitled "Peer Review" page 51).

Based on the overwhelmingly positive evaluations of the 1989 National Conference on Peer Review, the Council decided to hold a national conference every three years, with the next one scheduled for 1992.

Future Conferences: In planning for future conferences, the Council agreed that the educational/informational needs of dental society leadership, as well as the representatives from business and industry who recognize the Association as a resource for information about dental benefits plans and issues, are changing. These changing needs can and should be met in a variety of ways, e.g., problem-specific slide/tape presentations; videotapes; and regional and state dental benefits conferences which are currently sponsored by some of the state societies.

The Council believes that the mandatory annual Dental Benefits Conference, as directed by Resolution 104H (*Trans.*1980:554), does not provide sufficient flexibility to address issues in terms of available expertise and resources. Therefore, the Council recommends adoption of the following resolution:

3. Resolved, that beginning in 1991, the Council on Dental Care Programs shall present a conference on dental benefits issues and related matters as necessary, and be it further
Resolved, that Resolution 104H-1980 (*Trans.*1980:554), Annual Conference on Dental Prepayment, be rescinded.*

Federal Programs: The Council continues to monitor the dental component of the Medicaid and Medicare programs. With respect to the Council's efforts in Medicaid, the annual survey of constituent dental societies and state Medicaid programs was distributed in May 1990. The survey was sent out later than usual this year to effectively obtain information from those states with fiscal years that do not end until June 30, 1990. The survey instrument was divided into four sections targeting dental benefits and expenditures, Medicaid dental providers, dental services and program administration. The report of the survey of the dental component of state Medicaid programs is available from the Council upon request.

Working with the Council on Governmental Affairs and Federal Dental Services, the Council advised constituent societies about reforms to the Medicaid program and, more specifically, improvements made in eligibility and the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. With this information, constituent societies were asked to confirm that these improvements are implemented by the appropriate state agencies. Where these changes were not previously enacted, constituents were urged to lobby appropriate agencies to implement them. The Council has also urged constituent societies to become involved in Medicaid demonstration projects conducted by the Secretary of the Department of Health and Human Services (HHS) in order to ensure that they are responsible alternatives to

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***Note:** As the volume of policy being proposed for rescission is significant, this report will only provide the appropriate citations. Copies of the policies to be rescinded will be provided to the House of Delegates prior to its meeting and to all other individuals upon request.

operational programs and that the dental portion of the programs are soundly structured. Medicaid reforms enacted as part of the Omnibus Budget Reconciliation Act (OBRA) of 1989 are:

Eligibility. Effective April 1, 1990, all states must provide Medicaid coverage to pregnant women and infants to age one with family incomes up to 133% of the federal poverty level. This affects 29 states and the District of Columbia. The remaining states already meet or exceed this reimbursement. Those which exceed it are prohibited from reducing their eligibility level.

Also, beginning on April 1, states must provide Medicaid coverage to children up to age six whose family income is below 133% of the federal poverty level. The current authority (but not requirement) for states to cover ages six and seven whose family income is below 100% of the federal poverty level remains in effect.

It should be noted that states may implement these legislative changes later than April 1, but only if a change in state law is required (and not budget legislation), as determined by the Secretary of Health and Human Services (HHS). In these cases, the delay can only be until the beginning of the first calendar quarter following the end of the state's next regular legislative session after enactment of OBRA.

Additionally, the law requires the Secretary of HHS to conduct demonstration projects in several states to study alternatives for extending either Medicaid or another kind of coverage (e.g., employer-sponsored, state employees plan, an HMO) to pregnant women and children under age 20 who are otherwise ineligible for Medicaid and whose family income is below 185% of the federal poverty level. If an employer-sponsored plan is chosen, an employer contribution must be required.

In these demonstrations projects, premiums may be charged only to families with incomes between 100% and 185% of poverty and cannot exceed 3% of family income. The number of projects is unspecified, but annual funding is limited to $10 million for 1990, 1991 and 1992.

EPSDT. The screening requirements under EPSDT have been clarified and strengthened. Dental screenings by a dentist must begin at age three. States are no longer allowed to delay them until age five. Dental services must include all care necessary for the relief of pain and infections, restoration of teeth and maintenance of dental health. Where conditions requiring treatment exist, dental services must be provided even earlier than age three.

The law requires that dental screenings and services be provided at intervals which meet reasonable standards of dental practice, as determined by the state after consultation with recognized dental organizations. Also, the law provides for interperiodic screening services, including dental, at such other intervals as are necessary to determine the existence of certain conditions.

Reimbursement. The law also codifies a Health Care Financing Administration (HCFA) regulation that state provider reimbursement rates must be sufficient to enlist enough providers so that services are available under the plan at least to the extent that such care and services are available to the general population in the same geographic area.

State Reports. The law requires states to report annually to HHS with information on the effectiveness of the EPSDT program in reaching eligible children. One of the elements to be reported is the number of children receiving such services.

Additional information on legislative initiatives in Medicare and Medicaid is found in the 1990 annual report of the Council on Governmental Affairs and Federal Dental Services.

Health Maintenance Organizations (HMOs): The Council continues to monitor trends in the HMO industry in general and the role of dental care in HMOs in particular. Using data from other sources, the Council has compiled a list of HMOs which offer dental benefits. This list is available upon request.

As of March 1990, there were 597 federally qualified HMOs and 139 Competitive Medical Plans (CMPs). An additional 14 HMO and four CMP applications were pending. Nearly 35 million people were covered by the HMOs. Eighty-nine HMOs and 78 CMPs offered dental benefits as part of their package. Sixty-nine of those HMOs and 74 of the CMPs offered dental benefits as an option, while the remaining 20 HMOs and four CMPs offered dental benefits as part of the standard package.

Individual Practice Association (IPAs): The 1988 House of Delegates adopted Resolution 38H (*Trans.*1988:475) which directed that, upon request, the American Dental Association provide information to members and plan purchasers about dental individual practice associations that are established and/or directed by organized dentistry and that conform to Association policy, and where appropriate, discussion of IPAs be included in the purchaser information service program.

In response to the resolution, the Council on Dental Care Programs currently provides the publication *Individual Practice Associations and Dentistry* and reprints of relevant articles to members who request information. The Council also provides a speaker to dental groups interested in forming a dental IPA.

The Council is currently revising the IPA brochure in order to provide more current, relevant information. The new brochure will (1) provide an outline which further summarizes the steps required to establish an IPA, (2) highlight the importance of obtaining knowlegeable legal counsel prior to the establishment of an IPA, (3) include a glossary of pertinent terminology, and (4) replace the current appendix with a description of services available from the Association. The Council will also provide a list of organized dental IPAs in addition to the IPA booklet when information is sent to members. The revised publication will be available from the Council office upon request.

The Council is also considering revision of its publication, *Dental Prototype for HMOs.*

"Code on Dental Procedures and Nomenclature": The Council's Advisory Committee on the *Code* held its final meeting on September 24-26, 1989 in order to complete its two-year revision process for the 1990 publication of the *Code*. The Advisory Committee's report was submitted to the Council for discussion and action at its December 15-17, 1989 meeting. In accordance with the revision process, the Council's recommendations were forwarded to a Consensus Panel consisting of representatives from HIAA, DDPA, and the Blues, and three representatives of the Council in addition to the chairman of the Advisory Committee on the *Code* who served as the non-voting chairman of the Consensus Panel.

The Consensus Panel's report and recommendations were returned to the Council for discussion and review at its April 20-22, 1990 meeting. The Council's final report was reviewed by the Consensus Panel on May 11-12, 1990. The code revision process will be finalized by the Council at its meeting on July 29, 1990 and publication of the revised *Code* is scheduled for late 1990.

The revised *Code* will be published in conjunction with a user's manual which will clearly define each code. This will assist dentists and their staff in reporting treatment accurately and consistently to third-party payers.

Peer Review: Through its Peer Review Subcommittee, the Council has targeted several issues for which it will develop specific assistance initiatives for constituent societies. From statistics compiled through the National Peer Review Reporting System, the Council noted the recent decline in the number of cases which are successfully mediated. Based on this, and the response to the mediation workshop offered at the National Conference on Peer Review, the Peer Review Subcommittee met with the professional mediators who conducted the workshop to discuss ways in which the Council can support dental societies in improving the mediation stage of peer review. Based on this discussion, the Council decided to promote professional mediation training for constituent and component society peer review committee members in the following ways:

1. Work with ADA Publishers, Inc. staff to prepare an *ADA News* story on the importance of mediation skills and expertise in effectively resolving peer review cases and options available in obtaining professional mediation training.
2. Develop a mediation workshop as part of the 1990 Dental Benefits Conference.
3. Develop a free-standing mediation training program appended to the 1990 Dental Benefits Conference. This ten-hour session, to be held on July 28-29 at Association Headquarters, is directed to constituent society peer review chairmen in order to stimulate their interest in sponsoring a similar program for all peer review committee members in their state.

In comparing the mediation stage of the peer review process with techniques used by professional mediators, the Council considered a professional mediation technique called "conference mediation" which involves the mediator meeting jointly with both parties to a dispute. As a supplement to the traditional telephone mediation technique used by peer review committees, the Council agreed that "conference mediation" could increase the number of cases that are successfully mediated, thus reducing the overall time commitment required of peer review committee members. Therefore, this technique will be promoted by the Council in any education programs and materials related to mediation skills in peer review. The Council also agreed to develop a videotape presentation on mediation skills, tailored to peer review committees, in 1991.

In reviewing historical data from the National Peer Review Reporting System, the Council noted a dramatic decline in the number of cases submitted by third-party payers. It also reviewed the results of surveys conducted by the Council in 1982 and 1984 which suggested areas of third-party dissatisfaction with the peer review process. In May 1990, the Peer Review Subcommittee initiated a survey of local carrier claims offices to compile current information on these issues. The results of this survey will be used to develop initiatives to enhance the involvement of third-party payers in the peer review process.

The Council concluded that one motivator for both third-parties and subscribers to submit disputes to dental society peer review committees would be a statement in the Summary Plan Description (patient's benefit booklet) suggesting that any disputes regarding carrier benefit decisions based on treatment proposed or rendered be submitted to dental society peer review. Therefore, the Council recommends adoption of the following resolution:

4. Resolved, that patients and third-party payers be encouraged to use the dental profession's peer review process to address issues or disputes concerning dental treatment provided under dental benefits programs, and be it further

Resolved, that the Council on Dental Care Programs work with third-party payers, plan purchasers, benefits consultants and government agencies to include the following paragraph in the "claim appeals" section of the Summary Plan Description provided to dental benefits plan subscribers:

> State and local dental societies provide an impartial means of dispute resolution regarding your dental treatment. This process, called Peer Review, is available to you as an adjunct to the (insert name of benefit plan or benefit administrator) appeal process. For more information about Peer Review, contact your local dental society.

and be it further

Resolved, that Resolution 79H-1987 (*Trans.*1987:502), Utilization of Peer Review Process, be rescinded.*

The annual national peer review reporting system survey was forwarded to constituent dental societies in March 1990.

***Note:** As the volume of policy being proposed for rescission is significant, this report will only provide the appropriate citations. Copies of the policies to be rescinded will be provided to the House of Delegates prior to its meeting and to all other individuals upon request.

This survey included a section on peer review organization and administration. In an effort to maintain current information on peer review, constituent dental societies were also requested to send a copy of their peer review manuals and quality assessment manuals, if any, to the Council office. As of April 30, 1990, 28 surveys have been received in the Council office. A follow-up mailing to those states that have not responded will be conducted in early May. This year's survey also asks questions requested by the Council on Dental Practice about the handling of disputes between dentists and dental laboratories. The results of the 1990 survey are being sent to constituent dental societies and are available from the Council office upon request.

With the completion of the revised Peer Review Manual, the slide/tape presentation, "Peer Review: Making It Work," and the videotape, "The Joan Beck Case: How Peer Review Works," 1989 was a productive year for the Council in the area of peer review. The Council continues to conduct peer review assistance programs for peer review committee members, officers and staff at the request of constituent dental societies. In 1989, programs were conducted for both component societies of the Nevada Dental Association, The Dental Society of the State of New York, and a joint program was conducted for the Vermont State Dental Society and the New Hampshire Dental Society. The Council also conducted a program for the North Dakota Dental Association in January 1990.

In an effort to educate all dental societies in the ever-changing peer review process, the Council has strongly urged dental societies which have not sponsored a peer review assistance program within the last three years to do so in 1990. The Council will accommodate as many requests for programs as possible.

Contract Analysis Service: The last year has seen a leveling off in the number of contracts submitted for analysis but an increase in the complexity of the legal issues they represent. These range from contracts that require dentists to participate in an organization's non-UCR programs to contracts that call for involuntary termination of dentists for "over utilization."

Activities of the Service. Activities of the Service fall into three main categories: analysis of contracts, workshops and seminars, and research and dissemination of information about legal implications of dentist contracts with dental benefits organizations.

Analysis of Contracts. During 1989, the Service received 256 requests for contract analyses and processed 218. The number of members who have benefited from the analyses is incalculable, since many state and local societies distribute selected analyses to their entire membership.

Workshops and Seminars. The workshops and seminars on contract analysis remain an effective way to disseminate information to large numbers of dentists on contracting principles and pitfalls. From May 1, 1989 to April 30, 1990, the Service conducted six presentations on contract analysis and related legal issues.

Research and Dissemination of Information. The Service continues to respond to the increasingly sophisticated legal issues that affect members involved in contractual relationships with dental benefits organizations. For example, the Service was instrumental in developing a friend of the court brief which was filed by the Association's Division of Legal Affairs in the bankruptcy proceeding of a major health maintenance organization. The brief objected to the HMO's motion for an order that would prevent noncontracting physicians and dentists from collecting unpaid fees from patients who were members of the HMO. The motion was granted, but the order is being appealed.

The Service provides information to constituent and component dental societies on significant legal issues affecting dentists contracting. The Service was instrumental in developing a memorandum which was sent to state dental societies on the subject of open-ended clauses in service corporation contracts.

These clauses require the dentist to participate in any dental program marketed by the service corporation, regardless of the payment mechanism.

Effects of the Service. Dental benefits organizations have reacted to problems identified in the Service's analyses of their contracts by modifying certain terms. This trend should continue as members, assisted by the Service, become better educated about the legal implications of the contracts they are offered.

Purchaser Information Service: Over the past year, this Service has furthered its efforts to establish the Association as the authority and primary resource for dental benefits plan information. The primary activities of the Service are to promote direct reimbursement and other dental benefits plan models in accordance with the policies of the American Dental Association; to increase the number of individuals covered by a dental benefits plan; and to improve some currently existing dental benefits plans where the level of benefits and extent of coverage is less than optimal.

In response to Resolution 77H-1989 (*Trans.*1989:555), the Council revised its brochure for plan sponsors. This brochure provides employers and other plan purchasers with meaningful questions to ask when evaluating and selecting a dental benefits plan. It defines each type of plan design and identifies issues to consider when examining the various types.

Since August 1, 1989, a number of employers have contacted the Association to discuss their dental plans and the feasibility of implementing a direct reimbursement dental benefits plan. These requests are generated from dentist-to-patient communication; leads from the business-reply postcards inserted in two issues of the *ADA News;* and from the national advertising campaign. An average of 95 requests are now being received on a monthly basis. Based on responses to a follow-up survey, it is estimated that 5% have resulted, or will result, in the adoption of a direct reimbursement dental benefits plan.

Those employers most serious about implementing a direct reimbursement dental plan often request an actuarial estimate of the costs they should anticipate in the first year

of the plan. Overall, the Service has provided direct reimbursement cost estimates for 150 employers since August 1, 1989. Half of those groups requesting a cost estimate have had no previous dental benefits coverage. Those with a current plan often comment on its low level of coverage, difficulties with understanding the plan or general employee dissatisfaction with plan limitations and exclusions. Some of the larger groups requesting direct reimbursement information were: Tufts University, the City of Birmingham (Alabama), The New York Academy of Sciences, the State of Vermont and Johns Hopkins University.

The success of the actuarial cost estimate service has resulted in a need for cost estimate capability at the state and local level for those dental societies with active direct reimbursement campaigns. For this reason, the Council is sponsoring a training session for the appropriate constituent and component dental society staff in need of this capability.

Constituent and component dental societies have also taken advantage of the Council's three convention booths for exhibiting direct reimbursement and other dental benefits information. In the past year, a number of constituent or component societies have used these booths at a total of 21 state or local meetings of dentists or employers. In addition, the Council has exhibited dental benefits information and encouraged the adoption of dental benefits plans at the following annual conventions: Association of School Business Officials, Human Resource Management Marketplace, Consumer Federation of America, American Management Association's Human Resource Conference, American Society of Association Executives, American Association of School Administrators, Benefits Expo '89 and Personnel Magazine's Best of America Training and Personnel Show. A workshop on structuring a comprehensive dental benefits plan was presented at the latter two major human resources conventions.

In addition to talking to convention attendees, Council members and staff have given presentations at 22 dental society meetings and other gatherings of interested employers and benefits managers such as personnel conventions, employer luncheons hosted by a dental society, chamber of commerce meetings and service club meetings (e.g. Kiwanis).

Many of the plan purchasers and decision makers who approach the Association regarding their dental benefits are seeking general dental benefits plan information. They wish to make minor changes in coverage for an already-existing plan or wish to know if their plan is in keeping with Association policy. For these reasons, the Council continues to offer to review plans for employers, commenting on plan language as well as on the scope and level of coverage as it relates to Association information and policy. In the past year, this service has been well-received by 15 employers who wished to evaluate and improve their dental benefits, including: Ameritech, the Corning Hilton, Greyhound, Kansas City Power & Light, Kraft, Johnson & Higgins and Geisinger Medical Center.

The Council has again initiated an incentive program to encourage direct reimbursement campaigns and other Purchaser Contact efforts at the constituent and component dental society levels. This project was first undertaken in 1987. A project fund has been set aside to assist in the costs of relevant projects. The Council has established guidelines for the disbursement of the fund. They include a limit of the lesser of $3,000 per constituent society or one-third of the dental society's budget for the project; projects of constituent societies will be given priority over projects of components; and second projects by a constituent will be considered at the year end as funds allow. It is hoped that this assistance will serve, as it did in 1987, to stimulate greater activity in this area at the state and local level.

Reporting and Reimbursement Practices: Through its Reporting and Reimbursement Practices Subcommittee, the Council continued to address issues related to the insurance industry's aggressive pursuit of fraudulent activity in health benefits plans. As reported to the 1989 House (*Reports* 1989:51), the Council accepted an invitation from the National Health Care Anti-Fraud Association (NHCAA) to serve on its Board of Governors Liaison/Advisory Committee. NHCAA was formed to represent third-party payers and law enforcement agencies in formulating general policy for the control of health care fraud, facilitating cooperation among the industry, and developing and promoting anti-fraud activities. The first meeting of this Committee was held on November 13, 1989 in conjunction with the fifth Annual NHCAA Conference in Miami. Other meetings are scheduled for June and November 1990. In addition to the Association, other organizations represented on this Committee include the American Medical Association, Health Insurance Association of America, National Association of Insurance Commissioners, National Coalition of State Legislatures, Consumer Health Information Research Institute, Podiatric Medical Review Consultants, the International Association of Special Investigative Units, benefit consulting groups and business health coalitions.

The inaugural meeting of the NHCAA Committee served primarily to define the Committee's role in assisting the Board of Governors to develop NHCAA policy and to identify priority issues to be addressed by the Committee. The following five issue areas comprise the Committee's immediate agenda and provided the focus of Council activities during 1990:

1. Definition of fraud;
2. Nondisclosure of waiver of patient copayment ("overbilling");
3. "Overcoding" and "unbundling of procedures";
4. "Downcoding" by carriers; and
5. Communications between carriers and providers/ patients.

At its December 14, 1989 and March 16-17, 1990 meetings, the Subcommittee met with the immediate past-president of the American Association of Dental Examiners and a representative of the Health Insurance Association of America to discuss these issues in detail.

The Council first considered the different types of

fraudulent and abusive practices that may occur under dental benefits plans. On the subject of nondisclosure of waiver of patient copayment ("overbilling"), the Council concluded that the ADA *Principles of Ethics and Code of Professional Conduct* adequately communicate the Association's opposition to this fraudulent practice. However, the Council noted that only 15 states have addressed this issue in their dental practice acts, and that the quality and depth of these legal prohibitions vary greatly from state-to-state. Therefore, the Council recommends adoption of the following resolution:

5. Resolved, that constituent dental societies be urged to pursue enactment of legislation that prohibits overbilling by a dentist, consistent with Association policy, and be it further
Resolved, that third-party payers be urged to support this legislative objective.

On the subject of advice or recommendations that could be given to a member who has knowledge of a colleague who routinely engages in overbilling, the Council decided that members should be advised to report documented cases to their dental society judicial committee. The Council also decided to work with the Council on Ethics, Bylaws and Judicial Affairs as it develops a videotape presentation on ethics.

In reviewing other specific fraudulent and abusive claim reporting practices, the Council developed the following working definitions to be used as a basis for discussion of the issues with the NHCAA and other third-party organizations.

Overcoding. Billing a third-party payer for a more complex and/or higher cost procedure than was actually performed. (Example: reporting a prophylaxis as scaling and root planing, scaling in the presence of gingival inflammation, or gingival curettage.)

Unbundling of Procedures. Reporting component pieces of a given procedure and their itemized charges in place of the accepted global procedure code with a single global charge. (Example: reporting root canal therapy as pulp vitality tests, radiographs, medicament, root canal procedure and follow-up office visit, each with an individual charge.)

Downcoding. A practice of third-party payers in which benefits are determined based on a less complex and/or lower cost procedure than was reported. (Example: benefitting two one-surface amalgam restorations placed on the same tooth on the same day as one two-surface amalgam restoration.)

In reviewing these subjects, the Council noted that, in addition to a deliberate intention to misreport, these practices may result unintentionally from a poorly designed coding system and/or one which is not adequately supported by knowledgeable education assistance. The Council concluded that its current structure for maintaining the *Code* including carrier and specialty representation, the consensus panel review process, publication of the "User's Guide" to the *Code,* and a conference for seminar presenters and third-party representatives, satisfactorily attempts to address these factors.

In order to achieve consistency in discussion of issues related to fraudulent and abusive practices in dental benefits plans, the Council believes it is important to standardize definitions of certain terms which categorize the various types of practices that may occur. In this regard, the Reporting and Reimbursement Practices Subcommittee worked with the Division of Legal Affairs to develop definitions that can be used as a basis for discussions with NHCAA and other insurance industry organizations.

In considering a definition of fraud, the Council agreed that separate definitions are necessary to distinguish practices that may be engaged in by third-party payers from those that may be engaged in by providers and patients. The Council first developed a definition to describe fraudulent practices engaged in by dentists or patients submitting claims to a dental benefits plan.

On the subject of third-party fraud, the Council concluded that it is a much more difficult task to categorize many problematic third-party payment practices as fraud. However, a substantial body of law has developed concerning "bad faith" conduct that is applied to such activities as mishandling of "losing" claims, failing to respond timely or accurately to claim inquiries, and purposely requiring unnecessary or unreasonable background information to pay a claim. Most third-party activities that, while not fraudulent, might be considered "abusive" claims practices would be considered conduct in "bad faith." The Council has developed a definition to describe these abusive practices by third-party payers.

The Council also concluded that there is one area of third-party activity that seems to fit more easily into the definition of fraud. This is the area of "downcoding" in which the third-party payer deliberately changes treatment codes or descriptions of treatment reported by the treating dentist in order to effect a lower benefit. The Council developed a definition to describe these practices.

In order to provide the Council with an established base from which to work in addressing the issues of dental benefits plan fraud and abuse, the Council recommends that the definitions of the above practices become Association policy. Therefore, the Council recommends that the following resolution be adopted:

6. Resolved, that the following definitions related to fraudulent and abusive practices in dental benefits plans be adopted:

> *Claims Reporting Fraud:* The intentional misrepresentation to a third-party payer of material facts concerning treatment provided and/or charges made, with the expectation that the misrepresentation would cause a payment higher than that which would have been paid had the misrepresentation not occurred.
>
> *Bad Faith Insurance Practices:* The failure to deal with a beneficiary of a dental benefits plan fairly and in good faith; or activity which impairs the right of the beneficiary to receive the benefits of a dental benefits plan.
>
> Some examples of bad faith insurance practices

include: evaluating claims based on standards which are significantly at variance with the standards of the community; failure to properly investigate a claim for benefits; and unreasonably and purposely delaying and/or withholding payment of a claim.

Claims Payment Fraud: The intentional manipulation or alteration of material facts as submitted by a treating dentist so that payment to the beneficiary and/or the treatment dentist would be less than that which would have been paid had the manipulation or alteration not occurred.

Overcoding: Billing a third-party payer for a more complex and/or higher cost procedure than was actually performed.

Unbundling of Procedures: Reporting component pieces of a given procedure and their itemized charges in place of the accepted global procedure code with a single global charge. (Also referred to as "Hyperitemization.")

Downcoding: A practice of third-party payers in which benefits are determined based on a less complex and/or lower cost procedure than was reported.

During its consideration of communications between carrier and provider/patient, the Subcommittee reviewed many recent examples of explanation of benefits language that are provided to patients to indicate reasons why a benefit has been reduced or denied based on the fee charged or the treatment performed and agreed that potential interference in the dentist-patient relationship due to these statements is becoming more pronounced. In reviewing current Association policy regarding explanation of benefits statements (*Trans.*1982:522;1984:561), the Subcommittee noted that the phrase "...or a statement of similar intent...." has allowed both the Council and carriers considerable latitude in selecting and approving explanatory language to communicate the Association's intent. Over the years, this latitude has caused a great deal of confusion regarding the Council's specific recommendation on this issue.

With advice from the Division of Legal Affairs, the Council developed recommended language to be used by third-party payers in explaining any reduction or denial of benefits. In the opinion of legal counsel, this language will meet federal ERISA requirements and preserve the intent of current Association policy. Therefore, the Council recommends adoption of the following resolution:

7. Resolved, that in all communications from a third-party payer or other benefits administrator which attempt to explain the reason(s) for a benefit reduction or denial to beneficiaries of a dental benefits plan, the following statement be included:

> Any difference between the fee charged and the benefit paid is due to limitations in your dental benefits contract. Please refer to (insert pertinent provisions of summary plan description) of your summary plan description for an explanation of the specific policy provisions which limit or exclude coverage for the claim submitted.

and be it further
Resolved, that in reporting the benefit determination to the beneficiary, the following information be reported on the explanation of benefits statement:

1. the treatment reported on the submitted claim by ADA procedure code numbers and nomenclature; and
2. the ADA procedure code numbers and nomenclature on which benefits were determined.

and be it further
Resolved, that the Council on Dental Care Programs work with third-party payers, plan purchasers, benefits consultants and government agencies to implement this policy, and be it further
Resolved, that Resolution 96H-1982 (*Trans.*1982:522) as amended by Resolution 102H-1984 (*Trans.*1984:561) be rescinded.*

The Council also reviewed related Association policy on bulk benefit payments (*Trans.*1987:506). Consistent with the above policy recommendation, the Council decided that bulk benefit payment statements sent to the dentist should contain the same information regarding codes and nomenclature submitted as those used to determine benefit payment. The Council also decided to recommend changing the reference to frequency of bulk payments from a measure by individual claim dates to a minimum payment frequency. Therefore, the Council recommends adoption of the following resolution:

8. Resolved, that in the interest of efficient dental office financial management, bulk benefit payments made by a third-party payer should include a statement containing, at a minimum, the following information for each claim payment represented in the bulk benefit check:

1. Subscriber (employee) name;
2. Patient name;
3. Dates of service;
4. Specific treatment reported on the submitted claim, by ADA procedure code number and nomenclature;
5. Total fee charged;
6. Specific ADA code number and nomenclature on which benefits were determined;
7. Total covered expense;
8. Total benefits paid; and
9. In instances where benefits are reduced or denied, an explanation of the reason(s) that the total covered expense differs from the total fee charged, consistent with Association policy on Explanation of Benefit Statements.

***Note:** As the volume of policy being proposed for rescission is significant, this report will only provide the appropriate citations. Copies of the policies to be rescinded will be provided to the House of Delegates prior to its meeting and to all other individuals upon request.

and be it further
Resolved, that bulk benefit payments should be issued to dentists at intervals of not longer than every ten business days, and be it further
Resolved, that the Council on Dental Care Programs work with the insurance industry and dental service plans to incorporate this policy into their administrative procedures, and be it further
Resolved, that Resolution 4H-1983 (*Trans.*1983:540) as amended by Resolution 56H-1987 (*Trans.*1987:506) be rescinded.*

In regard to other forms of written communications to dentists, the Council decided that it is extremely difficult, if not impossible, to monitor and regulate written and oral communications from carriers to dentists prospectively, noting that the range of issues and occasions for this communication are endless. The Council decided that situations of offensive and disruptive written communications should be handled on a case-by-case basis, and directed staff to continue its practice of monitoring written communications by carriers and responding directly to the source.

Based on the Subcommittee's extensive review of the issues, the Council noted that current Association policy on fraud and abuse, related specifically to the Medicare and Medicaid programs (*Trans.*1976:863), is too narrow to reflect the Council's current activities on the subject. Therefore, the Council recommends adoption of the following resolution:

9. Resolved, that the American Dental Association opposes all forms of fraudulent activity by any party to a dental benefits plan, and be it further
Resolved, that the Council on Dental Care Programs, in conjunction with other appropriate Association agencies, work cooperatively with insurance industry organizations, government agencies and other appropriate national organizations to develop effective strategies for detection and discipline of fraudulent and abusive practices under publicly and privately funded dental benefits programs, and be it further
Resolved, that in this effort, attention be given to such practices engaged in by dental benefits administrators, patients and dentists, and be it further
Resolved, that Resolution 129H-1976 (*Trans.*1976:863), Elimination of Illegal Practices in Government Programs, be rescinded.*

In order to enhance its ability to assist members in resolving problems with insurance industry claims administration practices, the Council decided to institute a tracking program for logging and categorizing member complaints. Under this program, based on a similar system used by the New Jersey Dental Association, constituent societies will be encouraged to document all member complaints using a standardized reporting form developed by the Council. This documentation will be compiled by the Council annually, and complaints will be categorized by issue and by third-party payer. These data will allow the Council to pinpoint trends in administrative practices and focus attention on specific carriers that present the greatest frustration to members and their patients. The Council will introduce this program at its Dental Benefits Conference in July 1990.

Utilization Management: Resolution 4H-1989 (*Trans.*1989:542) established the Association's position of statistically-based utilization review programs in dentistry. The Council's Utilization Management Subcommittee will meet on June 1-2, 1990 to develop strategies for implementing this policy. A complete report on this subject will be presented in a supplemental report to the House.

Response to Resolution 60-1985 Regarding Customary Fee: As reported previously to the House of Delegates (*Supplement 1,* 1987:327; *Reports* 1989:52), the Council has experienced difficulty in obtaining from dental benefit carriers the claims data necessary to complete the development of guidelines and methodologies for determining fee levels on which benefits are decided under UCR dental benefits plans. Although this difficulty has resulted from general opposition to the project by national carrier associations, fear of anti-trust repercussions has been the primary obstacle to some individual carriers that are interested in participating in the project.

In January 1989, the Association requested an advisory opinion from the Federal Trade Commission which would affirm the Association's ability to conduct this project and carriers' ability to participate by sharing claims data with the Council's consulting actuary. In February 1990, this affirmative opinion was finally received and has prompted several additional carriers to agree to participate with the Council.

Despite the frustrations in obtaining the data necessary to successfully complete this important project, the Council and its actuarial consultant, with the continued support of the National Association of Insurance Commissioners, continue to work diligently toward the stated goal. Further details on the Council's progress will be provided in a supplemental report to the House.

Resolution 74-1989 (*Trans.*1989:554), which would urge constituent societies to pursue legislation requiring disclosure of the percentile that is contractually paid in each insurance contract, was referred to the Council as part of its Customary Fee project. A full report on the disposition of this matter will be made in the Council's final report to the House on Resolution 60-1985 (*Trans.*1985:327).

Third-Party Liaison: The Council maintains continual liaison with the dental benefits industry through its representation to national carrier associations as well as its direct dialogue with representatives of individual carriers. Council representatives to national carrier associations are: Dr. James B. Killinger, Health Insurance Association of America; Dr. Stuart B. Fountain, Delta Dental Plans Association; Dr. French E. Hickman, Blue Cross and Blue Shield Association; Dr. Scott M. Dubowsky, National Healthcare Anti-Fraud Association; Dr. Roger R. LaCoste,

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***Note:** As the volume of policy being proposed for rescission is significant, this report will only provide the appropriate citations. Copies of the policies to be rescinded will be provided to the House of Delegates prior to its meeting and to all other individuals upon request.

Self Insurance Institute of America (SIIA); Dr. George A. Kirchner, International Classification of Diseases (ICD-9); Dr. Edward A. Straka, Group Health Association of America (GHAA); Dr. Arnold J. Hill, National Association of HMO Regulators; Dr. H. Raymond Klein, National Association of Prepaid Dental Plans; Dr. George A. Kirchner, American Association of Preferred Provider Organizations; and Dr. James B. Killinger, American Association of Dental Consultants.

Representatives of these liaison organizations are invited to meet annually with the Council to discuss issues of mutual interest and concern. Council representatives also meet with the HIAA Dental Relations Committee at its three regularly scheduled meetings during the year to discuss dental benefits issues of concern to the Association. Major issues discussed during the past year include: explanation of benefits language, inconsistent claims denials, qualifications of dental consultants and downcoding by carriers. Council representatives frequently meet with carrier representatives on specific issues and activities through designated Council subcommittees.

In addition to formal meetings with individual third-party payer representatives and their national associations, Council representatives frequently attend, and give presentations to, carrier meetings and conferences. Among others, Council and staff members attended the annual meeting of Delta Dental Plans Association in San Francisco, conferences sponsored by GHAA and SIIA; and were featured speakers at national meetings of the Dental Insurance Consultants, Inc., the American Association of Preferred Provider Organizations, the National Association of Prepaid Dental Plans and the American Association of Dental Consultants.

Medically Necessary Care: In 1988, the House of Delegates adopted Resolutions 36H and 37H (*Trans.*1988:474). These policies were developed because of the numerous problems encountered by dentists who treat cancer patients, cleft palate patients, patients with craniofacial anomalies, very young patients whose dental treatment requires general anesthesia, etc.

The Council has met with limited success in working with third-party payers to resolve the problem of "medically necessary care." The threat of reporting the third-party payer for having unqualified personnel determine what is "medically necessary" has resulted in payment of claims; but while this resolves a problem for one patient it does not address the principle involved.

The Council has found that while dental consultants are regularly involved in reviewing dental claims, medical consultants, i.e., licensed physicians, are not used to the same extent to interpret the language of medical policies. Instead, registered nurses, licensed practical nurses, dental hygienists and dental assistants are hired for this purpose.

Resolution 37H-1988 encourages state dental societies to seek legislation in an effort to get language clarified so that needed care does not fall between the cracks of uncoordinated health plans. One of the major obstacles in moving forward with the directive in this policy is the lack of a definition of "medically necessary care."

The Council believes that legislation will have a greater impact if it includes a formal policy of the Association which defines "medically necessary care." The Department of State Government Affairs has drafted model legislation for use by state dental societies. This model legislation will be available once a definition for "medically necessary care" has been approved by the House of Delegates.

In addition, assistance and advice to plan purchasers and benefits consultants will be greatly enhanced if Association policy clearly defining "medically necessary care" can be cited.

In drafting a definition of "medically necessary care," the Council sought assistance from the Federation of Special Care Organizations which, in turn, consulted with the Department of Veterans Affairs and the American Medical Association. The perspectives of these agencies were similar to the Council's and are reflected in the Council's proposed definition.

The Council on Dental Care Programs recommends the following resolution for adoption:

10. Resolved, that the following definition of "medically necessary care" be adopted:

> Medically necessary care means the reasonable and appropriate diagnosis, treatment, and follow-up care (including supplies, appliances and devices) as determined and prescribed by qualified, practicing dentists or physicians in treating illness, disease, injury, trauma, or birth developmental malformations. Medically necessary care is for the purpose of controlling or eliminating infection and pain, eliminating disease, and restoring facial configuration or function necessary for speech, swallowing or chewing.

and be it further

Resolved, that the appropriate agencies of the Association distribute this definition of "medically necessary care" to third-party payers, plan purchasers, professional health organizations and state and federal regulatory agencies.

Recommendations for Policy Revisions: As part of the Council's ongoing project to review and update those policies for which it is directly responsible to see that the intent, language and terminology are relevant and current, the Council has identified the following policies for recommended action:

Contract Dental Organizations. In 1985, the promotion by third-party payers of alternative dental benefits plan concepts was at its peak. Various new programs were being offered to plan purchasers through capitation plans (HMOs) and plans that required dentists to discount their fees, preferred provider organizations (PPOs).

While there was little confusion about the intent of these new concepts, there was a great deal of confusion about what the new product names meant to patients, plan purchasers and to the profession. Members expressed concern over the term "preferred provider" because it implied that those dentists who participated in the programs would be perceived as superior to those who did not. In an

effort to clarify the concept of a PPO the 1985 House of Delegates adopted Resolution 6H (*Trans.*1985:581), which reads as follows:

> **Resolved,** that this Association believes the term "Contract Dentist Organization" more appropriately defines the alternative delivery system otherwise known as "Preferred Provider Organization" and encourages the use of the term "Contract Dentist Organization" where appropriate, and be it further
> **Resolved,** that the Association does not endorse the term "Preferred Provider Organizations" but realizes that in certain forms of communication discretionary use of the term is sometimes necessary. Therefore, in certain correspondence "Contract Dentist Organization" be used with "Preferred Provider Organization" in parenthesis, and be it further
> **Resolved,** that Resolution 19H-1984 (*Trans.*1984:529) be rescinded.

The policy has not fulfilled the expectations of the House. In fact, the policy has created some confusion. There are numerous contract dentist arrangements on the market. Delta Dental Plans require contracts, as do the Blue Cross/Blue Shield Plans.

Individual Practice Associations (IPAs) are contract dentist organizations and so are capitation plans and HMOs. The term "Contract Dentist Organization" is not used by third-party payers, plan purchasers or most dentists. As familiarity with PPOs increased and employees learned that they would receive discounted dental fees for "preferring a participating dentist over a non-participating dentist" the need to emphasize the distinction in the 1985 policy lessened. In addition, the Association's Contract Analysis Service, which is available to all members, has provided immediate information regarding new trends in contracting arrangements. This information is not only used by members to make decisions about contracts, but is also used by the Association's Purchaser Information Service.

The health benefits marketplace is active and dynamic. In order to stay abreast of the many variations on the basic alternative dental benefits plan concepts constantly introduced by third-party payers, the Council believes that it will be more effective to educate members and plan purchasers about new plans than trying to change plan names. The Council, therefore, offers the following resolution for adoption:

11. Resolved, that current policy on Contract Dental Organizations, Resolution 6H-1985 (*Trans.*1985:581) be rescinded.*

Unfair Legislation. Over the past 16 years, the Association has adopted four policies on unfair legislation in response to government actions to subsidize HMOs and other forms of health care delivery.

Rather than continue this fragmented approach, the intent of each of these policies has been included in one broad-based policy which opposes the use of government subsidies and waivers to support such programs. Therefore, the Council offers the following resolution for adoption:

12. Resolved, that the American Dental Association continue to actively oppose legislation that would provide selected health care delivery systems with an unfair advantage over other forms of health care delivery through federal subsidies or waiver of mandated requirements, and be it further
Resolved, that the appropriate agencies of the Association, in cooperation with constituent societies, disseminate information on this subject to the appropriate leadership at the federal and state levels, and be it further
Resolved, that Resolution 88H-1979 (*Trans.*1979:635), Inclusion of Health Maintenance Organizations in Certificate of Need Requirements; Resolution 89H-1979 (*Trans.*1979:636), Removal of Support for Fee-for-Service Dentistry Appended to Health Maintenance Organizations; Resolution 127H-1979 (*Trans.*1979:530), Government Subsidized Health Care Delivery Systems; and Resolution 54-1974-H (*Trans.*1974:686), Unfair Legislation, be rescinded.*

Assignment of Benefits. The House of Delegates has adopted three resolutions on this issue. The first was Resolution 100H-1977 (*Trans.*1977:909), the second was Resolution 93H-1985 (*Trans.*1985:584), and the third was Resolution 74H-1986 (*Trans.*1986:517) which amended the policy adopted by Resolution 93H-1985.

These resolutions addressed the members' desire for the right to determine whether to accept or reject payment from prepaid programs and extended the same right to patients who wished to assign their benefits. In addition, the resolutions included language prohibiting discrimination in selecting health care providers and a request for legislation that would mandate provision by insurance companies of equal services for equal premiums to all clients.

The Council felt that these resolutions addressed so many different concerns that the main issue was obscured.

In order to focus on assignment and the problems members are experiencing with assignment of benefits, the Council developed a new policy specific to that issue. The Council believes that other issues addressed in the policies in question are adequately covered in other Association policies.

The Council recommends rescission of the current policies on assignment of benefits for the following reasons:

1. There can be no guarantee of "equal services for equal premiums" in that plan purchasers may choose to buy completely different plans for the same or a similar price. The Council believes that the current policy tries to address inequitable reimbursement levels under plans that purport to be the same.
   This matter is currently being addressed by the study on customary fee.
2. The Association has separate policies regarding freedom of choice of provider, Resolution 50H-1983 (*Trans.*1983:582), and on requiring that fee-for-service,

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***Note:** As the volume of policy being proposed for rescission is significant, this report will only provide the appropriate citations. Copies of the policies to be rescinded will be provided to the House of Delegates prior to its meeting and to all other individuals upon request.

freedom of choice dental plans are offered with capitation plans, Resolution 40H-1988 (*Trans.*1988:478).

3. The remaining concerns in the current policy are dealt with in the Association's policy entitled: "Timely Payment of Dental Benefits by Insurance Carriers," Resolution 64H-1988 (*Trans.*1988:498).

The Council, therefore, offers the following resolution for adoption:

13. Resolved, that the American Dental Association supports the right of each dentist to accept or reject assignment of benefits from any dental benefits plan, and be it further

Resolved, that the Association supports the right of every patient to assign his/her benefits payment to the treating dentist if the dentist agrees to accept such assignment, and to have the assignment honored by the third-party payer, and be it further

Resolved, that when a third-party payer inadvertently submits payment directly to the patient, contrary to the patient's stated assignment preference, it is the responsibility of the third-party payer to submit the correct payment to the dentist and reclaim the erroneously submitted payment from the patient, and be it further

Resolved, that Resolution 93H-1985 (*Trans.*1985:584) as amended by Resolution 74H-1986 (*Trans.*1986:517) and Resolution 100H-1977 (*Trans.*1977:909) be rescinded.*

Preauthorization. In 1971, the House of Delegates adopted Resolution 40-1971-H (*Trans.*1971:521) which stated the House's disapproval of the insurance industry concept of denying payment to a beneficiary, to which he is normally entitled, solely on the basis of lack of preauthorization.

The Council is still firmly committed to this statement, but believes that in today's cost-containment environment this policy, alone, does not offer appropriate guidance to members and, in fact, could be detrimental.

Many dental benefits plans include specific preauthorization requirements which, if not precisely followed, will result in decreased benefits for patients. In some instances, noncompliance with preauthorization requirements means a loss of the entire benefit.

The Council has received calls from members who did not know that preauthorization was required or chose to ignore preauthorization requirements stipulated in their patients' dental plans and found that the patients refused to pay for treatment claiming that the dentists should have complied with preauthorization requirements. This is a "no win" situation for dentists who could end up losing their patients.

In addition, dental benefits plans are not consistent in the dollar amounts or dental procedures for which preauthorization is required. Some plans require preauthorization for any treatment of $100, or over $200, or for all crown and bridge work, or for certain types of extractions, etc.

In order for the Association to advise members appropriately, the Council offers the following resolution for adoption:

14. Resolved, that the American Dental Association disapproves of the insurance industry concept of denying payment to a beneficiary, to which he/she is normally entitled, solely on the basis of lack of preauthorization, and be it further

Resolved, that because failure to obtain preauthorization for specific types of dental treatment and/or for treatment in excess of a specific dollar amount may result in a reduction or loss of benefits for the patient, dentists are encouraged to determine whether their patients' dental benefits plans require preauthorization before commencing treatment, and be it further

Resolved, that Resolution 40-1971-H (*Trans.*1971:521), Preauthorization, be rescinded.*

Audits of Private Dental Offices. In 1977, the House of Delegates adopted Resolution 132H (*Trans.*1977:915) which stated that it was inappropriate for the American Dental Association to advise member dentists on the advisability of complying with requests for in-office audits, and that such decisions should be made independently by the individual dentists after consulting with his own attorney for a determination of the legal implications of such decision.

The Council believes that this policy does not fully reflect the current climate of alternative dental benefits plans and the fact that many dentists have signed contracts under which they agree to comply with office audit procedures, some of which may be vague or undefined.

Where dentists have signed contracts, it would be appropriate for a member to consult his or her attorney if the audit appears to go beyond the scope outlined in the contracts. For example, if the contract does not state whether the audit is confined to records of patients covered by the contract plan, and the auditor attempts to review all patient records, the dentist needs a lawyer to advise him or her of his/her rights and potential liabilities.

The Council believes that it would be more helpful to members if the policy made clear that there may be instances when an audit is required by an express contract between the dentist and the dental benefits organizations.

In the absence of a contract, a dentist should consult an attorney for advice about his/her rights and obligations to respond to an audit request.

With these concerns in mind, the Council offers the following resolution for adoption:

15. Resolved, that where the dentist is under no direct contractual obligation with a third-party payer, the decision to comply with requests for in-office audits should be made independently by the individual dentist after consulting with his/her attorney for a determination of the legal implications of such decision, and be it further

Resolved, that in those instances where the dentist has expressly agreed in a contract to comply with office audit procedures, if the audit of dental records appears to go beyond the scope of the audit procedure outlined in the contract, the dentist should immediately seek advice from

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***Note:** As the volume of policy being proposed for rescission is significant, this report will only provide the appropriate citations. Copies of the policies to be rescinded will be provided to the House of Delegates prior to its meeting and to all other individuals upon request.

his/her legal counsel in order to be informed of his/her rights and potential liabilities regarding such audit, and be it further

Resolved, that Resolution 132H-1977 (*Trans.*1977:915), Audits of Private Dental Offices, be rescinded.*

Policy on Fees: Over the past 15 years, the Association has adopted four policies on fees in response to the various cost-containment measures introduced into the marketplace by third-party payers. They are: Mutual Agreement on Fees, Resolution 20-1975-H, (*Trans.*1975:656); Policy on Fees, Resolution 22H-1977 (*Trans.*1977:918); Discrimination Against Professionals Regarding Establishment of Fees, Resolution 121H-1979 (*Trans.*1979:636); and Third Party Fee Schedules, Resolution 54H-1983 (*Trans.*1983:543). Rather than continue this fragmented approach, the Council believes it would be more appropriate to express the Association's position regarding fees in a single policy that will encompass all current and foreseeable third-party fee intervention. Therefore, the Council offers the following policy for adoption:

16. Resolved, that the fiscal and health interests of patients are best served by the existence of an economic climate within which a dentist and his/her patient are able to freely arrive at a mutual agreement with respect to fees for service, and be it further

Resolved, that the American Dental Association considers third-party intervention in fee determination to be potentially anti-competitive in nature and to be a disservice to the public which is interested in securing the best possible dental care for themselves and their families, and be it further

Resolved, that the Association is opposed to any law, regulation or third-party intervention that disrupts the relationship between the dentist and patient, including, but not limited to, encouraging patients to select dentists principally on the basis of cost, and be it further

Resolved, that if a disagreement with regard to fees arises between a dentist, a patient, and/or a third party, the American Dental Association should transmit the complaint to the appropriate constituent and component dental society which should then be available to assist in resolving the disagreement within the limitations of applicable law, and be in further

Resolved, that Resolution 20-1975-H (*Trans.*1975:656), Mutual Agreement on Fees; Resolution 22H-1977 (*Trans.*1977:918), Policy on Fees; Resolution 121H-1979 (*Trans.*1979:636), Discrimination Against Professionals Regarding Establishment of Fees; and Resolution 54H-1983 (*Trans.*1983:543), Third Party Fee Schedules, be rescinded.*

Ownership of Radiographs. In 1971, the House of Delegates adopted Resolution 41-1971-H (*Trans.*1971:523) which states that it is recognized that radiographs are the property of the dentist rather than the patient or a third party carrier.

As it stands, this policy is inaccurate in that several states have passed laws indicating that, upon request, radiographs are the property of the patient.

The Council believes that the proposed new policy entitled "Guidelines on Use of Radiographs" in the next section of this report, addresses the intent of the above stated policy:

11. Radiographs are an integral part of the dentist's clinical records and, as such, should be considered the property of the dentist.

The Council believes that guideline #11 is a more appropriate way to deal with the intent of the 1971 policy without being in conflict with some state laws. For these reasons, the Council supports the rescission of Resolution 41-1971-H (*Trans.*1971:523) as presented in the following section on the *Guidelines on the Uses of Radiographs in Dental Care Programs* (see below).

Response to Assignments from the 1989 House of Delegates:

Rescission of Policy, "Medicare Provisions for Hospital Dental Care Benefits". Resolution 2H-1989 (*Trans.*1989:542) rescinded this 1967 policy.

Rescission of Policy, "Commitment to Better Oral Health: 'Crisis' Rhetoric". Resolution 3H-1989 (*Trans.*1989:542) rescinded this 1973 policy.

Use of Statistics in Utilization Review. Resolution 4H-1989 (*Trans.*1989:542) established the Association's policy regarding statistically based utilization review. Strategies to implement this policy will be developed for the Council's review by the Subcommittee on Utilization Management.

Approval of Statement on Dental Consultants. Resolution 5H-1989 (*Trans.*1989:542) has been disseminated to the third-party payer organizations with which the Council has liaison relationships. The Statement is provided to third-party payers when the Council has occasion to intervene in a treatment decision issue. In addition, the Statement has been provided to various dental publications.

Approval of Policy on "Closed Panel Dental Benefits Plans". Resolution 6H-1989 (*Trans.*1989:545) created a new policy which has been incorporated into the Council's *Policies on Dental Care Programs.*

Benefits for Services by Qualified Practitioners. Resolution 7H-1989 (*Trans.*1989:546) created a new policy which has been incorporated into the Council's *Policies on Dental Care Programs.*

Revisions of "Guidelines on the Use of Radiographs In Dental Benefits Plans". Resolutions 8-1989 and 8S-1-1989 (*Trans.*1989:547) were referred back to the Council for further review. This policy has been revised six times since it was first adopted in 1971 (*Trans.*1971:423). The Council reviewed the "Guidelines" last year and recommended a revised and edited version to the 1989 House of Delegates. Members were uncomfortable with some of the recommended charges and felt that the "Guidelines" should be less narrative. In an effort to reflect the needs of members while at the same time providing a clear statement

*__Note:__ As the volume of policy being proposed for rescission is significant, this report will only provide the appropriate citations. Copies of the policies to be rescinded will be provided to the House of Delegates prior to its meeting and to all other individuals upon request.

of intent for the profession and for third-party payers, the Council offers the following guidelines for adoption:

Guidelines on the Use of Radiographs in Dental Care Programs

The American Dental Association's recommendations on selection criteria for radiographs states that diagnostic radiography should be used only after clinical examination, review of the patient's history, and consideration of the dental and general health needs of the patient. The type, frequency, and extent of radiograph examination necessary for each individual patient will be provided in accordance with the dentist's professional judgment.

The Association believes that the following guidelines should be applied in the use of radiographs in dental benefits plans:

1. Radiographs should be taken only for clinical reasons as determined by the patient's dentist. Clinical radiographs may be used as part of a system for determining those benefits to which the patient is entitled under the terms of a contract. However, third-party payers should not request that radiographs be taken for administrative purposes and dentists should not comply with such requests.

2. When a dentist determines that it is appropriate to comply with a third-party payer's request for radiographs, a duplicate set should be submitted and the originals retained by the dentist.

3. There are many instances in which a determination of benefits cannot be made solely on the basis of radiographs and it is improper for third-party payers to deny benefits or make determinations about treatment that could not ordinarily be made without proper examination of the patient.

4. Third-party payers shall not use radiographs to infringe upon the professional judgment of the treating dentist, or to interfere in any way with the dentist-patient relationship. All questions of interpretation of radiographs must be reviewed by a dentist consultant.

5. Patients should be exposed to radiation *only* when clinically necessary, as determined by the treating dentist. Postoperative radiographs should be required only as part of dental treatment.

6. It is important that radiographs be correctly mounted and are of diagnostic quality.

7. Third-party payers should protect the confidentiality of all records, including radiographs, which are submitted to them by dental offices. All radiographs submitted to third-party payers should be returned to the treating dentist within fifteen (15) working days.

8. Radiographs held by parties other than the treating dentist should not be transmitted to any agency or entity without written consent of the dentist or patient.

9. Where a claim or predetermination request indicates that radiographs are enclosed, the third-party payer should immediately notify the submitting dentist's office if the radiographs are missing.

10. A patient's predetermination request or claim should not be prejudiced by the third-party payer's loss or misplacement of radiographs.

11. Radiographs are an integral part of the dentist's clinical records and, as such, should be considered the property of the dentist. Because it is necessary for a dentist to maintain accurate and complete records, third-party payers should accept copies of radiographs in lieu of originals.

12. Any additional costs incurred by the dentist in copying radiographs and clinical records for claims determination should be reimbursed by the third-party payer or the patient.

17. Resolved, that the "Guidelines on the Use of Radiographs in Dental Care Programs" be adopted, and be it further

Resolved, that Resolutions 41-1971-H (*Trans.*1971:423); 50-1972-H (*Trans.*1972:667); 33-1974-H (*Trans.*1974:654); 125H-1976 (*Trans.*1976:867); 6H-1984 (*Trans.*1984:524); 57H-1986 (*Trans.*1986:516); and 2H-1987 (*Trans.*1987:499) be rescinded.*

Amendment of "Standards for Dental Benefits Plans" and Rescission of "Guidelines for the Group Purchase of Dental Plans". Resolution 9H-1989 (*Trans.*1989:547) has been incorporated into the Council's *Policies on Dental Care Programs.*

Payment for Prosthodontic Treatment. Resolution 10H-1989 (*Trans.*1989:547) has been incorporated into the Council's *Policies on Dental Care Programs.* It has also been distributed to the third-party payer organizations with whom the Council has liaison relationships.

Evaluation of Dental Care Programs. Resolution 11H-1989 (*Trans.*1989:548) has been incorporated into the Council's *Policies on Dental Care Programs.*

Definition of Direct Reimbursement. Resolution 12H-1989 (*Trans.*1989:548) clarified the definition of direct reimbursement. The definition has been incorporated into the revised direct reimbursement promotional materials and in the Council's *Policies on Dental Care Programs.*

Amendment of Policy, "Tax Deductibility of Dental and Medical Expenses". Resolution 13H-1989 (*Trans.*1989:548) has been incorporated in the Council's *Policies on Dental Care Programs.*

Recision of Policy, "Opposition to Pro-Competition Legislation". Resolution 14H-1989 (*Trans.*1989:549) rescinded this policy.

***Note:** As the volume of policy being proposed for rescission is significant, this report will only provide the appropriate citations. Copies of the policies to be rescinded will be provided to the House of Delegates prior to its meeting and to all other individuals upon request.

Mandatory Coverage for Treatment of Temporomandibular Joint Dysfunction. Resolution 15H-1989 (*Trans.*1989:549) has been incorporated in the Council's *Policies on Dental Care Programs.* It has been distributed to all third-party payer organizations with whom the Council has liaison relationships, to numerous state departments of health, insurance regulators and to individuals who request the Association's policy on TMD.

UCR Terminology. Resolution 22H-1989 (*Trans.*1989:553) was referred to the Council for incorporation into its study on "Customary Fee." A separate report on "Customary Fee" is contained in an earlier section of this report (see page 56).

Communication of the Importance of Radiographic Examinations to Third-Party Payers. Resolution 40H-1989 (*Trans.*1989:555) has been incorporated into the Council's *Policies on Dental Care Programs.* It has been distributed to third-party payer organizations and is promoted by the Association's Purchaser Information Service.

Authority for Code Revisions. Resolution 50H-1989 (*Trans.*1989:552) has been incorporated into the Council's *Policies on Dental Care Programs.*

UCR Disclosure Definition. Resolution 74-1989 (*Trans.*1989:554) has been included in the Council's continuing effort to require clarification of explanation of benefits statements.

Procedure Codes for Copying Records/Radiographs. Resolution 75-1989 (*Trans.*1989:555) will be considered by the Advisory Committee on the *Code* in the next code revision process.

Proposal to Review ADA Brochure "Building a Quality Dental Benefits Plan". Resolution 77H-1989 (*Trans.*1989:555) required that the Council's brochure entitled "Building a Quality Dental Benefits Plan" be revised. As directed, the revised brochure was reported to the Board of Trustees. The brochure, as approved, has been printed and is used in the Council's work with plan purchasers. The revised brochure is entitled "Selecting A Quality Dental Benefits Plan."

ADA "Code on Dental Procedures and Nomenclature". Resolution 97-1989 (*Trans.*1989:554) directs the Council to review its guidelines for adding new codes. This will be undertaken by the Council following final revision of the 1990 *Code.*

Summary of Resolutions

New Policies/Directives:

5. Resolved, that constituent dental societies be urged to pursue enactment of legislation that prohibits overbilling by a dentist, consistent with Association policy, and be it further **Resolved,** that third-party payers be urged to support this legislative objective.

6. Resolved, that the following definitions related to fraudulent and abusive practices in dental benefit plans be adopted:

Claims Reporting Fraud: The intentional misrepresentation to a third-party payer of material facts concerning treatment provided and/or charges made, with the expectation that the misrepresentation would cause a payment higher than that which would have been paid had the misrepresentation not occurred.

Bad Faith Insurance Practices: The failure to deal with a beneficiary of a dental benefits plan fairly and in good faith; or activity which impairs the right of the beneficiary to receive the benefits of a dental benefits plan.

Some examples of bad faith insurance practices include: evaluating claims based on standards which are significantly at variance with the standards of the community; failure to properly investigate a claim for benefits; and unreasonably and purposely delaying and/or withholding payment of a claim.

Claims Payment Fraud: The intentional manipulation or alteration of material facts as submitted by a treating dentist so that payment to the beneficiary and/or the treating dentist would be less than that which would have been paid had the manipulation or alteration not occurred.

Overcoding: Billing a third-party payer for a more complex and/or higher cost procedure than was actually performed.

Unbundling of Procedures: Reporting component pieces of a given procedure and their itemized charges in place of the accepted global procedure code with a single global charge. (Also referred to as "Hyperitemization.")

Downcoding: A practice of third-party payers in which benefits are determined based on a less complex and/or lower cost procedure than was reported.

10. Resolved, that the following definition of "medically necessary care" be adopted:

Medically necessary care means the reasonable and appropriate diagnosis, treatment, and follow-up care (including supplies, appliances and devices) as determined and prescribed by qualified, practicing dentists or physicians in treating illness, disease, injury, trauma, or birth developmental malformations. Medically necessary care is for the purpose of controlling or eliminating infection and pain, eliminating disease, and restoring facial configuration or function necessary for speech, swallowing or chewing.

and be it further
Resolved, that the appropriate agencies of the Association distribute this definition of "medically necessary care" to third-party payers, plan purchasers, professional health organizations and state and federal regulatory agencies.

Amendment/Rescission of Current Policies:

3. Resolved, that beginning in 1991, the Council on Dental Care Programs shall present a conference on dental benefits issues and related matters as necessary, and be it further
Resolved, that Resolution 104H-1980 (*Trans.*1980:554), Annual Conference on Dental Prepayment, be rescinded.

4. Resolved, that patients and third-party payers be encouraged to use the dental profession's peer review process to address issues or disputes concerning dental treatment provided under dental benefits programs, and be it further
Resolved, that the Council on Dental Care Programs work with third-party payers, plan purchasers, benefits consultants and government agencies to include the following paragraph in the "claim appeals" section of the Summary Plan Description provided to dental benefits plan subscribers:

> State and local dental societies provide an impartial means of dispute resolution regarding your dental treatment. This process, called Peer Review, is available to you as an adjunct to the (insert name of benefit plan or benefit administrator) appeal process. For more information about Peer Review, contact your local dental society.

and be it further
Resolved, that Resolution 79H-1987 (*Trans.*1987:502), Utilization of Peer Review Process, be rescinded.

7. Resolved, that in all communications from a third-party payer or other benefits administrator which attempt to explain the reason(s) for a benefit reduction or denial to beneficiaries of a dental benefits plan, the following statement be included:

> Any difference between the fee charged and the benefit paid is due to limitations in your dental benefits contract. Please refer to (insert pertinent provisions of summary plan description) of your summary plan description for an explanation of the specific policy provisions which limit or exclude coverage for the claim submitted.

and be it further
Resolved, that in reporting the benefit determination to the beneficiary, the following information be reported on the explanation of benefits statement:

1. the treatment reported on the submitted claim by ADA procedure code numbers and nomenclature; and
2. the ADA procedure code numbers and nomenclature on which benefits were determined.

and be it further
Resolved, that the Council on Dental Care Programs work with third-party payers, plan purchasers, benefits consultants and government agencies to implement this policy, and be it further
Resolved, that Resolution 96H-1982 (*Trans.*1982:522) as amended by Resolution 102H-1984 (*Trans.*1984:561) be rescinded.

8. Resolved, that in the interest of efficient dental office financial management, bulk benefit payments made by a third-party payer should include a statement containing, at a minimum, the following information for each claim payment represented in the bulk benefit check:

1. Subscriber (employee) name;
2. Patient name;
3. Dates of service;
4. Specific treatment reported on the submitted claim, by ADA procedure code number and nomenclature;
5. Total fee charged;
6. Specific ADA code number and nomenclature on which benefits were determined;
7. Total covered expense;
8. Total benefits paid; and
9. In instances where benefits are reduced or denied, an explanation of the reason(s) that the total covered expense differs from the total fee charged, consistent with Association policy on Explanation of Benefit Statements.

and be it further
Resolved, that bulk benefit payments should be issued to dentists at intervals of not longer than every ten business days, and be it further
Resolved, that the Council on Dental Care Programs work with the insurance industry and dental service plans to incorporate this policy into their administrative procedures, and be it further
Resolved, that Resolution 4H-1983 (*Trans.*1983:540) as amended by Resolution 56H-1987 (*Trans.*1987:506) be rescinded.

9. Resolved, that the American Dental Association opposes all forms of fraudulent activity by any party to a dental benefits plan, and be it further
Resolved, that the Council on Dental Care Programs, in conjunction with other appropriate Association agencies, work cooperatively with insurance industry organizations, government agencies and other appropriate national organizations to develop effective strategies for detection and discipline of fraudulent and abusive practices under publicly and privately funded dental benefits programs, and be it further
Resolved, that in this effort, attention be given to such practices engaged in by dental benefits administrators, patients and dentists, and be it further
Resolved, that Resolution 129H-1976 (*Trans.*1976:863), Elimination of Illegal Practices in Government Programs, be rescinded.

11. Resolved, that current policy on Contract Dental Organizations, Resolution 6H-1985 (*Trans.*1985:581), be rescinded.

12. Resolved, that the American Dental Association continue to actively oppose legislation that would provide selected health care delivery systems with an unfair advantage over other forms of health care delivery through federal subsidies or waiver of mandated requirements, and be it further
Resolved, that the appropriate agencies of the Association, in cooperation with constituent societies, disseminate

information on this subject to the appropriate leadership at the federal and state levels, and be it further
Resolved, that Resolution 88H-1979 (*Trans.*1979:635), Inclusion of Health Maintenance Organizations in Certificate of Need Requirements; Resolution 89H-1979 (*Trans.*1979:636), Removal of Support for Fee-for-Service Dentistry Appended to Health Maintenance Organizations; Resolution 127H-1979 (*Trans.*1979:530), Government Subsidized Health Care Delivery Systems; and Resolution 54-1974-H (*Trans.*1974:686); Unfair Legislation, be rescinded.

13. Resolved, that the American Dental Association supports the right of each dentist to accept or reject assignment of benefits from any dental benefits plan, and be it further
Resolved, that the Association supports the right of every patient to assign his/her benefits payment to the treatment dentist if the dentist agrees to accept such assignment, and to have the assignment honored by the third-party payer, and be it further
Resolved, that when a third-party payer inadvertently submits payment directly to the patient, contrary to the patient's stated assignment preference, it is the responsibility of the third-party payer to submit the correct payment to the dentist and reclaim the erroneously submitted payment from the patient, and be it further
Resolved, that Resolution 93H-1985 (*Trans.*1985:584) as amended by Resolution 74H-1986 (*Trans.*1986:517) and Resolution 100H-1977 (*Trans.*1977:909) be rescinded.

14. Resolved, that the American Dental Association disapproves of the insurance industry concept of denying payment to a beneficiary, to which he/she is normally entitled, solely on the basis of lack of preauthorization, and be it further
Resolved, that because failure to obtain preauthorization for specific types of dental treatment and/or for treatment in excess of a specific dollar amount may result in a reduction or loss of benefits for the patient, dentists are encourage to determine whether their patients' dental benefits plans require preauthorization before commencing treatment, and be it further
Resolved, that Resolution 40-1971-H (*Trans.*1971:521), Preauthorization, be rescinded.

15. Resolved, that where the dentist is under no direct contractual obligation with a third-party payer, the decision to comply with requests for in-office audits should be made independently by the individual dentist after consulting with his/her attorney for a determination of the legal implications of such decision, and be it further
Resolved, that in those instances where the dentist has expressly agreed in a contract to comply with office audit procedures, if the audit of dental records appears to go beyond the scope of the audit procedure outlined in the contract, the dentist should immediately seek advice from his/her legal counsel in order to be informed of his/her rights and potential liabilities regarding each audit, and be it further
Resolved, that Resolution 132H-1977 (*Trans.*1977:915), Audits of Private Dental Offices, be rescinded.

16. Resolved, that the fiscal and health interests of patients are best served by the existence of an economic climate within which a dentist and his/her patient are able to freely arrive at a mutual agreement with respect to fees for service, and be it further
Resolved, that the American Dental Association considers third-party intervention in fee determination to be potentially anti-competitive in nature and to be a disservice to the public which is interested in securing the best possible dental care for themselves and their families, and be it further
Resolved, that the Association is opposed to any law, regulation or third-party intervention that disrupts the relationship between the dentist and patient, including, but not limited to, encouraging patients to select dentists principally on the basis of cost, and be it further
Resolved, that if a disagreement with regard to fees arises between a dentist, a patient, and/or a third party, the American Dental Association should transmit the complaint to the appropriate constituent and component dental society which should then be available to assist in resolving the disagreement within the limitations of applicable law, and be it further
Resolved, that Resolution 20-1975-H (*Trans.*1975:656), Mutual Agreement on Fees; Resolution 22H-1977 (*Trans.*1977:918), Policy on Fees; Resolution 121H-1979 (*Trans.*1979:636), Discrimination Against Professionals Regarding Establishment of Fees; and Resolution 54H-1983 (*Trans.*1983:543), Third Party Fee Schedules, be rescinded.

17. Resolved, that the "Guidelines on the Use of Radiographs in Dental Care Programs" be adopted, and be it further
Resolved, that Resolutions 41-1971-H (*Trans.*1971:423); 50-1972-H (*Trans.*1972:667); 33-1974-H (*Trans.*1974:654); 125H-1976 (*Trans.*1976:867); 6H-1984 (*Trans.*1984:524); 57H-1986 (*Trans.*1986:516); and 2H-1987 (*Trans.*1987:499) be rescinded.

Council on Dental Practice

Bletsas, George L., Michigan, 1990, chairman
Player, T. Carroll, South Carolina, 1991, vice-chairman
Amundson, Vernon L., Minnesota, 1992
Bushee, Eleanor J., Illinois, 1991
Chaput, Ronald A., Massachusetts, 1993
DeNicola, Ross J., Jr., Louisiana, 1991
Grubb, Richard V., Maryland, 1993
Hall, Charles R., Alabama, 1990, *ad interim*
Harrison, Thomas C., Texas, 1993
Hearon, Donald L., Washington, 1992
Manning, Frank T., Wyoming, 1990
Polizotto, Scott H., Indiana, 1991
Prevost, Gibbs M., Sr., Tennessee, 1992
Sniderman, Marvin, Pennsylvania, 1993
van Dyk, William, California, 1992
Westcott, Robert C., New York, 1990
Kiser, Anthony L., secretary
Bramson, James B., associate secretary
Oberg, S. William, assistant secretary

Meetings: The Council met in the Headquarters Building on December 3-6, 1989 and May 10-12, 1990. The Council met in joint session with the Council on Dental Education on December 4, 1989. Dr. James F. Mercer, Seventh District trustee, serves as the Board of Trustees liaison to the Council.

The Council is organized into three subcommittees to facilitate its work activities. These three subcommittees are the Subcommittee on Dental Team Members (Committee A), the Subcommittee on Dental Students, Young and Established Dentists (Committee B) and the Subcommittee on Special Programs (Committee C). The subcommittees met in conjunction with regularly scheduled Council meetings immediately prior to the plenary sessions.

Personnel: At the December 1989 meeting of the Council, Dr. T. Carroll Player was unanimously elected vice-chairman for 1989-90. The 1990 annual session will mark the retirement of Dr. George L. Bletsas, 1989-90 Council chairman, Dr. Frank T. Manning and Dr. Robert C. Westcott. Dr. Charles R. Hall is an *ad interim* appointment to complete the term of current ADA Trustee, Dr. Heber Simmons, Jr. The Council wishes to express its appreciation to these individuals for their thoughtful, determined leadership and for many contributions during their tenure. During the year, Ms. Kathryn A. Lienau joined the CDP staff as manager of practice management projects.

Responses to Assignments from the 1989 House of Delegates:

Litigation Stress Support Groups. The 1989 House of Delegates approved Resolution 16H (*Trans.*1989:556) as submitted by the Council. Subsequently, dental society executives and presidents were informed of the adoption of the resolution, and they were reminded of the availability of the Council publication, *Guidelines for the Development of Dental Society Litigation Stress Support Groups.* They were also notified of the availability of videotapes of portions of a litigation stress support group training session held in Louisiana in December 1989 which can be used by dental societies to help them identify the important issues that need to be addressed in developing such support groups. These videotapes are available on loan free from the Council office.

Approval of "ADA Policy Statement on Dental Care and Recovery from Chemical Dependency". The 1989 House of Delegates approved Resolution 17H (*Trans.*1989:556) as submitted by the Council. Subsequently, dental society executives and presidents were informed of the adoption of the resolution and were encouraged to schedule the seminar "Treating the Active or Recovering Chemically Dependent Patient" for their members.

Expansion of ADA OPTIONS Program. The 1989 ADA House of Delegates approved Resolution 63H (*Trans.*1989:557) which was assigned to the Council on Dental Practice. The Council has communicated this resolution to all dental schools interested in hosting the seminar "Starting Your Dental Practice" during the 1990-91 academic year. Moreover, prior to each seminar, the state dental society is informed of the upcoming seminar and invited to send representatives to attend on behalf of the society.

Strategies in Response to Auxiliary Personnel Shortages. Resolution 73H (*Trans.*1989:534) was jointly assigned to the Council on Dental Practice and the Council on Dental Education (CDE). Those activities of the Council on Dental Education are discussed in the CDE report to the House of Delegates (see page 117). The Council on Dental Practice addressed itself to the segment of the resolution regarding the development of programs to improve the retention of personnel currently employed in dental practices.

The Council has approved a new seminar entitled "Help Wanted: Solid Solutions for the Personnel Shortage." This seminar is designed to discuss the demographic considerations which will affect the dental work force in the next ten years, and to assist dentists in hiring and retaining quality workers. Emphasis on personnel management, employee motivation and employer-employee relations is heavily stressed. This seminar previewed in March 1990.

As another measure to implement Resolution 73H, the Council is cooperating with the American Dental Assistants

Association (ADAA) for "Dental Assistants Recognition Week." The week of April 15-21, 1990 was designed to allow the dentist to provide recognition for his/her dental assistants. To implement this activity immediately, the Council agreed to assist ADAA in the development of a standard logo, to be used yearly, for the recognition week. The Council also developed institutional advertising "slicks" and distributed these and the logo to over 600 dental editors nationwide through the "Dental Editor's Update" mailing in cooperation with the Division of Communications. These ads were carried by many dental journals, typically in the spring or winter issue. An *ADA News* article appeared in the April 9, 1990 issue regarding the recognition week. ADAA has used the material in its journal and in the promotional effort to its state societies. The Council, in conjunction with the ADAA is interested in expanding this recognition week activity in 1991 to include other promotional materials.

The Association's Board of Trustees financially supported a survey of practicing dentists, dental hygienists and dental assistants in North Carolina. A fourth survey instrument contained questions for dental hygienists who have left the field, probing why they left and what factors would encourage them to re-enter. This study was conducted during 1990 and preliminary data is expected this fall.

OPTIONS '90: Completing its seventh successful year of operation, the OPTIONS Program has continued to grow in both popularity and impact. Response from corporate sponsors, dental students, dental schools and organized dentistry continues to be extremely positive.

Representatives of the American Student Dental Association (ASDA) were involved in promoting student attendance at the seminar in their respective schools and assisted in the distribution of materials at the seminar site. This has proven to be a tangible benefit of organized dentistry and is enhancing both ASDA's and the Association's image among students and faculty.

OPTIONS '90 focused upon the business needs and concerns of junior and senior dental students faced with career and business decisions. The program conveyed this information to the students by two methods.

First, the Association's publication, *The Successful Dental Practice: An Introduction,* was distributed to approximately 4,300 senior dental students. This 120-page manual includes a discussion of several of the aspects of starting a dental practice, including career options, location, associateships, practice building and office design. Corporate sponsors' names were printed on the inside front cover of this publication.

Second, a one-day practice management seminar, "Starting Your Dental Practice," was scheduled at 25 dental school campuses in 1989-90 and reached students representing 29 different dental schools. Over 3,600 students from these schools attended. This concentrated seminar covers such topics as dentistry's future, locating a practice, practice purchase, personnel and staffing decisions, office communications, the cost of doing business, insurance processing, billing and collections, appointment scheduling and marketing strategies. A comprehensive seminar manual was distributed to all participants to use as an ongoing reference and as a gift from the corporate sponsors and organized dentistry. The seminar manual also informed the students how they could access the services of the Association for assistance with important career decisions.

In order to finance OPTIONS '90, the following corporate sponsors or organizations contributed through the American Fund for Dental Health: A-dec, Inc., American Academy of Dental Practice Administration Endowment and Memorial Fund, American Dental Trade Association, Beecham Products, CIGNA, Colwell Systems, Inc., Dentsply International, Inc., The Equitable Life Assurance Society of the United States, Great-West Life Assurance Company, Healthco International, The Pelton and Crane Company, Poe and Associates, Inc., Procter and Gamble Company Oral Health Group, Henry Schein, Inc., 3M Dental Products and the Warner-Lambert Company.

It should be noted that several of the above sponsors have been supportive of the OPTIONS Program since its inception in 1983. The American Dental Association is appreciative of their continuing generous support of dentistry.

Sponsor Recognition. Corporate sponsors received the following benefits and recognition: a feature article in the September 18, 1989 *ADA News,* distributed to 140,000 dentists and subscribers; a feature article in the December 1989 issue of *ASDA News* distributed to 14,000 ASDA members throughout the United States; formal acknowledgment on the inside front cover of the publication *The Successful Dental Practice: An Introduction,* distributed to all senior dental students (this publication also included a letter from the Presidents of the American Dental Association and the American Fund for Dental Health); a feature editorial in the April 1989 *CDA Journal,* the monthly publication of the California Dental Association; acknowledgment on the inside front cover of the seminar manual, "Starting Your Dental Practice," distributed to all junior and senior dental students participating in the seminar; distribution of sponsor literature to all seminar participants; opportunities for sponsors to send representatives to student seminars; and formal recognition by the American Dental Association including a plaque presentation to all sponsors at an Awards Luncheon during the Association's annual session.

OPTIONS '90 seminars were presented on the dates indicated below (the first school listed after each date is the seminar site and students from the listed neighboring schools also attended): October 7, 1989, Georgetown University; October 19, Ohio State University; October 20, University of Alabama; October 23, University of Texas/San Antonio; October 24, Baylor College of Dentistry; October 25, Louisiana State University; November 18, University of Detroit and University of Michigan; November 28, State University of New York, Stony Brook; January 18, 1990, Oregon Health Sciences University; January 19, University of Missouri/Kansas City; January 20, University of Washington; January 24, University of Tennessee; January 25, University of Mississippi; January 27, University of North Carolina; January 29, Medical University of South Carolina; February 1, University of Nebraska and Creighton

University; February 3, University of West Virginia; February 5, MeHarry Medical College; February 5, University of Iowa; February 6, University of Indiana; February 17, Boston University, Harvard University and Tufts University; and February 19, University of Puerto Rico.

Representatives of the respective constituent societies and the Commission on the Young Professional were invited to discuss the important role of organized dentistry as part of the introductory comments to the seminar. Each seminar included three professional instructors from the following group: Dr. George Bletsas, Council chairman and private practitioner, Michigan; Dr. James Bramson, associate secretary, Council on Dental Practice; Dr. Anthony Kiser, secretary, Council on Dental Practice; Dr. Nick Minden, faculty member, University of Florida; Ms. Paula Perich, assistant executive director, Division of Membership and Marketing Services, American Dental Association; Dr. Michael Perich, assistant executive director, Division of Dental Practice, American Dental Association; Dr. Terryl Propper, graduate student, University of North Carolina; Dr. David Schwab, communications and marketing consultant, Illinois; Dr. William van Dyk, private practitioner and Council member, California; Dr. Emmett Zimmerman, private practitioner and member, American Academy of Dental Practice Administration, Louisiana.

OPTIONS '91: The OPTIONS '91 Program is being reviewed to ensure its relevancy to dental students' needs. The Council has also selected additional speakers for the 1991 program after issuing a request-for-proposal. Over 50 interested individuals applied. With continued corporate support, this program will again be offered to dental schools throughout the United States in 1990-91.

Survey of Dentist Career Patterns: Women currently comprise approximately 25% of all entering dental students. The increasingly larger percentage of women in the profession has given rise to a number of questions regarding their patterns of practice. In 1988, the Council, in conjunction with the Bureau of Economic and Behavioral Research, conducted the *Survey of Dentist Career Patterns.* The *Survey* contained questions to allow a determination of gender differences in career or practice characteristics. A report of the findings of the *Survey of Dentist Career Patterns* was completed by the Council and was made available through the Council offices on request. This report was the basis for an extensive article on women dentists in the profession, appearing in the September 4, 1989 *ADA News.*

Shortages of Dental Office Staff Manpower: The 1987 House of Delegates approved Resolution 92H (Trans.1987:514) directing the appropriate agencies of the Association to study several issues related to dental office staff manpower. A joint report of the Council on Dental Practice and the Council on Dental Education was developed and presented to the 1988 House of Delegates in response to Resolution 92H-1987 (*Reports* 1988:117). There have been several continuing projects or activities resulting from this resolution. For example, the *Guide to Enhancing the Availability and Retention of Dental Team Members* was completed and has now been reprinted four times. It continues to be requested by state societies, typically when a task force is being planned. Seven different *ADA News* articles were published during this past year on various shortage issues that ranged from salary and benefits to coverage of the Council's meetings and the national conference.

As another response to shortage issues, the Council was a co-sponsor, along with the Council on Dental Education for the National Conference on Recruitment and Retention of Dental Team Members. This Conference, held on October 2-3, 1989 at Association Headquarters in Chicago, was designed to identify and share recruitment and retention tools that have been used successfully in various areas of the country. In addition, the meeting agenda was constructed to give participants a better understanding of the issues underlying shortages as well as ideas for strategies that could be implemented in the educational and practice settings.

Invitations were mailed to all constituent societies, recognized specialty organizations, federal dental services and accredited allied dental health programs. A total of 237 conference participants were registered, ten of whom were from the Council on Dental Practice. An extensive packet of resource material was provided to each participant.

The program began with a plenary session highlighting presentations by Mr. George Keller on "The Environment of Higher Education" and Mr. Wayne Burkhan on "The Power of Paradigms." The afternoon session was primarily planned by the Council on Dental Practice and consisted of eight separate workshop sessions on the following topics: employee salary and benefits, employee leasing, cafeteria style benefit programs, a sampler of the new CDP "Help Wanted" seminar, placement services, job interviews, curriculum designs, and incentives for retention and re-entry. Several Council members and staff conducted or participated in these workshops. The Conference was recorded and audiocassettes are available for purchase through the Council on Dental Practice. The Conference ended with a decision to convene a joint meeting of the Councils on Dental Practice and Education.

Joint Meeting of the Council on Dental Practice and the Council on Dental Education: This meeting was held on December 4, 1989 and began with a plenary session highlighting an overview of the shortage issue, the results of the National Conference on Recruitment and Retention of Dental Team Members and the demographic trends affecting shortages. Three individual work groups conducted more in-depth discussion of particular issues. These three groups were: Non-traditional Educational Programs and Students; Licensure; and Certification. Each group's report was discussed by the joint Councils.

A number of recommendations were approved by the Councils. These recommendations were then assigned to the appropriate Council or assigned shared responsibility and later were prioritized by mail ballots to the Council members. The Council on Dental Practice received its assigned recommendations and discussed them at its May 1990 meeting. Several recommendations require additional

study and a report back to the Council. Others have been implemented through written communication to other agencies or through articles in Association publications.

Dental Assistant Focus Groups: The Council conducted two separate focus group discussions with Chicago-area dental assistants in March 1990 to investigate those factors which lead to satisfaction/dissatisfaction with their careers. Porter-Novelli, a Chicago-based communications and public relations firm, was used to facilitate the focus groups. The research from these groups is being used in the existing seminars and publications, including the Council's newest seminar aimed at hiring and retaining dental office personnel in a more competitive job market.

Chemical Dependency Issues: The Council nominated the following nine members to its Advisory Committee on Chemical Dependency Issues (ACCDI) for 1990: Drs. Robert C. Westcott, chairman, New York; Ross J. DeNicola, Jr., vice-chairman, Louisiana; Samuel H. Adams, II, Texas; Don P. Bowermaster, Ohio; Carol A. Friedel, Washington; Robert F. Goodrich, Tennessee; Dennis R. Miers, Louisiana; Patrick J. Sammon (Ph.D.), Kentucky; and David N. Thompson, Sr., Florida.

The Council co-sponsored, with The Dental Society of the State of New York, the First Regional Conference on Chemical Dependency in the Dental Profession on October 7, 1989. The Conference, held in New York City, attracted 70 persons from 15 states. Four plenary presentations and a question-and-answer session covered such topics as: the uniqueness of chemical dependency in health professionals, a conspiracy of silence in the profession, early identification strategies and how to intervene with chemically dependent colleagues. The Fourth National Conference on Chemical Dependency in the Dental Profession was held July 25-26, 1990 at Association Headquarters and the Second Regional Conference on Chemical Dependency is planned for November 1-2, 1991 in Williamsburg, Virginia.

Council staff continued liaison with the Executive Director and Executive Committee of the Auxiliary to the American Dental Association (AADA) and the American Student Dental Association (ASDA), concerning chemical dependency activities. As a result of this liaison, ACCDI member, Dr. Dennis Miers addressed the Tri-Regional ASDA Convention in Salt Lake City in March 1990. Staff also interfaced with other health professionals concerned with chemical dependency at meetings of International Doctors in Alcoholics Anonymous (IDAA) and the Society for Professional Well-Being.

Council staff wrote articles on chemical dependency that were published in two dental publications, *The Journal of the California Dental Association* and the *Journal of Dental Practice Administration*. Staff assisted the editor of the latter publication in the development of a special issue of that journal devoted to the theme: "DENTISTRY FACES ADDICTION: How to become part of the solution." The special issue is to be distributed to more than 200,000 dentists, dental school administrators, dental faculty members and students in the U.S. and Canada.

A Chemcial Dependency Help-Information Center was staffed by ACCDI and Council volunteers at the 1989 annual session in Honolulu and additional education materials were distributed at the Health Screening Program. A half-day scientific program on chemical dependency in dentistry was sponsored by the Council. Presenters included Council staff and members of the ACCDI.

The Council and its ACCDI have been concerned about the issues of dental management in active and/or recovering chemically dependent (alcohol and other drug dependent) patients. A growing interest on the part of dental practitioners about the management of active and/or recovering chemically dependent patients has been evidenced by (1) inquiries for information on the subject based on the *Drug-Free America* ads which have appeared in dental publications during 1987-89, (2) the appearance of articles on the subject in dental publications and (3) telephone inquiries received in the Council office. In the 1989 *Drug-Free America* ads, readers were encouraged to write the Council office to obtain information on how to identify and treat patients who may be using alcohol and other drugs. Through the end of 1989, more than 1,000 inquiries had been received. In March 1990 the first ADA seminar, "Treating the Active or Recovering Chemically Dependent Patient" was held in Las Cruces, New Mexico with 70 dentists and dental office staff in attendance. The presenter was Dr. Don P. Bowermaster, an ACCDI member and oral surgeon from Ohio.

At its November 1988 meeting, the Council directed that the University of Utah School on Alcoholism and Other Drug Dependencies Dental Section be designated as the primary "training resource" for members of the dental family seeking either basic or advanced education concerning chemical dependency and assistance in starting and developing dental society chemical dependency help programs. The Second Dental Section, conducted in 1989, drew an attendance of 29 dentists, two dental hygienists and one dental student, from 17 states. Eleven dental schools and three state dental boards were represented. Council assistant secretary, S. William Oberg, was a member of the School Planning Committee and served as Section Leader. Former ACCDI member, Dr. Alfred C. Peters of Massachusetts, was the designated faculty member. The 1990 Utah School Dental Section was held June 17-22 in Salt Lake City.

Forensic Dentistry Issues: Council member Dr. Robert C. Westcott, Council consultant Dr. Norman Sperber and the Council secretary attended the annual meeting of the American Academy of Forensic Sciences, held in Cincinnati in February 1990. Mass disaster identification and child abuse identification continue to be issues of active concern among forensic dentists. The Council continues to distribute the *Proceedings: First National Conference on Dentistry's Role and Responsibility in Mass Disaster Identification* on request and it is working with the forensic community to implement certain recommendations contained in that report.

Council Publications: Of the nine revenue-producing materials developed by the Council, *The Successful Dental Practice: An Introduction, Building Successful Associateships,*

Successful Valuation of a Dental Practice and *Handbook of Dental Letters* continue to be the most popular sellers during 1990.

Building Successful Associateships and *Successful Valuation of a Dental Practice* were the first two publications to be revised as part of the Council's newly-introduced "Successful Dental Practice Library." *The Successful Dental Practice: An Introduction* (formerly the *Dental Practice Information Manual*) has now been incorporated into the Salable Materials Program of the Association. *Planning for Successful Growth Partnerships and Group Practice Arrangements, Successful Financial Planning, Successful Patient Communication and Dental Letters, Planning for Successful Retirement* and *Personal Success in Dentistry* are all under development for completion in 1990. The Council has also planned two additional publications for inclusion in the "Success Library"—"Financial Arrangements in the Successful Dental Office" and "Successful Dental Office Design"—scheduled for completion in 1991.

Retirement Brochure: The Council completed work on a new retirement brochure that is available upon request from the Council offices. It is also used by the Department of Membership Records as an insert in mailings that go to any member who is eligible for life membership.

Seminar Programs: The Council identified several additional topic areas for future seminar development. Some of these seminars will target the needs and concerns of young dental professionals.

The Council is directing or coordinating the development of the following new seminars in 1990:

1. "The Team Approach to Periodontal Therapy," presented by Dr. Samuel Low. This seminar is being developed in cooperation with the American Academy of Periodontology.

2. "Treating the Active or Recovering Chemically Dependent Dental Patient," presented by Dr. Don P. Bowermaster. This seminar previewed in March 1990 and is available for society sponsorship.

3. "Help Wanted: Sound Solutions for the Personnel Shortage," presented by Ms. Robin Wright. Ms. Wright previously conducted the ADA seminar titled "Interpersonal Skills for the Dental Team." That seminar has been extensively revised to include information about office personnel shortages, personnel management, employee motivational issues and strategies for hiring and retaining quality dental employees.

4. "Oral and Maxillofacial Surgery—Update 1990s," has been approved for development by the Council in conjunction with the American Association of Oral and Maxillofacial Surgeons.

5. "Cosmetic Dentistry in General Practice" has been approved for development by the Council and Dr. Jacqueline Dzierzak was selected at the Council's May 1990 meeting as the seminar presenter.

6. "Reducing Stress in Dental Practice" has been approved for development by the Council and Dr. Peter Menconi was selected at the Council's May 1990 meeting as the seminar presenter.

7. Seminars on financial planning are provided by the Council. Three individuals—Mr. Glenn Kautt, Dr. David Kuperman and Mr. Joel Stillman, from the same firm—were selected at the Council's May 1990 meeting.

8. Specialty seminars for general practitioners are being developed in conjunction with the American Academy of Pediatric Dentistry, the American Association of Endodontists, the American Association of Orthodontists and the Federation of Prosthodontic Organizations (FPO). The seminars will highlight the cooperative interaction that is needed in a team treatment approach to patient care.

The seminar "The Do's and Don'ts of Associateships and Practice Valuation" was presented during the Association's annual session in Honolulu and covered in an *ADA News* article on November 20, 1989.

Associate Listing Services: The Council routinely receives telephone inquiries regarding placement of associates in dental offices. In 1988, the Council published the results of a survey conducted by David Born, Ph.D., University of Minnesota. This year, another survey of these placement services is being done to update the *Directory of Dental Placement Services in the United States* and this listing will include services that place dental hygienists. Single copies of this *Directory* are available from the Council's offices to members on request at no charge. After the initial mailing of over 1,200 copies to dental schools, dental societies and dental libraries, the Council has filled single requests for more than 500 additional copies.

As a companion publication to the *Directory,* the Council published *Guidelines for Establishing a Dental Placement Service.* These *Guidelines* are designed to serve as a step-by-step aide to those organizations operating a placement service. Several states have indicated an interest in either establishing a placement service or expanding the scope of existing services as another means to assist in response to manpower shortages of dental team members.

Computers in Dental Practice: In response to the increasing number of dentists who are seeking to incorporate or update computer systems in their dental practices and the growth in the electronic insurance claims processing industry, the Council initiated the following five projects in 1990: (1) development of a handout document "Guidelines for Selecting Practice Management Computer Systems," (2) development of a directory of electronic claims processing vendors as a companion document to the Council on Dental Care Programs' "Guidelines on Electronic Claims Processing," (3) development of a request for proposal (RFP) for a Success Library publication, *The Use of Computer Systems in the Successful Dental Practice,* (4) development of an RFP for an ADA seminar on the uses of computer systems in dental practice, and (5) a recommendation that the Association become involved with voluntary standards organizations that will be establishing electronic data interchange standards for systems used in dental practice.

1990 Survey of Non-Clinical Dentists: In an attempt to discover why 1,400 dentists left clinical practice and pursued other careers, the Council authorized the development and distribution of the *1990 Survey of Non-Clinical Dentists,* in cooperation with the Council on Community Health, Hospital, Institutional and Medical Affairs and the Bureau of Economic and Behavioral Research.

Liaison with the Dental Laboratory Industry: The Council continues to maintain formal liaison activities with the dental laboratory industry to allow for discussion of mutual concerns. Representatives of both the National Association of Dental Laboratories (NADL) and the Dental Laboratory Conference (DLC) were in attendance at the Council's December 1989 meeting. The Council Chairman and staff attended the annual session of NADL, June 19-23, 1990.

Recognition Program for Meritorious Service by Certified Dental Technologists: The Council continues to annually implement 1987 House of Delegates Resolution 28H (*Trans.*1987:496) regarding recognition for certified dental technologists. With assistance from the NADL, the Association communicated with each of the certified dental technologists reaching their 25th anniversary in 1989. The NADL provided the Council with the names of those individuals who qualified for this distinction. Personal letters of congratulations from Dr. R. Malcolm Overbey, Association president, were sent.

Policy Statement on Prosthetic Care and Dental Laboratories: The Council approved in May 1989, a consolidation and revision of ADA policy statements on prosthetic care and dental laboratories. In reviewing the existing policy statements on dental laboratories, the Council determined that some of these policies related to dental laboratory regulation were vague. Moreover, the Association's Department of State Government Affairs had indicated that it was receiving requests for clearer guidance from states where legislation to regulate dental laboratories had been introduced.

As a result, a draft policy statement was reviewed by the Council at its December 1989 meeting and discussed with the dental laboratory industry representatives in attendance at the meeting. The representatives of the NADL voiced opposition to certain sections of the statement and suggested several revisions. The Council adopted the draft policy statement, in principle, with certain revisions, and directed that it be circulated to constituent societies, the federal dental services, and the specialty and allied dental organizations for comment.

Ten organizations responded with comments and suggestions to the draft policy statement. At its May 1990 meeting, the Council carefully considered all responses. Of particular note were the numerous suggestions from the NADL, many of which are incorporated into this final version of the policy statement adopted by the Council. However, some of the NADL's other comments, such as its request that references to the NADL's policy positions on infection control and denturism be reflected in the ADA's policy statement, were not included. The Council recognizes and appreciates the strong support that the NADL has given to the Association over the years in these two areas of mutual concern. With respect to the need for laboratory regulation to protect the public's welfare, there is a fundamental difference of philosophy between the ADA and NADL.

The Council also discussed the FPO's concern regarding state licensure of dental laboratories and its suggestion to follow the concept framed in a dental laboratory regulation law in Texas. After due consideration and input from the Council on Government Affairs and Federal Dental Services, the Council on Dental Practice determined that it did not wish to recommend the model represented in the Texas legislation in the Association's policy statement.

With these considerations in mind, the Council submits the following policy statement for consideration by the House of Delegates:

Policy Statement
on Prosthetic Care and Dental Laboratories

Introduction: Patient care in dentistry often involves the restoration or reconstruction of oral and peri-oral tissues. The dentist may elect to use various types of prostheses to treat the patient and may utilize the supportive services of a dental laboratory and its technical staff to fabricate the prostheses according to specifications determined by the dentist.

Since the dentist-provider is ultimately responsible for the patient's care, the Association believes that he/she is the only individual qualified to accept responsibility for prosthetic care. At the same time, the dental profession recognizes and acknowledges with gratitude and respect the significant contributions of dental laboratory technicians to the health, function and esthetics of dental patients.

This statement outlines the Association's policy on the optimal working relationship between the dentist and dental laboratory, the regulation of dental laboratories and issues regarding the provision of prosthetic care. A glossary of terms is a part of this statement.

Because of the dentist's primary role in providing prosthetic dental care, the Association, through its Department of State Government Affairs and the Council on Dental Practice, provides upon request assistance to state dental societies in dealing with issues addressed in this statement.

Diagnosis and prosthetic dental treatment: It is the position of the American Dental Association that diagnosis and treatment of full and partial denture patients must be provided only by licensed dentists and only within the greater context of evaluating, treating and monitoring the patient's overall oral health. The Association believes that the dentist, by virtue of education, experience and licensure, is best qualified to provide denture treatment to the public with the highest degree of quality. As a result of its belief that dental care is the responsibility of a licensed dentist, the Association opposes prosthetic dental treatment by any

other individuals. Further, the Association will actively work to prevent the enactment of any legislation or regulation allowing such activity or programs, on the grounds that it would be dangerous and detrimental to the public's health.

Working relationships between dentists and dental laboratories: The current high standard of prosthetic dental care is directly related to, and remains dependent upon, mutual respect within the dental team for the abilities and contributions of each member. The following guidelines are designed to foster good relations between dental laboratories, dental laboratory technicians and the dental profession.

The dentist, being duly licensed, should:

1. provide the laboratory with signed written instructions detailing the work which is to be performed and prescribing the appropriate materials to be used;
2. provide the laboratory with accurate impressions, casts, interocclusal records or mountings;
3. identify the margins, postdam, borders, relief and/or prosthetic design on all submitted cases;
4. furnish a shade description, photograph, drawing or shade button that most closely achieves the desired results;
5. provide a verbal or written approval for the laboratory to proceed with the fabrication of the prosthesis or approve modifications, if notified by the laboratory that a submitted case may have questionable areas or unclear instructions and submit written approval to the laboratory after the item in question has been clarified;
6. retain a copy of the written instructions for a period of time as may be required by law;
7. follow appropriate laboratory infection control protocol as outlined in the ADA's infection control guidelines.

The dental laboratory should:

1. produce dental prostheses following the written instructions provided by the dentist and using the impressions, casts, interocclusal records or mountings as submitted;
2. review the case with the prescribing dentist for clarification if a question arises;
3. match the shade as described in the original instructions, within the limitations of the materials available for use;
4. notify the dentist immediately if it is determined that work on the case cannot proceed;
5. fabricate the prostheses in a timely manner;
6. inform the dentist of the materials used in the fabrication of the case;
7. follow appropriate laboratory infection control protocol as outlined in the ADA's infection control guidelines.

Instructions to dental laboratories: Complete and clearly written instructions foster improved communication and working relationships between dentists and dental laboratories and can prevent misunderstandings. State dental practice acts may specify the extent and scope of written instructions that are provided to dental laboratories for the fabrication of dental prosthetic devices. These acts may describe the written instructions from the dentists to the dental laboratory as a "prescription" while other states refer to the instructions as a "work authorization" or "laboratory work order." Realizing that terminology in state dental practice acts differs, constituent dental societies are urged to investigate appropriate terminology for their dental practice acts regarding the term(s) used to describe the written instructions between a dentist and a dental laboratory and between dental laboratories for subcontract work, since the term selected may have tax implications depending on state tax revenue codes.

Identification of dental prostheses: The Association urges members of the dental profession to mark, or request the dental laboratory to mark, all removable dental prostheses for patient identification. Properly marked dental prostheses assist in identifying victims in mass disasters, may be useful in police investigations and help prevent loss of the prosthesis in institutional settings.

Shade selections by laboratory personnel: Selection of the appropriate shade is a critical step in the fabrication of an esthetically pleasing prosthesis. The Association believes when a dentist requests the assistance of the dental laboratory technician in the shade selection process, that assistance on the part of the dental laboratory technician does not constitute the practice of dentistry, providing the activity is undertaken in consultation with the dentist and that it complies with the express written instructions of the dentist. Such assistance is most appropriately provided in the office of the dentist.

Regulation of laboratories: The relationship between a dentist and a dental laboratory requires professional communication and business interaction. The dental laboratory staff may serve as a useful resource, providing product and technical information that will help the dentist in the overall planning of treatment to meet each patient's needs. The dental laboratory staff may also consult with the dentist about new materials and their suggested uses. The Association applauds such cooperative efforts so long as the roles of the

parties remain clear: the dentist must be responsible for the overall treatment of the patient and the dental laboratory is responsible for constructing high quality prosthetic appliances to meet the specifications determined by the dentist.

Some dentists may choose to own or operate a dental laboratory for the fabrication of dental prostheses for their patients or those patients of other dentists. The Association opposes any policy that prevents, restricts, or precludes dentists from acquiring ownership in dental laboratories.

In some states the issue of dental laboratory regulation has been addressed through requirements for registration, certification, licensure bills and some hybrids thereof. The Association believes the basic tenet of regulation by any governmental agency is the protection of the public's health and welfare. In the delivery of dental care, that collective welfare is monitored and protected by state dental boards that have the jurisdictional power, as legislated under the state dental practice act, to issue licenses to dentists. These boards also have the power to suspend or revoke such licenses if such action is deemed warranted.

For decades, the public health and welfare has proven to be adequately protected under the current system of dental licensure. The dentist carries the ultimate responsibility for all aspects of the patient's dental care, including prosthetic treatment. In a free market society, dentists select dental laboratories that provide the best quality services and prostheses. As the dental laboratories do not shoulder the ultimate responsibility for the public's welfare, the Association believes that licensure of dental laboratories is not warranted and opposes governmental regulation or licensure of dental laboratories.

The Association opposes the creation of additional regulatory boards to oversee dental care. The Association believes that a single state board of dentistry in each state is the most effective and cost-efficient means to protect the public's dental welfare.

Glossary of Terms Relating to Dental Laboratories

Introduction: This glossary is designed to assist in developing a common language for discussion of laboratory issues by dental professionals and public policy-makers. Certain terms may also be defined in state dental practice acts, which may vary from state to state.

Must: indicates an imperative need or duty; an essential or indispensable item, mandatory.

Should: indicates a suggested way to meet the standard; highly desirable.

May or Could: indicates a freedom or liberty to follow suggested alternatives.

Dental Laboratory: an entity engaged in the business activity of fabricating or repairing dental prosthetic or orthodontic devices as directed by the specific written instructions of a licensed dentist.

Dental Prosthetic Device: an artificial appliance fabricated to replace one or more teeth or other oral or peri-oral structures in order to restore function and esthetics.

Laboratory Certification: a form of voluntary self-advancement in which a recognized, non-governmental agency verifies that a dental laboratory technician or a dental laboratory has met certain predetermined qualifications and is granted recognition.

Laboratory Registration: a form of regulation in which a governmental agency requires a dental laboratory or dental laboratory technician to meet certain predetermined requirements, and also requires registration with the agency and payment of a fee to conduct business within that jurisdiction.

Laboratory Licensure: a form of regulation in which a governmental agency, empowered by legislative fiat, grants permission to a dental laboratory technician or dental laboratory to provide services to dentists following verification of certain educational requirements and a testing or on-site review procedure to ensure that a minimal degree of competency is attained. This form of regulation requires payment of a licensing fee to conduct business within a jurisdiction and may mandate continuing education requirements.

Prescription/Work Authorization/Laboratory Work Order: written directions or instructions from a licensed dentist to a dental laboratory authorizing the construction of a prosthetic device or appliance. The directions or instructions included often vary from state to state but typically include: (1) the name and address of the dental laboratory, (2) the name and identification number, if needed, of the patient, (3) date, (4) a description of the work necessary and a diagram of the design, if appropriate for the appliance, (5) the specific type of the materials to be used in the construction of the appliance and (6) the signature and license number of the requesting dentist.

18. Resolved, that the "Policy Statement on Prosthetic Care and Dental Laboratories" be adopted, and be it further

Resolved, that Resolutions 47-1972-H (*Trans.*1972:656), Diagnosis and Treatment by Unqualified Persons; 96-1973-H (*Trans.*1973:740), Regulation of Laboratories and Technicians; 60-1974-H (*Trans.*1974:691), Regulation of Laboratories and Technicians; 67H-1977 (*Trans.*1977:932,933), ADA Position on the Provision of Denture Treatment; 39H-1977 (*Trans.*1977:937), Terminology for Laboratory Procedure Orders; 7H-1980 (*Trans.*1980:564), Regulation of Laboratories and Technicians; and 7H-1986 (*Trans.*1986:522), Documentation of Materials Used for Prosthetic Devices and Appliances, be rescinded.*

***Note:** As the volume of policy being proposed for rescission is significant, this report will only provide the appropriate citations. Copies of the policies to be rescinded will be provided to the House of Delegates prior to its meetings and to all other individuals upon request.

Liaison with the American Dental Hygienists' Association: The Subcommittee on Dental Team Members met with representatives of the American Dental Hygienists' Association at the May 1990 Council meeting.

Panel of Dental Team Consultants: The Council conducted a one-day meeting on June 15, 1990, with a group of six dental hygiene consultants, all of whom were in the clinical practice of dental hygiene for at least five years. These practicing dental hygienists were queried regarding the office environment, employee-employer relations, office management, staff recruitment and retention, compensation and other practice management issues. This group also reviewed and commented on Council sponsored seminars, publications and other program activities.

Liaison with the American Dental Assistants Association: Representatives of the American Dental Assistants Association met with the Subcommittee on Dental Team Members in May 1990. The report of the dental assistants focus groups was used to discuss differences in job characteristics between satisfied and dissatisfied dental assistants.

The Council also collaborated with ADAA regarding "Dental Assistants Recognition Week." This activity is described in this report as a partial response to 1989 ADA House of Delegates Resolution 73H (*Trans.*1989:534) (see page 65).

Practice Management Articles/Topics: The Council continues to be actively involved in identifying and developing articles and topics relevant to current needs on practice management. Articles appeared in *ADA News* on the following: associateships, employee leasing, chemical dependency, leadership, retirement planning, restrictive covenants, staff building, collections, time management, office management strategies, investing and practice financing. In addition, two "Dental Practice Today" sections were published in *ADA News*. On November 25, 1989, the section contained an extensive review of computers in the dental office. On March 5, 1990, the "Dental Practice Today" section was devoted to electronic claims processing of dental insurance reimbursement. Furthermore, a lengthy article on rural dentists was published in the September 18, 1989 *ADA News*.

Resource Files: The Council continues to maintain and update resource files on over 40 practice management topics. Approximately 250 telephone inquiries and written requests are processed monthly.

Summary of Resolutions

Amendment /Rescission of Current Policies:

18. Resolved, that the "Policy Statement on Prosthetic Care and Dental Laboratories" be adopted, and be it further

Resolved, that Resolutions 47-1972-H (*Trans.*1972:656), Diagnosis and Treatment by Unqualified Persons; 96-1973-H (*Trans.*1973:740), Regulation of Laboratories and Technicians; 60-1974-H (*Trans.*1974:691), Regulation of Laboratories and Technicians; 67H-1977 (*Trans.*1977:932, 933), ADA Position on the Provision of Denture Treatment; 39H-1977 (*Trans.*1977:937), Terminology for Laboratory Procedure Orders; 7H-1980 (*Trans.*1980:564), Regulation of Laboratories and Technicians; and 7H-1986 (*Trans.*1986:522), Documentation of Materials Used for Prosthetic Devices and Appliances, be rescinded.

Bureau of Economic and Behavioral Research

Nash, Kent D., director
Wagner, Karen S., manager, Survey Operations

Organization: The Bureau of Economic and Behavioral Research is responsible for collecting, compiling, analyzing and disseminating practice, economic and statistical information of concern to the dental profession. The Bureau is administratively organized to respond to the need for developing future programs sensitive to the Association requirements for economic and behavioral studies and collection of data. Bureau personnel currently number nine full-time staff members. Part-time staff members are employed to assist the Bureau in various data collection and data analysis activities. The Bureau assists other Association agencies and related dental organizations with the conduct of research and surveys, and disseminates information to the membership, profession and the public.

Economic Research

Background: Economic studies and analyses of data related to dentistry have focused on several Association-related activities and are summarized in this report. Many of these studies include the analysis of data collected from previous Bureau surveys, and other studies include the analysis of data collected by other Association agencies and outside sources.

Reporting of Manpower Data: The 1981 House of Delegates adopted Resolution 124H (*Trans.*1981:571) requiring the Association to examine and report data related to the number of licensed dentists, the rate of increase (growth) in the number of licensed dentists, the number of dentists being graduated, projected trends in the number of new graduates and relate the information to the amount and trends in dental disease. A final report on Resolution 124H was prepared in 1982 (*Supplement 2,* 1982:390). This report is in response to reporting issues related to dental manpower on a continuous basis as required by the resolution. In addition, these data and reports are provided in partial response to Resolution 105H adopted by the 1984 House of Delegates (*Trans.*1984:537) to assist constituent societies to compile statistics on the number of dentists.

The "1989 Survey of Dental Practice, Special Reports". The Bureau prepared and distributed several reports to states on selected topics about the practice of dentistry in the United States. These reports were prepared using results from the *1989 Survey of Dental Practice.* The topics covered include general characteristics of dentists in private practice, employment status of dentists, employment of nondentist staff, solo and nonsolo dentists in private practice, income from private practice, patients of private practitioners and sources of payment for dental services.

In general, each report contains information for all dentists combined, general practitioners and specialists, statistics by region, and in some cases, by age of dentists. All reports contain a breakdown of results for all independent dentists and all solo dentists. Independent dentists own or share in the ownership of a private practice. Solo dentists, a subgroup of all independent dentists, are the only owners of the practice and do not practice with any other dentist. All reports are available on request from the Bureau of Economic and Behavioral Research.

The Number and Projected Trends in Dental School Graduates. A survey of all dental schools is conducted annually by the Department of Educational Surveys, Division of Education. The survey contains a six-part questionnaire to collect: (1) general data, (2) faculty data, (3) financial statistics, (4) data on advanced education programs, (5) enrollment and graduates statistics and (6) curriculum information. A summary of information collected in the twenty-second Annual Survey of Dental Education Institutions is contained in the published *Annual Report on Dental Education 1989/1990.* As a supplement to the Annual Report on Dental Education, the Council also prepares and publishes "Dental Education Trend Analysis" containing historical and current statistics on undergraduate dental education in the United States. Several topics are addressed in the report including the number of applications to dental schools, first-year enrollment statistics and projections, dental school attrition, dental school graduates, tuition and fees, advanced specialty education and licensure examination data. The following are selected results obtained about the number and projected trends in dental school graduates:

a. The estimated number of applicants to the nation's dental schools has declined steadily since 1975. The number of applicants declined to an estimated 4,964 in 1989 from a high of 15,734 in 1975.

b. The decline in dental school applicants has averaged about 7.9% per year since 1975.

c. The 1989 ratio of applicants to first-year enrollments in dental school declined to a level of 1.25 which was considerably lower than in 1975. The 1989 ratio was slightly higher than in 1988.

d. Estimates for 1989 suggest a continued but slower decrease in the number of applicants to dental school.

e. From 1970 to 1978, the number of first-year enrolled dental students increased by 38% or about 4.1% per year. Between 1978 and 1988, first-year enrollment has declined by 4.1% per year.

f. The number of dental school graduates in 1989 was 4,312 compared with 3,749 in 1970. This represents an average annual rate of growth in new dentists of 1% per year since 1970.

g. Projections suggest that the number of new graduates will continue to decline to a level of about 4,000 dentists during the 1990s.

h. The number of women dental graduates in 1989 reached 1,188 representing 27.6% of the graduating class. Women also represented 34.4% of the 1989-90

first year enrollment and 32.7% of the total predoctoral enrollment in dental schools.

Even with this decline in numbers of graduates, current projections indicate that the supply of dentists will increase throughout the remainder of the century.

Forecasts of the Supply of Dentists. Over the past decade, dentistry has witnessed a decline in the number of applicants to dental school (begun in 1975), a decline in first-year enrollments in dental school (begun in 1978), a leveling off of the number of graduates but declining since 1983, closing of five dental schools and a relatively constant number of graduates from advanced specialty programs. Even with these trends, it has been projected that the total number of dentists will continue to increase throughout most of the remainder of the century although at a diminished rate of growth.

The ten-year dental manpower projections shown in Table 1 are derived from the Dental Manpower Model (DMM) which was developed for the American Dental Association by RRC, Inc., an economic research firm located in Bryan, Texas. The DMM is an entity-based projection model in that every dentist is individually represented. The model allows for the examination of the effects from changes in a state's or multiple states' economic and/or dental education environment on the dental manpower conditions nationally or in each of the 50 states. Once a projection is made over time, the model retains extensive information about each dentist including age, gender, specialty, primary and secondary occupation, state location, dental school, years since graduation and activity status (active or retired) for each year of the projection period. The DMM also takes into account population size and population growth, per capita income, tax rates, graduates, first year enrollments and attrition from dental school. Table 1 contains forecasts for the period 1990-2000 for all active dentists and private practitioners. Also included in Table 1 are assumptions about first year enrollments, graduates and the U.S. population 20-24 years of age. Table 2 contains forecasts of the age distribution of professionally active dentists for the years 1990, 1995, 2000 and 2005.

The projections presented in Tables 1 and 2 reflect revisions in the estimates of the number of dentists based on results of the recent 1987/88 *Distribution of Dentists* (census) survey. Similarly to previous years, the number of active dentists and private practitioners are projected to continue to increase slowly throughout the remainder of the century. Growth in the number of dentists is projected, however, to drop to nearly zero by the year 2000 indicating that the number of new dentists entering the profession will be nearly offset by the number of dentists leaving the profession (retirement, death and working in an occupation unrelated to dentistry). First year enrollment in dental schools is projected to continue declining through the year 1994 with modest increases through the remainder of the forecast period. The number of graduates is expected to decline throughout the 1990-2000 period shown in the tables. Although not shown in the tables, the U.S. population 20-24 years of age grew from about 17,200,000 in 1970 to a high of 21,820,000 in 1982. Since then, the size of this population has declined to about 20,510,000 in 1986 and is expected to continue to decline over most of the period of 1990-2000. The U.S. population 20-24 years of age is expected to reach 16,480,000 in 1997 and then begin increasing. Part of the decline in first year's enrollment and expected future declines reflect a general demographic decline in the 20-24 year age group.

Table 2 contains a forecast of the percent distribution of active dentists by age. According to the results, the age distribution of active dentists will shift toward the relatively older age categories over the period 1990-2005. In 1990, the percent of dentists under 40 years was estimated to be 39.3% and is expected to decline to about 25% by 2005. This future decline reflects the relatively large growth in the number of new dentists in recent years, an increase in retirement rates, and the continued decline in first year enrollments and graduates. The dentist age group of 40-54 generally reflects the most productive period for dentists during the lifework experience. In 1990 it was estimated that 39% of dentists were in this highly productive age group compared with an expected 47.1% in the same age group by 2005.

Table 1

Projections of Professionally Active Dentists and Private Practitioners in the U.S., 1990-2000

Years[1]	Active	Private Practice	1st-Year Enrollment	Graduates	U.S. Population 20-24 Years[2]
1990	140,594	128,254	3,922	4,099	18,566
1991	140,988	128,694	3,924	3,933	18,569
1992	141,293	129,076	3,912	3,776	18,344
1993	141,677	129,530	3,916	3,581	18,088
1994	142,043	129,824	3,911	3,530	17,623
1995	142,273	130,131	3,899	3,531	17,129
1996	142,331	130,233	3,882	3,521	16,578
1997	142,444	130,390	3,869	3,524	16,480
1998	142,436	130,582	3,862	3,520	16,485
1999	142,430	130,566	3,864	3,509	16,743
2000	142,370	130,562	3,876	3,493	17,138

Source: American Dental Association, Dental Manpower Model, Bureau of Economic and Behavioral Research, May 1989.

[1] U.S. population projections are based on the U.S. Department of Commerce, Bureau of Economic Analysis. Dentists projections reflect the closing of five dental schools and have been revised based on the 1987/88 Distribution of Dentists Survey.

[2] U.S. population 20-24 years, in thousands.

Table 2

Projection of Percent Distribution of Professionally Active Dentists by Age, Selected Years 1990-2000

Age Group	1990	1995	2000	2005
Less than 30	4.46	3.38	3.11	3.19
30-34	16.42	12.03	10.41	10.01
35-39	18.45	17.55	13.24	11.73
40-44	16.89	18.19	17.47	13.30
45-49	12.74	16.23	17.66	17.06
50-54	9.09	11.88	15.28	16.78
55-59	8.65	7.91	10.44	13.55
60-64	5.99	6.44	5.97	8.00
65-69	4.35	3.31	3.56	3.41
70-74	1.89	1.96	1.59	1.71
75 and older	1.07	1.12	1.27	1.26
Total	100.00	100.00	100.00	100.00

Source: American Dental Association, Dental Manpower Model, Bureau of Economic and Behavioral Research, May 1989.

Bureau Surveys

Background: The Bureau is responsible for conducting a number of surveys regarding the private practice of dentistry and providing assistance to the Association and other dental related agencies regarding the design and conduct of surveys.

Survey of Recent Graduates (Update of the "Distribution of Dentists"): This survey provides the Association with self-reported current information regarding the number, location and practice status of recent dental school graduates. The survey is conducted annually, and the information obtained is merged with information gathered by the *Distribution of Dentists* (census) survey, thereby enlarging the population base used for the Bureau's periodic surveys. Information concerning address changes is forwarded to the Department of Membership.

In July 1989, a survey was mailed to 4,559 dentists who graduated dental school in 1988 and who are listed in the Association files as residing in the United States. Follow-up mailings were sent and telephone follow-up interviews were attempted with those still not responding. By December, surveys had been completed for 85.6% of the 1988 graduating class. Selected results from the survey are:

a. Almost 98% of 1988 dental school graduates are professionally active and about 76.5% are in private practice.

b. Two percent of the graduates are looking for openings, waiting for boards, or otherwise not actively practicing dentistry.

c. Of the 1988 graduates in private practice, approximately 30% are either sole proprietors, partners, or shareholders in the practice where they work, 38% are nonowner associates and 20% work as independent contractors.

d. Approximately 27% of the 1988 graduates are female, 97% of them are professionally active and 77% are in private practice.

A professionally active dentist is defiend as a dentist who indicated one of the following active occupational categories for current primary or secondary occupation: private practicing dentist (more than 30 hours per week); private practicing dentist (less than 30 hours per week); dental school faculty/staff member; armed forces; other federal services; state or local government employed; hospital staff dentist; intern/resident; other student and other health/ dental organization staff member.

An active private practitioner is defined as a dentist who indicated a primary or secondary occupation of private practicing dentist, full- or part-time.

1990 Survey of Dental Practice: The 1990 *Survey of Dental Practice (SDP)* is the current version of the series of surveys that has been conducted since the early 1950s by the American Dental Association's Bureau of Economic and Behavioral Research. Since 1982, the survey has been conducted on an annual basis. Its purpose is to provide reliable information on characteristics of the private practice of dentistry in the United States. The survey consists of detailed questions dealing with visits to the dentist, hours and weeks worked in private practice, net income from private practice, occupational status, employment status in the practice, practice personnel mix, expenses, auxiliary employment and wages, and other selected characteristics.

The initial mailing of the 1990 *SDP* was sent to a random sample of 4% of the nation's private practitioners during February 1990. Follow-up mailings were conducted during March and April. Preliminary results will be available from the Bureau in the fall.

1989 Survey of Dental Practice: The 1989 *Survey of Dental Practice* was initially mailed in February 1989 to a random sample of private practitioners which included general practitioners and specialists. Nonrespondents were contacted through two mail and one telephone follow-up yielding a final response rate of 55.1%. The following are selected results of the 1989 *SDP*.

General characteristics of the private practice of dentistry in the United States. Nationwide, almost all dentists who work in private practice do so as a primary dental occupation (98.5%). Only 7% work in both a primary and secondary private practice and 1.5% practice in a private office as a secondary occupation only. Of the dentists working in private practice as a secondary occupation only, 39% work primarily as dental school faculty, 22.4% are interns or residents, and about 10% each are government employees (11.9%) or work as hospital staff (9.3%). A primary occupation unrelated to dentistry was reported by 5.3% of these dentists.

As in prior years, most dentists in private practice are owners of their practices. Just over half of private practitioners (56.3%) were sole proprietors in an unincorporated practice, 6.9% were partners in an unincorporated practice and 26.2% were shareholders in an incorporated practice. Approximately 10.6% of private practitioners are nonowners: 6.6% are employed as associates on a salary, commission, or percentage basis and 4% are employed as independent contractors.

The solo dentist practice continues to be the most typical size of private practice. Approximately 65.6% of the nation's private practitioners were working in a practice with no other dentist, while 21% were working with one other dentist and 13.4% with two or more dentists.

Slightly more than half (57.3%) of the nation's private practitioners are under the age of 45; 23.2% are under the age of 35 and 13.4% are 60 years of age or older. Just under three-quarters of current private practitioners (70.5%) graduated from dental school since 1965 and 44.6% have graduated since 1975.

Most dentists (78%) practice dentistry on a full-time basis (32 hours per week or more). About 41.7% of the private practitioners reported having worked 40 hours or more per week. On an annual basis, 65.7% of the private practitioners worked 1,600 hours or more, while 29.3% worked 2,000 hours or more.

Dentists in private practice are distributed relatively

equally among the four major U.S. census divisions. About 26.3% are located in the northeast, 26.2% in the north central, 26.2% in the south and 21.4% in the west.

The rest of this section focuses on independent dentists who are in private practice as a primary occupation. An independent dentist is one who owns or shares in the ownership of a private practice. Those owners who practice with no other dentist are referred to as solo dentists. Independent dentists comprise 91.7% of the nation's private practitioners who are in private practice as a primary occupation.

Patients and patient visits. Table 3 shows the average number of patient visits per week among independent dentists. Excluding hygienist appointments, the mean number of scheduled appointments for all independent dentists was 60; general practitioners treated an average of 52.7 scheduled patients, while specialists treated an average of 92.8 visits per week. Including emergency and walk-in visits, the average total number of visits treated by an independent dentist per week was 65.5. This average was slightly lower among general practitioners (58.1) and slightly higher among specialists (98.8).

In 1988, independent dentists worked an average of 47.7 weeks and 37.4 hours per week. General practitioners and specialists averaged virtually the same amount of time in practice. An average of 33.1 hours per week were spent in direct patient treatment.

Table 3

Mean Number of Appointments and Visits Per Week for Independent and Solo Dentists, 1988.

Appointments and Visits Per Week*	All Dentists (weighted)	General Practitioners	Specialists
		Independent Dentists	
Scheduled appointments actually treated	60.0	52.7	92.8
Walk-in and emergency visits	5.5	5.4	6.0
Total visits per week	65.5	58.1	98.8
		Solo Dentists	
Scheduled appointments actually treated	58.8	52.0	92.6
Walk-in and emergency visits	5.1	5.2	4.9
Total visits per week	63.9	57.1	97.5

*Appointments and visits do not include patients scheduled primarily for a hygienist visit.

Source: American Dental Association, 1989 Survey of Dental Practice.

Table 4

Net Income of Independent Dentists, 1988

Source	All Independent Dentists (weighted)	Independent General Practitioners	Independent Specialists
		Mean Income	
Primary practice	$85,690	$78,260	$119,300
Private practice	86,970	79,140	122,700
Total from dentistry	87,410	79,850	123,610
		Median Income	
Primary practice	75,000	70,000	100,000
Private practice	75,000	70,000	102,000
Total from dentistry	75,000	70,000	104,000

Source: American Dental Association, 1989 Survey of Dental Practice.

Nearly two-thirds (61.1%) of independent dentists' patients were between 15 and 64 years of age. An average of 21.8% were under 15 years of age and 17.1% were 65 years of age or older. Nearly half (47.1%) of the patients seen by all independent dentists had annual family incomes of $30,000 or more. Independent specialists estimated that 54.5% of their patients had annual family incomes in this group, while independent general practitioners estimated 45.5% of their patients to be in this group.

It was estimated that 62.2% of patients seen by independent private practitioners were covered by a private insurance program that paid or partially paid for their dental care. An estimated 5.5% were covered by a public assistance program and an average of 32.3% were not covered by an insurance program.

Net income of independent dentists. Dental fees, the costs of operating a practice, the amount and mix of dental services provided, and the market conditions for dental services, are all intricately related to determine income from the private practice of dentistry. The level and growth of dental income are indicators of the economic dental practices and are influential factors for those considering entering the dental profession. In the 1989 *Survey of Dental Practice*, dentists were asked to report net income earned from their private practices, (that is, gross income minus expenses before personal income taxes), plus income from any other dental sources. Three estimates of income earned from the practice of dentistry are reported in Table 4: (1) net income from the dentist's primary private practice, (2) total net income from private practices and (3) total net income from all dental sources. Since most independent dentists worked in a private practice as a primary occupation, it is not surprising that most income reported was earned from the primary practice alone. Primary practice earnings represented 98% of an independent dentists' total dental income.

Among independent dentists practicing full- or part-time during 1987, the average net income from primary practice was $85,690. Independent general practitioners averaged $78,260, while independent specialists earned an average of $119,300 from a primary private practice. Primary practice earnings represented 98% of the average general practitioner's total dental income and 96.5% of a specialist's total dental income.

The average net incomes reported in Table 4 are for all independent practitioners who worked in private practice on a full- or part-time basis. The mean net income from primary practice for all independent dentists working full-time (32 or more hours per week) was $96,910; this figure was $83,300 for independent general practitioners and $131,400 for independent specialists. Among all independent dentists working 1,600 hours or more per year, the average net income was $96,020. For independent general practitioners who worked 1,600 hours or more per year, the average net income was $82,520, compared with an average of $132,060 for independent specialists.

Adjusted for inflation, the mean net income of independent dentists increased from the early 1950s until 1972, when adjusted income began to decline. Between

1972 and 1983, adjusted annual income for independent dentists declined 25.1%. However, between 1983 and 1988 there has been a return to increasing adjusted incomes. Independent general practitioners' real income increased 1.5% over the 1984 to 1988 period and independent specialists real income decreased 0.8%. Among all independent dentists, the increase in real income was 2.3%.

Practice gross income and total expenses for solo dentists. Table 5 contains the mean gross income (total billings) and mean total expenses of operating a solo dental practice during 1988. The table also contains the distribution of sources for gross income. In 1988, gross income for solo dentists averaged $228,260. Solo general practitioners averaged $214,630, and solo specialists earned an average of $298,010 in gross income.

The mean practice expenses of solo dentists in 1988 were estimated to be $146,723; solo general practitioners averaged $138,555 and solo specialists averaged $191,244. Since 1987, the average reported expenses of operating a practice increased by 2.4% for all solo dentists. Expenses increased by 4.2% for general practitioners and decreased by 1.7% for solo specialists. Table 5 also contains the average ratio of expenses to gross income. In 1970, the ratio of expenses to gross income was estimated to be 48%. In 1988, this figure rose to 63.8% for all solo dentists.

Among solo dentists, the percent of gross income paid through direct patient payment ranges from 44.6% among general practitioners to 55.9% among specialists. The percentage paid through private dental insurance ranges from 38.8% among specialists to 49.5% among general practitioners. The percentage of gross income paid by government programs was 5.2% among general practitioners and 4.8% among specialists.

Quarterly Survey of Dental Practice (QSDP) (Panel Survey of Private Practitioners): Since 1982 the Bureau has collected data on a quarterly basis from a panel of private practitioners representing approximately 2% of the nation's private practitioners. Besides providing a means for collecting current information on the economics of the private practice of dentistry, the survey generates an historical (that is, time series) set of statistical information that can be used to forecast future developments in dental economics.

Table 5

Gross Income, Total Expenses and Percent Distribution of Gross Income by Source of Payment for Solo Dentists, 1988

	All Solo Dentists (weighted)	Solo General Practitioners	Solo Specialists
Income/Expenses			
Mean gross income	$228,264	$214,626	$298,014
Mean total expenses	146,723	138,555	191,244
Ratio (total expenses/ gross income x 100)	57.6%	58.8%	50.9%
Sources of Payment of Gross Income			
Direct patient payment	46.6%	44.6%	55.9%
Private insurance	47.7	49.5	38.8
Government programs	5.1	5.2	4.8

Source: American Dental Association, 1989 Survey of Dental Practice.

Time series data from the *Quarterly Survey of Dental Practice* is being used to update *Dental Practice and Economic Trends*, a report on trends in dental and national economics last published in 1986. The update should be available in the fall of 1990.

The *QSDP* also provides data to support articles in the *Dental Practice Outlook (DPO). DPO* is published monthly and contains information about practice, economic, and financial conditions affecting dentists and the private practice of dentistry. Recent articles include a cost-benefit analysis of new dental technology, utilization of alternative dental prepayment plans and trends in dental hygienists' wages.

Subscription information can be obtained from the Bureau or RRC, Inc., 3833 Texas Avenue, Suite 256, Bryan, Texas 77802. *DPO* is published by RRC, Inc. in cooperation with the American Dental Association and serves as a source of nondues revenue for the Association.

Survey of Dental Services Rendered: The 1990 *Survey of Dental Services Rendered* is a major source of information on the frequency of utilization of dental procedures by private practitioners and provides data for analysis of patient flow into dental offices and the dental services they receive. This survey is the fourth in a series of surveys that began in 1959 and is conducted approximately every ten years.

Approximately 9,000 private practicing dentists will be sent a questionnaire and work log. Two mail follow-ups and a telephone call to encourage the response of nonrespondents will be conducted. The questionnaire collects information on practice characteristics, staffing and work load. Participants will also record in a log the dental procedures they complete for each patient treated. Dentists will be asked to respond for one day, Monday through Saturday.

Results of the survey will show changes in patterns of dental services rendered. The results will also permit estimates of the total number of each dental service provided during 1990, by age and sex of the patient.

1990 Survey of Dental Fees: The Bureau is currently conducting a fee survey to update the information on dental fees and procedures gathered in1985. The survey sample includes both general practitioners and specialists. Results of the 1990 fee survey will appear in *The Journal* in 1991.

Other Association Survey Services: A major effort of the Bureau is in assisting other Association agencies and dental related groups with the conduct of research and surveys. In 1990 four divisions asked assistance from the Bureau in the conduct of national surveys.

Within the Divison of Dental Practice, the Council on Dental Care Programs received assistance in conducting the 1989 *Survey of Public Education on Alternative Dental Benefit Plans.* All component and constituent dental societies were surveyed. The Bureau conducted the survey, analyzed the data and prepared the final report. The report was mailed to all component and constituent dental societies.

The Council on Community Health, Hospital, Institutional and Medical Affairs requested assistance in

conducting the 1990 *Access Survey*. This project will quantify the efforts made by the dental profession in providing services to institutionalized, homebound, handicapped, elderly, low income and migrant individuals, as well as AIDS patients and remote area residents. The *Access Survey* is conducted biennially and is sent to all component and constituent dental societies. The Bureau is responsible for conducting the survey, analyzing the data and preparing a final report.

The Office of Quality Assurance was assisted in designing the survey instrument, budgeting, conducting, and analyzing the 1989 *Survey of Dental Qaulity Assessment and Quality Assurance Programs in the United States.* The project produced a directory containing the addresses of over 500 organizations with dental quality assessment or quality assurance programs along with a short description of each program. Data from the survey is being used to develop a report detailing the state of dental quality assurance in the U.S.

Within the Division of Membership and Marketing Services, the Department of Membership requested assistance in obtaining basic demographic information about dentists who had been added to the master file since the most recent *Distribution of Dentists* census survey. The Bureau mailed 1,330 survey cards to these dentists, sent two follow-up mailings to nonrespondents and telephoned the dentists who had not responded to any of the mailings. The Bureau coded and cleaned the data then transferred the information to the Department of Membership.

Also, in late 1989, the Bureau conducted a *Membership Needs and Opinion Survey* on behalf of the Department of Membership Development and Services (DMDS). Surveys were sent to to 9,099 dentists, a sample of which included current members, past members, and new members. Results were forwarded to the DMDS in January 1990.

The Bureau also assisted staff of the Department of Marketing and Seminar Services in coordinating a nationwide study of consumers regarding their behavior and attitudes toward issues in dentistry. The Association had commissioned the Gallup Organization, Inc., of Lincoln, Nebraska to conduct monthly consumer opinion studies utilizing their Omnibus survey.

The Department of Dental Society Services requested assistance regarding survey design, budgeting, and the conduct of the *Survey of Component Dental Societies*, which requests demographic information of the local societies.

The Department of Dental Society Services mailed surveys to all national dental organizations to obtain information about revenue, budget and membership. The Bureau coded, cleaned and analyzed the data from this survey project. A report based on the results of the 1989 *Survey of National Dental Organizations* was delivered in January 1990.

The Bureau assisted the Human Resources Department, of the Division of Finance and Business Affairs, in processing data from the 1989 Human Resources Management Association of Chicago's *Survey of Employee Assistance Programs.* Data from the survey was tabulated and a final report was written based on the results.

Bureau staff assisted the Council on Dental Research, of the Division of Scientific Affairs, in survey design, coding and data cleaning for the 1989 *Health Screening Program* surveys. These surveys are conducted every year at the Association's annual session. The Bureau also assisted in processing data from an audiology test conducted as part of the health screening program at the Greater New York Dental Meeting, held in November 1989. Cleaned data from both of these projects were transmitted to the Council on Dental Research in the spring of 1990.

As a source of nondues revenue, the Bureau has developed a new report and conducted additional studies. The Bureau provides the 1989 *State and County Demographic Reports* as a source of nondues revenue. Each report contains the following: (1) a dentist profile that includes county-level estimates of the number of dentists broken down by primary occupation, specialty, age, and sex; (2) a county population profile that contains 1980 benchmark data, current estimates, and a five-year projection; and (3) a methodology section that includes definitions of the terms used in the reports and suggestions for evaluating a new practice area.

The 1990 *Members Retirement Survey* was commissioned by the Council on Insurance in conjunction with the Equitable Life Assurance Society. The survey investigated the retirement needs of Association members who do not currently participate in the Association-sponsored retirement program. The Bureau assisted in designing and formatting this survey. Survey mailings, data coding, cleaning and analysis were performed by the Bureau.

The Missouri Dental Association has contracted with the Bureau to survey 45% of Missouri dentists with a special version of the 1990 *Survey of Dental Practice.* A final report will be prepared in the fall of 1990.

Also as a source of nondues revenue in 1989, the Bureau conducted special versions of the national *Survey of Dental Practice* for the Vermont State Dental Society and the Kentucky Dental Association. Response rates for these surveys were 62.7% and 55%, respectively. Bureau staff assisted in survey design and budgeting as well as the conduct and analysis of the data. Final reports were produced and forwarded to each state society for distribution in 1990.

Publications and Presentations:

1. American Dental Association, 1989 *Survey of Dental Practice* (a series). Titles included: "Income from the Private Practice of Dentistry," "General Characteristics of Dentists," "Employment Status of Dentists," "Dentists in Nonsolo and Solo Practice," "Employment of Dental Practice Personnel," "Sources of Payment for Dental Services," "Patients of Dentists in Private Practice" and "Patient Visits to the Dentist." Bureau of Economic and Behavioral Research, 1990.

2. American Dental Association. "Changes in the Manpower Pool: The Recent Experience" Bureau of Economic and Behavioral Research, 1990.

3. American Dental Association. "Dental Practice and Economic Trends." Bureau of Economic and Behavioral Research, 1990.

4. American Dental Association, 1989 *Survey of Dental Practice–Vermont Version.* "Dentists in General Practice in the State of Vermont," and "The Characteristics and Employment of Dental Hygienists in the State of Vermont," Bureau of Economic and Behavioral Research, 1989.

5. American Dental Association, 1989 *Survey of Dental Practice–Kentucky Version.* "Dentists in General Practice in the State of Kentucky," Bureau of Economic and Behavioral Research, 1989.

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

Council on Insurance

Seldin, Leslie W., New York, 1992, chairman
McCall, Douglas H., Kentucky, 1991, vice-chairman
Allen, Zoel G., Texas, 1993
Bitler, Glenn F., North Carolina, 1993
Coratola, Joseph J., Connecticut, 1993
Dickerson, John D., Ohio, 1990
Katz, Eugene E., Pennsylvania, 1992
Knox, John E., Illinois, 1991
Lehman, John P., California, 1991
Marks, Clifford, Florida, 1990
McKrill, Edward M., Alaska, 1992
Nash, Kevin C., Iowa, 1990
Sokoloff, Jack P., Delaware, 1992
Toso, Donald R., Louisiana, 1991
Treacy, John P., Wisconsin, 1990
Utzinger, David H., Arizona, 1993 *ad interim*
Johnson, Brian M., secretary
Dwyer, David R., associate secretary
Kelner, Steven M., assistant secretary

Meetings: The Council met at the Headquarters Building on September 15-16, 1989 and on April 6-7, 1990. It also conducted a telephone conference call on February 15, 1990. It is scheduled to meet again August 24-25, 1990.

Vice-Chairman: Dr. Douglas H. McCall was reelected vice-chairman of the Council at the April 1990 meeting.

Group Term Life Insurance Program: As of December 31, 1989, a total of 75,982 members were participating in the Term Life Plan. Enrollment consisted of 66,050 member dentists, 2,428 dental school graduates and 7,504 predoctoral students. Additionally, 17,579 members were insuring their spouse and 9,897 were covering their eligible dependent children under the Program by year-end.

During 1989, the volume of insurance in force rose by approximately $984 million, to a total of more than $13.5 billion. The average amount of coverage carried per member increased by 6.9% to $177,687. The Council attributes the high level of participation to the Term Life Plan's competitive rates and benefit provisions, the premium credit feature and special efforts to retain graduating dental students.

The favorable financial experience of the Term Life Plan continued in 1989, with a 48.6% ratio of claims to premium. Based upon actuarial projections, the Council determined that approximately $14.6 million in surplus funds were available for distribution in 1990. This produced a credit for each participant equivalent to 45% of the premium for coverage in force during 1989.

At year-end 1989, more than 7,300 participants were insured at the Term Life Plan's $500,000 coverage maximum. Given this high level of participation, the Council approved an increase in the maximum benefit to $750,000, effective January 1, 1990. However, coverage amounts in excess of $500,000 may not be available to members who also participate in the Universal Life Plan, if the combined protection under both plans would exceed $1 million.

At its April 1990 meeting, the Council identified a number of opportunities to further enhance the value of the Term Life Plan. These include an 18% aggregate reduction in rates, effective January 1, 1991. This cost reduction will be allocated among the participants based upon loss experience at each age. This will produce an average rate decrease of 17.81% for participants under the age of 60, 22.95% for those aged 61 to 65 and 31.54% for participants aged 66 to 70. Actual reductions will vary by age. Based upon an analysis conducted by Great-West Life of past claims and actuarial projections of future mortality and program growth, it was concluded that the premium adjustments could be implemented without compromising the long-term financial stability of the Plan.

In addition, the Council also sought to respond to requests by participants that higher amounts of protection be made available after age 61. Currently, coverage under the Plan is reduced by 10% of the original amount at ages 61, 62, 63, 64, 65, 66 and 71. The Council accepted a proposal to revise the scheduled coverage reductions effective January 1, 1991. The new schedule will allow the full amount of protection to continue in force through age 64. The 10% coverage reductions will now commence at age 65 and continue annually until age 71. The effect of this change will be to increase the amount of protection in force for all participants 61 to 69 years of age.

Lastly, the Council reexamined the value of the Program's Paid-Up Life Insurance feature. For participants who renew coverage at least until age 71, the Term Life Plan coverage can be exchanged for a lesser insurance benefit that remains in force for life with no premium required. At age 71, the participant becomes eligible to receive either $500 of paid-up insurance, or a $500 cash payment, for each $7,500 of Term Life coverage held under the Program at the time. If the insured does not elect the Paid-Up Benefit at age 71 but continues paying premiums, the benefit increases in subsequent years until age 75, when it has a value of $1,000 for each $7,500 of protection in force.

The Council noted that the value of these Paid-Up benefits is somewhat diminished by the fact that the member will be paying a premium of $260 (less credits) for each $7,500 of protection that is renewed. The fact that continuation of the Paid-Up feature is not guaranteed further dilutes its appeal, particularly among younger

members. Moreover, many participants do not renew coverage to age 70 and yet are required to contribute to the funding for this benefit. Consequently, the Council concluded that the Paid-Up feature adds little to the Program's advantages, while its cost to participants is considerable.

For these reasons, the Council accepted a proposal to eliminate the Paid-Up feature effective January 1, 1991. Recognizing that some older members may be relying upon this benefit and may not be able to purchase permanent life insurance protection, the Council agreed that all participants currently over the age of 60 would remain eligible for Paid-Up benefits. Those insureds 59 years of age or younger who may want post-retirement coverage, are permitted to convert their term insurance to the ADA Universal Life Program, without submitting medical evidence of insurability. Essentially, this would enable them to carry their existing term coverage up to age 90 at very competitive rates.

Noncontributory Life Plan: The life insurance program for predoctoral student members was introduced in 1981 in response to House of Delegates Resolution 100H-1980 (*Trans.* 1980:580). The Plan offers $25,000 of term life insurance without payment of premium until July 1 of the year following the year of graduation from dental school. The expense of the program is borne by the ADA Group Term Life Program.

Total enrollment in the Noncontributory Plan is 9,932. In 1989, approximately 53% of the participants who graduated in 1988 elected to continue coverage on a premium paying basis. This influx of younger members into the Term Life Plan should continue to have a positive impact on claims experience and thus benefit all insureds. It also provides another reason to maintain Association membership.

Group Universal Life Insurance Program: The Group Universal Life Insurance Program was introduced as a new benefit of membership in September 1987. The Program is underwritten and administered by the Great-West Life Assurance Company.

The ADA Universal Life Plan combines life insurance protection with a tax-advantaged investment. Premium contributions that exceed the cost of the life insurance protection and administrative fees, earn interest on a tax-deferred basis and form a "cash-value." These monies can be left to accumulate in the policy, be withdrawn or borrowed by the insured or used to pay future insurance costs. Under current law, federal income taxation on the interest earnings are deferred until such time as this money is withdrawn from the policy. If paid to the beneficiary as part of the death benefit, the interest earnings escape federal income taxation entirely.

Currently, 649 members are participating in the Program. As of December 31, 1989, the average amount of coverage carried per member was $180,000 and deposits by participants totaled more than $1.4 million. Deposits to the Program are credited with a rate of interest that is guaranteed for one year. A new rate is set each month. These returns ranged from 9% to 9.25% during 1989 and were highly competitive with rates prevailing in the financial markets for investments of like maturities.

During 1989, over 3,300 members requested coverage proposals. However, the process of converting this interest into actual sales continues to be the Plan's biggest challenge. With the knowledge that the Program is competitive in terms of coverage, administrative costs and investment return, efforts are being focused on telemarketing as a means of overcoming some of the difficulties of selling a complicated financial product through the mails.

At the Council's request, a private letter ruling was sought from the Internal Revenue Service (IRS) to allow Association members to execute a tax-free exchange of an individual life insurance policy for a participating interest in the ADA Group Universal Life Plan. In addition, it would permit members to transfer the cash-value from the ADA Group Universal Life Plan to an individual annuity contract without increasing a tax liability. This ruling was issued by the IRS in February 1990.

The Council believes that the ruling makes this group product more accessible to dentists who are holding individual life contracts; and with the opportunity to convert to an annuity, increases the flexibility of universal life when cash is being used for retirement. It hopes that this special feature of the ADA Program will encourage greater numbers of members to take advantage of this membership benefit.

Members Retirement Program: The Association offers a tax-qualified Retirement Program as a benefit of membership, which is administered by the Equitable Life Assurance Society of the United States. Investment management services are provided by the Equitable Capital Management Corporation.

The Program offers a full service arrangement in which the dentist adopts a Master Plan, which is preapproved by the Internal Revenue Service, and Equitable provides investment management and administrative services. Alternatively, the dentist can elect to maintain an individually-designed and IRS-approved plan while using the ADA Program for investment purposes only.

Under the umbrella of a Master Plan, the dentist has a wide choice of design options. A defined contribution plan can be adopted as a profit-sharing or pension arrangement, or a combination of both. This offers the dentist/employer considerable flexibility in determining the annual contribution. It is computed as a percentage of each participant's compensation for that year. The total amount of these contributions, together with the investment gains or losses on these funds, less expenses, determines the benefits that will be available upon retirement. Currently, the maximum annual deposit to a defined contribution plan is limited to 25% of the participant's income, but not more than $30,000.

A defined benefit plan was introduced in 1987 as an alternative means of accumulating retirement savings. It allows the dentist/employer to determine the percentage of each participant's compensation that will be paid upon retirement. Such an approach requires ongoing annual contributions with little discretion to adjust the level of funding. Each year, an actuarial calculation is made as to the amount of money which, when combined with projected

investment earnings, will be needed to fund the promised benefit. Investment losses or gains that differ from actuarial assumptions are factored into future deposits.

The maximum annual benefit payable upon retirement is 100% of compensation or $102,582, whichever is less. With the introduction of the Tax Reform Act of 1986, the dentist must be age 65 and have ten years of participation in the plan to be eligible for the full $102,582 annual benefit. If an employer establishes a plan and retires early, annual benefits must be reduced.

A defined benefit approach may be attractive to those members who have a steady stream of income sufficient to fund such a plan and who are nearing retirement. However, there are a host of variables, such as the ages of employees as well as the existence and level of funding of any prior plans, that would enter into this decision. Therefore, dentists must evaluate a defined benefit plan in light of their particular circumstances. It is expected that the appeal of this product will be limited, as most participants would be better served by a defined contribution plan.

Changes in the Master Plan are filed by Equitable on behalf of the participants and for no additional fees. The Council believes that this is a major advantage of the Program, in that dentists having individually designed plans are likely to incur substantial legal and/or accounting fees to make certain that their plans are in compliance with the changing tax laws.

Other services provided by the Program are the processing and reporting of financial transactions as well as quarterly statements of invested assets. Participating members can also take advantage of consulting services on all aspects of the Program, information on investment performance and counseling in selecting retirement benefit options. The Program offers telephone transfer capabilities, which enable participants to reallocate their funds among certain investment alternatives. In addition, the employer is provided with partially completed forms and any necessary assistance in finalizing filings with the IRS, such as form 5500. Finally, under the full service arrangement, Equitable prepares all tax reports and handles the required withholding when amounts are distributed to retired participants.

The prime advantage of the investment only arrangement is the flexibility it offers. There are dentists whose needs extend beyond those of a structured retirement package and who prefer to work with a professional pension consultant for plan design and administration. Under the investment only arrangement, the dentist/employer can continue that relationship and still participate in any of the investment options available under the Association Program.

At the end of 1989, 13,798 dentists and their employees were enrolled in the Retirement Program. At year-end, there were 6,445 plans in effect with total invested assets of $755.9 million, as compared with $651.7 million in the prior year.

Participants allocated $543.2 million of their funds among the fixed income accounts, which provide a guarantee of both principal and interest. These include three- or five-year Guaranteed Rate Accounts, which are similar to a bank certificate of deposit or a Money Market Guarantee Fund.

The rate of interest credited to funds invested in the Guaranteed Rate Accounts remains unchanged until maturity. It is intended to be competitive with investments of like duration available in the financial marketplace and new rates are set weekly. These fixed income products are designed to hold funds for the entire three- or five-year period and premature withdrawals may be subject to certain restrictions or interest penalties. As of December 31, 1989, 33.7% or over $254 million of the participants' funds were allocated to the Guaranteed Rate Accounts.

The Money Market Guarantee Account offers short-term interest rates comparable to those of money market funds. At year-end 1989, 38.2% or over $288 million of the participants' funds were invested in this option. The interest rate credited on monies held in this Account changes monthly. Participants are able to make contributions at any time and there is never a market value adjustment upon withdrawal of funds.

Participants allocated 21.8% of their assets, or $164.9 million, to the Growth Equity Account, which is invested in a portfolio of blue chip common stocks. The percentage change in the Fund's unit value for the calendar year 1989 was 45.4% as compared with a 31.7% increase in the Standard & Poor's 500 Stock Index. For the period from January 1, 1979 to December 31, 1989, the average annual increase in the Growth Equity Account's unit value was 19.6% as compared to the 17.5% average annual increase in the Standard & Poor's 500 Stock Index.

The Strategic Balanced Account holds 4.1% of the participants' assets, or approximately $31.2 million. The fund is invested among stocks, bonds, cash and convertibles, with the percentage of the portfolio allocated among these markets being determined by the Equitable Capital Management Corporation. The gross percentage change in the Strategic Balanced Account's unit values for calendar year 1989 was 27.1%, as compared with a 23% increase in a 50%/50% composite of the Standard & Poor's 500 Stock Index and the Shearson Lehman Government/Corporate Bond Indices.

Approximately 1.2% of the participants' assets, or approximately $9.3 million, is invested in the Aggressive Equity Account which holds a portfolio of common stocks of primarily small- and intermediate-sized companies possessing outstanding growth potential. The objective of the Fund is to achieve higher returns than those of more conservative stock portfolios. However, coupled with the opportunity for greater returns is the higher risk inherent in the stocks comprising the portfolio. As a result, increases or decreases in unit values are expected to be greater than those of the market as a whole. The percentage change in the Aggressive Equity Account's unit value for calendar year 1989 was 47.7%, as compared with a 23% increase in the Lipper Small Company Growth Funds Average Index.

Approximately $7.2 million or 1% of the participants' total assets are held in the Real Estate Fund. It allows for participation in a high quality, commercial real estate account which has been structured to overcome previous obstacles to such investments through a diversification of commercial properties, greater liquidity of funds and a lower minimum contribution requirement. During 1989, the Fund's unit value increased by 9.6%. Of this growth, 7.1% was attributable to income generated by the real estate holdings and 2.5% by appreciation in the value of the properties.

The reported changes in the unit values for the aforementioned accounts assume that funds were invested for the entire period and are not an indication of future performance.

Members Individual Retirement Account (IRA): The Association-sponsored Individual Retirement Account was implemented in 1982 as a benefit of membership and is available to members, their spouse and employees. The Program is administered by the Integrity Life Insurance Company.

As of December 31, 1989, there were a total of 3,297 participant accounts as compared with 3,436 in the prior year. The total value of these Individual Retirement Accounts was approximately $46 million as compared with $37.6 million at the end of 1988.

As of December 31, 1989, the participants' contributions were allocated among the investment options as follows: Money Market Fund, 28.3%; Stock Fund, 26.7%; Bond Fund, 2.1%; Guaranteed Rate Accounts, 24.3%; Balanced Fund, 17.9%; Aggressive Stock Fund, 0.3%; High Yield Fund, 0.1% and Global Fund, 0.3%.

The percentage increase in unit values for the following funds for calendar year 1989 were as follows: Money Market Fund, 9.8%; Common Stock Fund, 25.4%; Bond Fund, 16.4%; Balanced Fund, 26.9%; Aggressive Stock Fund, 44%; High Yield Fund, 2.1% and Global Fund, 27.1%.

The reported changes in the unit values for the aforementioned funds assume that monies were invested for the entire period and are not an indication of future performance.

Group Income Protection Plan: As of December 31, 1989, a total of 28,557 members were participating in the Income Protection Plan. The Plan offers monthly benefits as high as $6,000 when an injury or illness prevents insured members from working in their special area of dental practice.

Participants may tailor protection to meet their particular needs. A variety of options are available, including either short- or long-term benefit periods, as well as four elimination periods. Additionally, application can be made for a Cost-of-Living Adjustment (COLA) rider that is intended to preserve the purchasing power of benefits paid to disabled insureds by adjusting payments for the impact of inflation. Lastly, a Future Increase Option offers eligible participants the ability to purchase additional amounts of protection in future years, regardless of health. During the period from November 1, 1988 to October 31, 1989, more than $14.3 million was paid to disabled participants.

At its April 6-7, 1990 meeting, the Council accepted a proposal to introduce a new coverage option under the Program. It offers the insured dentist the ability to satisfy the waiting period that must elapse before benefit payments commence with days of partial disability. In addition, the days of disability need not be consecutive and can be interspersed with days of return to full-time work. The only requirement is that the days of partial or total disability must be accumulated within a time frame that is not greater than twice the length of the waiting period. This compares to the Program's standard coverage which requires that waiting periods be satisfied with consecutive days of total disability.

In addition, the new benefit will allow the insured to qualify for partial (residual) disability benefits, even if he or she is never totally disabled. After suffering at least 30 days of total and/or partial disability, the insured could receive residual benefits if unable to work full-time. The new benefit option will be available to members who make application prior to their 50th birthday, but can be renewed until age 65. Issuance of the benefit will be subject to the dentist's meeting the Program's underwriting requirements and payment of an additional premium.

Hospital Indemnity Plan: The Hospital Indemnity Plan offers coverage intended to supplement major medical policies. It provides insured members with a benefit of up to $300 for each day they or one of their insured dependents is confined in a hospital. This protection is seen as a way of offsetting the considerable out-of-pocket expenses that can result from deductibles and other coinsurance features of most medical insurance plans. Issuance of coverage to members and their dependents under age 60 is guaranteed. However, benefits for certain "preexisting conditions" may not be available during the first two years coverage is in force.

As of March 15, 1990, there were 10,193 members insured under the Program. In addition, 7,142 members were insuring their spouse and 2,502 were covering their eligible, dependent children.

Given the high number of participants who were insured with the $200 daily benefit, the Council approved an increase in the coverage maximum to $300/day effective September 15, 1989. By year-end, nearly 700 participants had elected the $300 daily benefit, evidencing a strong demand for high coverage amounts. During 1989, over $1.3 million in benefits were paid to insureds who were hospitalized.

The favorable financial experience of the Hospital Indemnity Plan enabled the Council to grant a 40% credit to reduce the renewal premiums due September 15, 1989, March 15, 1990 and September 15, 1990 for participants under 65 years of age. In addition, the Council approved a 15% reduction in rates effective March 15, 1990.

The Council noted that changes in the health care delivery system are attempting to reduce the number of days individuals are required to be hospital-confined for certain procedures. In recognition of these practices, the Council accepted a proposal to expand the coverage provided by the Hospital Indemnity Insurance Plan. Specifically, the Council agreed that benefits should be paid to insureds undergoing surgery on an outpatient basis where the hospital's daily room and board charge is assessed. In addition, benefits will now be paid when an insured undergoes surgery in an "Ambulatory Surgical Center." This is defined as a facility which has an organized medical staff under the direction of a physician, equipped with permanent facilities for the performance of surgical procedures and which does not provide for overnight stays.

Lastly, benefits will now be afforded when an insured utilizes an approved "birthing center" rather than a hospital. Birthing centers are defined as facilities which primarily provide care and service for normal deliveries in full-term pregnancies, having a staff of medical professionals

including at least one physician and providing for nursing care on a 24-hour basis.

The new benefits will be implemented with the September 15, 1990 premium renewal.

Office Overhead Expense Plan: The Office Overhead Expense Plan provides the disabled insured with reimbursement of specific expenses incurred in maintaining the dental office until a return to work is possible. This complements disability insurance, which is intended to replace the disabled dentist's net income.

The Plan incorporates many of the most attractive features of overhead expense policies recently introduced by the insurance industry. Monthly benefits of up to $10,000 are offered with either a 15- or 30-day elimination period. Payments commence retroactively with the first day of disability, once the waiting period has been satisfied and can continue until 24 times the maximum monthly benefit has been paid. The plan includes a Waiver of Premium feature, a Survivor's Benefit and a Future Increase Option.

The Council believes that overhead expense insurance is an often overlooked coverage that is needed by dentists who maintain their own offices. Without such protection, the practitioner must rely upon disability income insurance or other personal resources to offset these expenses.

As of February 1, 1990, there were 7,670 participants in the Plan, which represents a 14% increase in enrollment from the prior year. The Plan continues to be most attractive to those members who are between 30 and 50 years of age—as this group represents over 88% of total participation.

During the year, over $1.65 million was paid to disabled participants.

The favorable financial experience of the Office Overhead Expense Insurance Plan permitted the Council to grant a 15% credit to reduce the renewal premiums due August 1, 1989, February 1, 1990 and August 1, 1990.

Professional Liability Insurance Program: The American Dental Association Professional Liability Insurance Program was introduced as a new benefit of membership in 1989. It is being offered under the auspices of the ADA Risk Purchasing Group, Inc. This enables the Association to restrict participation to member dentists.

The Program is fully insured by the Reliance Insurance Company, which has assets of approximately $2.8 billion and is rated A (excellent) by A. M. Best. Reliance, through its various insurance subsidiaries, is an "admitted carrier" in all states except Massachusetts, where the Company has withdrawn from the marketplace and the Program is not being offered. Thus, the Company is subject to regulatory oversight of its financial solvency and participates in state-operated guaranty funds, where available. These funds will provide a degree of protection for participants in the Association-sponsored program in the unlikely event that Reliance were to become insolvent.

Brokerage and administrative services for the Program are provided by Johnson & Higgins of Illinois. The contract between the Association and Johnson & Higgins initially provides for a conventional brokerage arrangement in which the Firm receives commissions for performing various policyholder and marketing services. The commissions are structured on a graduated scale, which decreases as participants' premiums rise.

At some future point, the relationship with Johnson & Higgins may convert to a joint venture. If the joint venture option is exercised by the Association, it will share in the revenues and expenses of the administrative operation to the extent of its ownership interest.

Ownership of the records of participants is at all times vested with the Association. The Association will also make its professional expertise available to the Program on claims and underwriting matters as well as loss prevention activities.

Although it was the Council's intent that the Program should be offered in all states, it was agreed that the Association would honor a noncompete clause between Johnson & Higgins and The Dentist's Insurance Company of California that effectively precludes offering coverage in California until January 1991.

The coverage afforded by the Program is written on the claims-made form. Unlike many competing policies, the Association Program provides protection for all procedures and treatments permitted by state dental practice acts. Similarly, the coverage is available to generalists and specialists.

An innovative premium structure has been developed that recognizes both anesthesia usage and the practitioner's special area of practice. As a result, rates have been established for each of the specialty groups and general practitioners. Within these broad categories, rates are further differentiated based upon any use of conscious sedation or general anesthesia.

Additional factors that will determine an individual dentist's premium include past claim history. A surcharge mechanism provides that a financial penalty will be imposed on those participants who have incurred claims but still remain insurable. This is intended to discourage adverse selection and, in part, address concerns that claim-free dentists subsidize the losses of others.

A dentist's rate may be further modified by a schedule of debits and credits, so that the premium could vary above or below the base rate by as much as 20%. The criteria for determining how the scheduled debits/credits will be applied to individual dentists is based on the measures they have taken to reduce the risk of a malpractice incident. These include participation in loss prevention programs within the past two years, successful completion of a home study program to be introduced by the Council in the coming months, attendance at approved continuing education programs within the past two years and certification in basic and/or advanced cardiac life support. Additional criteria may be added in the future.

Reliance's forecasts of needed premium levels have been adjusted downward. Regulatory filings submitted by competitors of the Association Program have showed a declining frequency in claims as well as a lowering of reserves for previously established losses. This information gave statistical credence to the Council's perception that dental malpractice trends have been improving. These conclusions, coupled with certain actuarial judgments, resulted in a decision by Reliance to significantly reduce premium levels in a majority of states and rating territories.

The Company also agreed to enhance the Program's offer

of the extended reporting endorsement at no cost in cases of retirement. Originally, the free reporting tail was to have been provided for dentists retiring at age 65, or older, who had been insured for at least five consecutive years. However, Reliance has now agreed to provide the endorsement to those retiring as early as age 59, thus providing the Program with another competitive advantage.

The initial solicitation of the membership to enroll in the program is being done on a state-by-state basis. Before enrollment materials can be mailed in a particular state, insurance regulators must approve both the Association's risk purchasing group filing and the insurance company's filing. The scope of this review will vary by state. This has proven to be a far more complex and protracted process than was originally anticipated. As a result, the Program was only being marketed in 25 states as of April 1990.

The Council is cognizant of the fact that there is currently fierce competition to insure dentists. Numerous carriers have entered the marketplace in recent years and the result has been rate levels that are stabilizing or, in some cases,declining. For this reason, it is not anticipated that the Association-sponsored Plan will be able to offer the lowest cost in every locale.

It is the Council's hope, however, that many dentists will be attracted to the Association Program, even if it does not offer immediate premium savings. Some may be encouraged by the fact that enrollment will be strictly limited to Association members. Others may take comfort in knowing that their Association has reviewed the terms and conditions of coverage, is involved in all facets of the Program's operation and serves as a members' advocate.

If successful, the Program can assure the long-term availability of a stable source of coverage at actuarially supportable rates. It will also offer an alternative to the companies that have not proven responsive to the needs of the profession and which seek to insure only those dentists who meet narrow criteria for insurability. Lastly, to the degree that the Program enjoys high levels of participation, it will provide dentistry with a means of influencing its own destiny in the professional liability insurance marketplace.

Risk Management Activities: The Council on Insurance continues to believe that one of the most effective means of controlling the rising cost of dental professional liability insurance is increasing the membership's awareness of the cause of malpractice allegations and use of proven techniques for reducing the likelihood of such incidents. Towards this end, the Council has conducted loss prevention programs at meetings of constituent and component dental societies. These are presented by a full-time loss prevention coordinator, who also prepares articles for Association publications, oversees the production of risk management videocassettes and responds to inquiries from individual members seeking advice on preventing claims.

The loss prevention seminar is offered on a half- or full-day format. It is available to all constituent and component dental societies as well as study clubs and other recognized dental groups. Although the subject matter can be changed to accommodate the needs of the sponsoring group, some topics are always covered. These include a discussion of record keeping, informed consent, doctor/patient relationships and various legal considerations.

The cost of the seminar includes a fee of $1,500 for each one-day presentation and travel expenses for speakers including transportation, meals and lodging. The sponsoring organization is also required to identify and retain, at its own expense, a local defense attorney acceptable to the Association, who is willing to provide a legal perspective on the issues to be discussed. Requests for the program should be directed to the Association's Marketing Services Department, Office of Seminar Development and Training.

The Council, in conjunction with Reliance National Risk Specialists, is currently developing a home study program focusing on the prevention of malpractice claims. This program is being targeted for Association members who are unable to attend the Association's risk management seminar. It will enable them to study the information in their homes and improve their risk management skills. Reliance has offered members who purchase the Home Study Program a 10% discount on their premiums if they demonstrate a thorough knowledge of the material by passing a posttest given upon completion of the course.

The Council has developed a series of videocassettes and accompanying manuals that focus on major causes of professional liability claims and methods by which such incidents can be avoided. Five tapes and manuals have been produced to date and distributed to the constituent and component dental societies for use by the membership. They are titled: "Diagnosing and Managing the Periodontal Patient," "Even Good Guys Get Sued: Recordkeeping, Informed Consent and Legal Considerations," "Professional Liability Aspects of the Doctor/Patient Relationship," "Risk Management Techniques for Oral Surgical Procedures" and "Risk Management Techniques for Endodontic Procedures." A sixth tape, focusing on prosthodontic procedures, is currently under development.

Evaluation of Conditions in Major Medical Insurance Marketplace: The Council has observed that the costs of medical insurance have been rising dramatically in recent years and, in some cases, have been coupled with reductions in coverage. This has been a cause of increasing concern to the membership and prompted inquiries as to the feasibility of developing an Association-sponsored medical insurance program.

In 1982, the House of Delegates directed the Council to study the feasibility of a national group health insurance plan. Its review focused on the causes of rising insurance costs, the problems encountered by existing dental society plans and other administrative and marketing considerations which are critical to the success of a group insurance program. Based on this analysis, it was determined that a national program would offer no significant economic advantages and that the existing constituent and component dental society plans were better able to respond to the membership's medical insurance needs.

The Council observed that the most significant cause of rate instability was, and continues to be, the rising costs of medical care. The Health Insurance Association of America (HIAA) has estimated that over the last five years, the health

care component of the Consumer Price Index has risen 7.6% annually, compared to an overall inflation rate of 3.6%. Compounding inflation's effects are federal and state regulations which permit government programs to pay less than their share of expenses in treating patients covered by Medicare and Medicaid.

If benefit payments increase in any given year as a result of inflation, it follows that insurance premiums will rise by at least a similar amount. The Council noted that the inflationary factor in the cost of health care is outside the control of any group insurance program.

A major consideration in determining the feasibility of a national major medical plan is whether or not it could be administered effectively. Such plans present unique problems because of their complexity. Some state and local societies employ the services of brokers or third-party administrators to assist participants in submitting claims or in resolving disputes. The availability of a local administrator and dental society staff to address these problems can be key to assuring membership satisfaction with the plan. For a national program to provide a similar level of service would be a considerable undertaking; and may not prove as manageable or responsive as the current structure.

Another issue to be resolved is how a national program would relate to existing constituent dental society plans. It is possible that an Association-sponsored medical program, requiring all participants to meet strict underwriting guidelines, could offer a lower initial cost and conceivably draw the healthiest members from state and local plans. This would leave these groups with participation consisting primarily of older and medically-impaired insureds. Consequently, these plans might fail and create a pool of uninsurable members who may be unable to find replacement coverage.

The alternative to such a competitive situation would be for dental societies to discontinue sponsorship of their plans in favor of a national program. While such an approach may appear logical, it is not without serious shortcomings. Undoubtedly, constituent societies whose medical plans are encountering declining enrollment or deteriorating claims experience would find a merger advantageous. However, where a state plan is stable and its participants are satisfied, there is no incentive to support the national program. Therefore, if only those groups with troubled plans agreed to a merger, the Association plan would have a tendency for financial instability from its inception. If so, plan consolidations would not offer any tangible economic benefits.

The Council noted that since the 1983 report was prepared, conditions in the medical insurance marketplace have worsened. Many commercial carriers have not found this line of business to be profitable because of the inability to implement needed rate increases without experiencing the effects of adverse selection. This is particularly true for group plans where participation is voluntary. For this reason, few, if any, insurers would be willing to write a national major medical plan for Association members that would meet the Council's specifications.

A survey of the insurance companies currently involved with the Association-sponsored programs was made to determine if they would be willing to write such a plan. The Great-West Life Assurance Company declined, citing the prospects for antiselection in a voluntary group, even if it is medically underwritten. The Life Insurance Company of North America was not interested, referencing many of the problems noted in the Council's 1983 study as well as the need for a network of managed care facilities that it believes are crucial to any such offering. The Equitable Life Assurance Society, which recently divested itself of a large segment of its medical business (Equicor) because of its negative impact on Company earnings, also expressed no interest.

The Council viewed the response of these companies already having a relationship with the Association as being indicative of the industry's indifference towards voluntary group medical insurance programs. The Council will continue to monitor the marketplace, but believes that state and local societies are in a better position to sponsor medical insurance programs that are responsive to the membership's needs.

Acknowledgments: The Council expressed its sincere regret at the death of former Council member, Dr. Daniel W. Benton of Utah.

The Council wishes to express its appreciation for the contributions of Drs. Benton, W. Phil Kennedy, George F. Lacovara and John T. Weatherall who have completed their service as members of the Council on Insurance, as well as Dr. Dwight Meierhenry, who has resigned from the Council. Dr. Meierhenry is being replaced, ad interim, by Dr. David H. Utzinger.

The success of the Association-sponsored insurance and retirement programs is due in no small part to the sound judgment and dedication of these member dentists.

Gift to Association Library: The Council wishes to thank the Life Insurance Company of North America for its generous donation of $36,000 to fund the purchase of a collection of rare books for the Association's library. This gift, made in recognition of the 25th anniversary of the Company's relationship with the Association, is very much appreciated.

Sculpture for Headquarters Building: The Council wishes to express its appreciation to the Great-West Life Assurance Company for its generous gift of an extremely fine Innuit Sculpture titled "Man and Bear: A Contest for Survival." The sculpture, which is on display at the Headquarters Building, was given in recognition of the 55th Anniversary of Great-West Life's relationship with the Association-sponsored Term Life Insurance Program.

Support for the American Fund for Dental Health: The Council wishes to acknowledge with gratitude the continuing support given to the American Fund for Dental Health by the Great-West Life Assurance Company and the Life Insurance Company of North America.

Support for the American Dental Association OPTIONS Program: The Council wishes to express its appreciation to

the Life Insurance Company of North America, Equitable Life Assurance Society of the United States and the Great-West Life Assurance Company for their financial support of the Association's OPTIONS Program, conducted for the benefit of junior and senior dental students.

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

Office of Quality Assurance

Klyop, John S., director
Ellek, Donalda, manager

Background: The Office of Quality Assurance coordinates quality assurance activities for the Association; maintains liaison and provides the profession's perspective on quality of care issues to other national organizations and governmental agencies; operates an information clearinghouse; and disseminates reports about quality assurance. The Special Board of Trustees Advisory Committee on Quality Assurance is the governing body for the Office of Quality Assurance.

Meetings: The Special Board of Trustees Advisory Committee on Quality Assurance includes Association President Dr. R. Malcolm Overbey; President-elect Dr. Eugene J. Truono; Dr. Douglas R. Franklin, Thirteenth District Trustee; Dr. James H. Gaines, Sixteenth District Trustee; Dr. Jack H. Harris, Fifteenth District Trustee; and Dr. James F. Mercer, Seventh District Trustee. Since the Office's 1989 report, the Special Committee held five meetings (May 9, 1989; May 17, 1989; January 7-8, 1990; February 12-13, 1990; and April 24, 1990) and has another scheduled for June 30-July 1, 1990.

Internally the Office of Quality Assurance receives advice from the Interagency Committee on Quality Assurance, which held its first meeting on April 16, 1990. Committee members include Ms. Mary Logan, assistant executive director, Division of Legal Affairs; Dr. Clifford H. Miller, assistant executive director, Division of Education; Dr. Enid Neidle, assistant executive director, Division of Scientific Affairs; Dr. Michael L. Perich, assistant executive director, Division of Dental Practice; Dr. Donalda Ellek, manager, Office of Quality Assurance; Ms. Marye Feldman, secretary, Council on Dental Care Programs; Dr. Anthony L. Kiser, secretary, Council on Dental Practice; Mr. John S. Klyop, secretary, Council on Community Health, Hospital, Institutional and Medical Affairs and director, Office of Quality Assurance.

Personnel: Donalda Ellek, Ph.D., is the new manager, Office of Quality Assurance. Prior to joining the Association, Dr. Ellek was a senior policy analyst in the American Medical Association, Office of Quality Assurance. In February 1990, Ms. Joyce Sigmon left the Office of Quality Assurance to become the executive director of the Auxiliary to the American Dental Association. Ms. Sigmon's work in the Office is very much appreciated.

Response to Assignments from the 1989 House of Delegates:

Utilization Management. Resolution 31H-1989 (*Trans.*1989:550) was assigned to the Special Board of Trustees Advisory Committee on Quality Assurance. The resolution called for the development of a business plan on parameters of dental care, to be submitted to the 1990 House of Delegates. In response to the assignment, the Interagency Committee on Quality Assurance formulated a proposal for a structure and process of developing dental practice parameters. The proposal was reviewed and discussed by the Special Committee and revisions were recommended. A revised draft will be completed for the Special Committee's review in June 1990. A detailed report of the dental practice parameters project in response to Resolution 31H-1989 will be provided in a supplemental report to the 1990 House of Delegates.

Surveys: Three surveys have been initiated and the data has been collected.

One survey is on the status of dental quality assessment and quality assurance programs in the United States. The data collection phase for this survey, which was described in the Office of Quality Assurance's 1989 Annual Report (*Reports:*1989:86) has been completed with an adjusted response rate of 87.1% (1,851 respondents). From information provided by this survey, the Office is preparing a status report on quality assessment and quality assurance in dentistry and a list and brief description of existing quality assessment and quality assurance programs. This survey updates a similar one that the Association conducted in the late 1970s.

Another survey on the status of dental practice parameters was conducted at the direction of the Special Committee. The survey was mailed to the eight national dental specialty organizations and selected other national dental organizations and state boards of dentistry. A preliminary report of the survey was provided to the Special Committee at its February 1990 meeting.

A third survey about the usefulness of literature distributed by the Office was mailed to persons who requested general information about quality assurance during the past two years.

Liaison Activities: The Office continues to maintain liaison with national health organizations with quality assurance activities. These include the American Medical Association, American Medical Peer Review Association, American Hospital Association, the Joint Commission on Accreditation of Healthcare Organizations, the Association for Health Services Research and the American College of Utilization Review Physicians.

Another continuing liaison activity is with the Health Care Quality Alliance. The alliance includes 29 organizations drawn from national, medical, dental, voluntary health, aging-related and health industry membership associations. The alliance recently completed a report on Health Insurance Benefit Restrictions and Access to Care. The report focuses on whether health benefit restrictions reduce patients' treatment choices and access to appropriate technologies. It describes the restrictions and their potential impact on patients. It also discusses how consumers can

learn about these restrictions and improve their access to either services or particular health plans. The Office participated in planning and reviewing the report.

Liaison activities provide opportunities to present the profession's perspective on quality assurance and to monitor those activities that could affect the practice of dentistry.

Joint Commission on Accreditation of Healthcare Organizations (JCAHO): The Office of Quality Assurance continues to monitor and participate in activities of the JCAHO and has attended specific meetings.

Staff attends the meetings of the Accreditation Project Steering Committee that oversees the "Agenda for Change" research and demonstration project. To date, the JCAHO has developed a set of organization and management indicators and five sets of clinical indicators that deal with the following specific diseases or specialties: cardiovascular, oncology, trauma, obstetrics and anesthesia. These indicators test each component system of a hospital and account for over one-third of inpatient care as measured by patient days. Since the JCAHO is interested in the effectiveness of the organization, not individual practitioners or a specific patient, future indicator development will focus on four major cross-cutting issues rather than continuation of the development of disease or specialty-specific indicators as originally planned. These issues are selection and effective performance of surgical/invasive procedures; effective use of laboratory tests and/or imaging procedures; effective use of medications; and prevention, detection and control of hospital-acquired infections.

The JCAHO will encourage professional organizations to develop the remaining disease or specialty-specific indicators for use in the hospitals' quality assurance programs. The JCAHO plans to assist other organizations in this process by publishing a primer on clinical indicator development later this year and by sharing staff expertise. Clinical indicators for dentistry are in the early stages of development. This process began in March 1989 at a regional workshop sponsored by the American Association of Hospital Dentists and continued at a workshop during the Special Care Issues in Dentistry Conference cosponsored in May 1989 by the Federation of Special Care Organizations in Dentistry and the Association's Council on Community Health, Hospital, Institutional and Medical Affairs. The Office of Quality Assurance serves as a major source of information for this clinical indicator project.

In 1990, the JCAHO expects to begin developing indicators for use in the nonhospital area, giving highest priority to home care, long-term care, managed care and mental healthcare.

The staff also attends meetings of the Quality Improvement Task Force. This task force includes a representative of the American Dental Association, Dr. James Crall. The task force has been formulating principles and discussing techniques for the improvement of patient care quality. The aim of the task force is to evaluate the present approach to quality assurance and propose principles for quality improvement. The principles are used to guide revision of the *Accreditation Manual for Hospitals* and will be applicable to standards revisions for all other JCAHO accreditation manuals.

Staff attended the seminar on Fundamentals of Monitoring and Evaluating Clinical Practice. The seminar provided practical guidance for setting up institutional mechanisms to monitor and evaluate quality of care and provided an overview of the quality process for support services.

Presentations and Publications: Mr. John S. Klyop will make a presentation at the Association's 1990 annual session entitled "Quality Assurance-Blueprint for the Future." It focuses on the American Dental Association's current and planned activities in the area of quality assurance. The presentation will also include information on national efforts to develop protocols, the experience of a large company, and experience in the development of an operational quality assurance program with special emphasis on the development and implementation of clinical indicators.

Publications in quality assurance include: a curriculum module on quality assurance in the *Geriatric Curriculum Resource Book for Dental and Dental Hygiene Educators* (to be published); a description of "Workshops: Generic quality screens and clinical outcome indicators for dentistry in hospitals and long term care facilities," *Special Care in Dentistry*, October 1989; "Focusing on Quality Assurance—The Profession's Collective Efforts," *Journal of Dental Education*, November 1989; Proceedings from a Quality Assurance Seminar at the 1989 American Association of Dental Schools' annual session, including "Trends in Quality Assurance in the Dental Profession," "Quality Assurance: One Schools' Response," "Quality Assurance in a School of Dentistry: Getting Started," and "Where is Quality Assurance Going in Dental School Curricula," *Journal of Dental Education*, April 1990.

Consultation: The Office continues to be a source of information and assistance about dental quality assurance matters, both nationally and internationally. Consultative services are provided through written and telephone communications and conferences with persons who visit the Headquarters Building. The Office also provides consultation with Association agencies.

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

Commission on Relief Fund Activities

Coppola, Samuel J., New York, 1990, chairman
Michaels, Emanuel W., Virginia, 1990, vice-chairman
Brett, George W., Pennsylvania, 1993
Capps, William R., Arkansas, 1991
Hinkle, Robert C., Ohio, 1992
Passantino, Frank R., California, 1992
Ragan, Robert T., Mississippi, 1991
Reitinger, Charles G., Colorado, 1993
Bramson, James B., secretary

Meetings: The Commission met in the Headquarters Building on August 10-11, and December 15, 1989 and on February 16, 1990. Dr. Heber Simmons, Jr., Fifth District trustee and ADA Board of Trustees liaison, attended the December 15, 1989 meeting. A meeting of the Commission is scheduled for August 16-17, 1990.

Election of Vice-Chairman: Dr. Emanuel W. Michaels was elected vice-chairman.

Revision of Relief Fund Application Form: The Commission considered proposed guidelines for use by constituent and component society relief funds in evaluating Relief Fund applications as mandated by Resolution 66H-1988 (*Trans.*1988:487). Dr. Richard Overgaard, Maine, past chairman, Commission on Relief Fund Activities, assisted the Commission in drafting proposed guidelines.

After extensive discussion, various amendments and additions were incorporated into this preliminary document. To solicit comment and in keeping with Resolution 66H, the draft guidelines were circulated to constituent dental society relief funds for review and comment. However, at the urging of legal counsel, final Commission action was deferred, pending the Court's ruling in the Disaster Fund litigation. The Court's ruling was finally issued in July 1989 and was viewed adversely by the Commission.

In light of the unfavorable Court ruling, the Commission asked legal counsel to again review the guidelines emphasizing appropriate modifications on any similar issues as discussed in the Disaster Fund ruling.

Legal counsel suggested several modifications and submitted these for Commission consideration at its February 16, 1990 meeting. The Commission approved the suggestions of legal counsel and directed that the revised guidelines be forwarded for Board of Trustees action. The Board of Trustees is expected to review these guidelines in mid-1990. The Commission intends to forward the guidelines to the 1990 House of Delegates in a supplemental report following action by the Board of Trustees.

Responses to Assignments from the 1989 House of Delegates

Amendments to ADA "Bylaws" Regarding Appointment of Chairman of Commission on Relief and Disaster Fund Activities: The 1989 House of Delegates approved Resolution 44H (*Trans.*1989:557) which sought to allow the Commission on Relief Fund Activities to elect its own chairman. Prior to this resolution, all Commissions except the Commission on Relief Fund Activities elected their own chairmen. The Commission meets in August and will annually hold the election for Chairman at that time.

Amendment of the "Indenture of Trust" of the ADA Disaster Victims Emergency Loan Fund: With the unanimous approval of Resolution 59H-1989 (*Trans.*1989:506), the House amended the ADA Disaster Victims Emergency Loan Fund *Indenture of Trust* to allow the creation of a new non-profit charitable corporation whose purpose is to provide charitable loans or grants. In addition, this resolution allowed a transfer of assets and dissolution of the Disaster Victims Emergency Loan Fund *Indenture of Trust* prior to December 31, 1989. A complete report of the formation and activity of this new charitable corporation is contained as a separate report to the House of Delegates from the ADA Endowment and Assistance Fund, Inc.

Revision of ADA "Bylaws" Regarding the Disaster Fund: Resolution 83H-1989 (*Trans.*1989:506) was approved by unanimous vote and deleted references to the Disaster Fund in the ADA *Bylaws*, since Resolution 59H-1989 had previously passed. Necessary changes to ADA *Bylaws* language have been made. Thus, the Commission is now known as the "Commission on Relief Fund Activities."

Program Activity

Financial Operations: As of the June 30, 1989 audited financial statements, contributions generated by the 1988-89 annual fund raising campaign amounted to $315,417, all of which were allocated to the Relief Fund. This exceeded the national campaign goal of $250,000. Contributions in the amount of $258,140 were transferred to constituent dental society relief funds.

From the ADA Relief Fund, $193,039 was disbursed in the form of grants to recipients during the fiscal year. For 1989, the Commission, in cooperation with constituent and component dental society relief funds, provided monthly financial assistance to 78 eligible recipients. Other expenses for the fiscal year were general and administrative—$104,403; investment and bank fees—$25,747; professional audit and accounting fees—$24,040; and solicitation campaign expenses—$83,645.

Investment Activities: Since June 1985, Lake Shore National Bank of Chicago has managed the investment

portfolio of the Relief Fund in accordance with guidelines adopted by the Commission members. The market value of the portfolio was $7,199,975 as of December 31, 1989.

The investment portfolio for calendar year 1989 showed a composite gain of 18.6%. The Consumer Price Index rose 4.7% in 1989. As of December 31, 1989, the return of fixed income investments, comprised of government bonds, cash equivalents and high grade corporate securities was 9.1%. The equity portion of the Fund increased 26.5% for the calendar year 1989, underperforming the 31.6% advance of the Standard & Poor's 500 Stock Index. The allocation of invested funds between stocks and bonds allows for diversification of assets, while providing interest and dividend income needed by the Commission to meet annual administrative, fund-raising and grant expenses. For the fiscal year ending June 30, 1989, interest and dividends amounted to $526,556 as compared to $495,724 the previous year.

The Commission agreed to continue investing in common stocks that offer growth potential and fixed income securities with attractive interest rates. As a matter of policy, the investment manager is prohibited from purchasing securities in any corporation that, as a major activity, manufactures, fabricates, processes, sells or otherwise furnishes dental supplies, machinery, equipment and materials, dentifrices or other agents related to oral hygiene, or tobacco products.

1989-90 Relief Fund Campaign: The Commission conducts an annual campaign to solicit charitable contributions on behalf of the Relief Fund. The fund-raising campaign consisted of three mailings to Association members, the first of which was sent in November 1989. Follow-up letters were targeted to previous years' donors and included a brochure that conveyed the importance of their contribution lending a helping hand. Testimonials were included from current and past recipients. Total contributions through April 6, 1990 amounted to $312,000. The Commission appreciates the generosity of these ADA members who, through their contributions, have helped improve the quality of life for less fortunate fellow professionals and their families.

Proposed Amendments to the Relief Fund Indenture of Trust

Name Change of Commission: The 1989 ADA House of Delegates unanimously approved Resolution 83H (*Trans.*1989:506) approving a name change for the Commission from the "Commission on Relief and Disaster Fund Activities" to the "Commission on Relief Fund Activities." However, Resolution 83H only affected the ADA *Bylaws* and did not insert the new Commission name in the Relief Fund's *Indenture of Trust.* Changes in the *Indenture of Trust* are similar to that of the *Constitution* and *Bylaws* in that the amendments shall lay over to the next year unless a unanimous vote of the House of Delegates is received. Such substitute wording is necessary in the ADA Relief Fund *Indenture of Trust* and is proposed by the Commission in a resolution presented in this report.

On a separate issue, the Commission on Relief Fund Activities and the ADA Board of Trustees had previously amended the Relief Fund *Rules,* Chapter I, Eligibility for Grants, to substitute the word "dentist" for "members of the dental profession." This change was made to the *Rules* in August 1986. Incorporating this additional amendment into the *Indenture of Trust* to comport with the *Rules* change is also suggested. Therefore, the Commission submits the following resolution and recommends its adoption.

Summary of Resolutions

Amendment/Rescission of Current Policy:

19. Resolved, that the heading, first paragraph and second "Whereas" clause of the Preamble to the ADA Relief Fund *Indenture of Trust* be amended throughout by deleting the words "and Disaster," wherever they appear, so that the entire amended section reads as follows:

> **Indenture of Trust between American Dental Association as Settlor and the Members of the Commission on Relief Fund Activities of the American Dental Association as Trustees for Charitable Purposes.**
>
> This *Indenture of Trust* executed the 30th day of September, 1948, by and between American Dental Association, a non-profit corporation organized and existing under the laws of the State of Illinois and having its principal office in the City of Chicago, County of Cook and State of Illinois, hereinafter sometimes called the "Association," party of the First Part, and the eight duly elected members of the Commission on Relief Fund Activities of American Dental Association, each of whom has subscribed his name hereto, hereinafter called the "Trustees," Parties of the Second Part,
>
> Witnesseth That:
>
> **Whereas** the Association for many years has made relief grants to members of the dental profession and their dependents, and
> **Whereas,** the Association desires to segregate specific funds for this purpose by establishing a living trust under which members of the Commission on Relief Fund Activities of the Association, from time to time, will act as Trustees;
>
> Now, therefore, in consideration of the premises, of the mutual covenant herein contained, and of other good and valuable consideration, the receipt whereof is hereby acknowledged, the parties hereto enter into the following "Articles of Agreement" with respect to the terms and conditions of such trust:

and be it further

Resolved, that Article III, Investment of the Trust Property, of the ADA Relief Fund *Indenture of Trust* be amended throughout by deleting the words "and Disaster," wherever they appear, so that the amended paragraph reads as follows:

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 laws 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 counsellor 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 counsellor periodically reports to the Trustees through the Commission on Relief Fund Activities Secretary, regarding purchases and sales of securities. The Trustees may from time to time select three of their members who together with the Treasurer of the Association and Chairman of the Commission would then constitute a Relief Fund Investment Committee. If so selected, the Committee shall monitor the activities of the investment counsellor and make recommendations to the Trustees on investment programs. Otherwise, the Commission as a whole shall monitor such activities.

and be it further

Resolved, that Article IV, Grants to Beneficiaries, first paragraph, of the ADA Relief Fund *Indenture of Trust* be amended by substituting the word "dentists" in place of the words "members of the dental profession," so that the amended paragraph reads as follows:

The purpose of the American Dental Association Relief Fund is to render financial aid to dentists and their dependents (including former dependents of deceased dentists), who because of misfortune, age, or physical or other disabling conditions are not wholly self-supporting, and to receive, accumulate, invest and expend monies and property for the attainment of such object. The Trust Property shall not be used for any purposes other than the charitable purpose hereinabove defined. No Trustee, no officer or employee of the Association, and no person connected in any way with the administration of the Trust Property shall receive any pecuniary benefit therefrom except such compensation, if any, as may be allowed by the Trustees for services actually rendered. No part of the Trust Property shall ever be used to carry on propaganda or otherwise attempt to influence legislation.

and be it further

Resolved, that Article VI, Trustees and Their Successors, of the ADA Relief Fund *Indenture of Trust* be amended throughout by the deletion of the words "and Disaster" wherever they appear, so that the amended section reads as follows:

Each Trustee herein named is a member of the Commission on Relief Fund Activities referred to in the *Bylaws* of the Association. Upon ceasing to be a member of said Commission on Relief Fund Activities (whether because of death, resignation, expiration of term or otherwise) each Trustee and each successor Trustee shall likewise cease to be a Trustee of this American Dental Association Relief Fund, and his or her successor as a member of said Commission on Relief Fund Activities duly elected or appointed pursuant to the *Bylaws* of the Association shall become a Trustee of this American Dental Association Relief Fund. An acceptance of the office of member of the Commission on Relief Fund Activities shall constitute an acceptance, as successor Trustee, of the obligations imposed by this *Indenture of Trust,* and, in addition, each successor Trustee shall signify his or her acceptance of this trust by signing his or her name in the appropriate place on Exhibit B which is annexed hereto and made a part hereof.

and be it further

Resolved, that Article IX, Amendment, of the ADA Relief Fund *Indenture of Trust* be amended throughout by the deletion of the words "and Disaster" wherever they appear so that the amended section reads as follows:

This *Indenture of Trust* may be amended or the trust thereby created may be terminated by due corporate action of the Association and in the absence of any other prescribed method, this trust may be amended or altered at any annual session of the House of Delegates of the Association by a two-thirds (2/3) majority vote of the members present and voting, provided notice of the proposed amendment or resolution to terminate this trust shall have been given to the members of the House of Delegates in advance of said session in the same way as notice is given of a proposal to amend the *Constitution* of the Association. Forthwith upon the adoption of any amendment to this *Indenture of Trust* a new Indenture of Trust shall be executed between the American Dental Association and the members of the Commission on Relief Fund Activities then in office. No amendment to this *Indenture of Trust* shall be effective to divert any portion of the Trust Property to any purpose other than a charitable purpose. Upon the termination of this trust the Trust Property shall revert back to the Association to be used by it exclusively for charitable purposes.

ADA Endowment and Assistance Fund, Inc.

Coppola, Samuel J., New York, 1990, chairman and president
Michaels, Emanuel W., Virginia, 1990, vice-president
Brett, George W., Pennsylvania, 1993
Capps, William R., Arkansas, 1991
Hinkle, Robert C., Ohio, 1992
Passantino, Frank R., California, 1992
Ragan, Robert T., Mississippi, 1991
Reitinger, Charles G., Colorado, 1993
Bramson, James B., secretary/treasurer

Meetings: The Board of Directors of the ADA Endowment and Assistance Fund, Inc. ("Endowment Fund") met in the Headquarters Building on February 16, 1990 and has scheduled another meeting on August 16, 1990. The ADA Board of Trustees, acting as the sole Member of the Endowment Fund, met in a shareholder's meeting on February 8 and April 26, 1990.

Shareholder Appointment to Endowment Fund Board: At the February 8, 1990 shareholder's meeting, the Board of Trustees reviewed a report which detailed the history of the Disaster Victims Emergency Loan Fund and the unanimous approval of Resolution 59H-1989 (*Trans.*1989:506). These actions allowed the creation of the Endowment Fund. The *Articles of Incorporation* and *Bylaws* of the Endowment Fund provide that the Board of Directors of the Corporation shall be the members of the Commission on Relief Fund Activities.

Two resolutions were passed at the shareholder's meeting by the Board of Trustees. First, the members of the Commission on Relief Fund Activities were appointed as the Board of Directors of the Endowment Fund and the Chairman of the Commission was directed to serve as the Chairman of the Board of Directors. The second resolution directed that the election of the Board of Directors shall occur annually simultaneous with appointments to the Commission on Relief Fund Activities.

Board of Directors Election of Officers: The Endowment Fund Board of Directors, at its February 16, 1990 meeting, elected the following officers: Dr. Samuel J. Coppola, president; Dr. Emanuel W. Michaels, vice-president; and Dr. James B. Bramson, secretary/treasurer.

1989 ADA House of Delegates Activities and Creation of a New Corporation: The Commission on Relief Fund Activities reported to the 1989 House of Delegates regarding the history of the Disaster Victims Emergency Loan Fund and the results of a July 28, 1989 U.S. Court of Claims' unfavorable ruling revoking its tax exemption. The Court held that the Disaster Fund did not prove by a preponderance of the evidence that it was entitled to retain a charitable tax exemption, on the grounds that:

1. There was private inurement to the benefit of individuals (i.e., member dentists), and the Disaster Fund's activities were primarily for the benefit of such private individuals, rather than for charitable purposes;
2. The individuals who received the loans in some instances were not from a charitable class of poor and distressed persons.

After a legal review of the Court's ruling, it was determined that the Disaster Victims Emergency Loan Fund had a low probability of recovery of taxes paid, a low probability of regaining its tax exempt status and a high cost of appeal. Therefore, the Commission voted to forego an appeal.

Resolution 59H, unanimously approved by the 1989 ADA House of Delegates, amended the Disaster Victims Emergency Loan Fund *Indenture of Trust* to allow the creation of a new charitable organization broader in scope. Subsequent to the House's directive, the Commission on Relief Fund Activities met on December 15, 1989 to review and approve the necessary documents to establish the new charitable non-profit corporation. It also met to begin development of appropriate rules to govern the charitable program activity. The Commission took several actions at this meeting, including:

—approved *Articles of Incorporation* and *Bylaws*, as amended, for the ADA Endowment and Assistance Fund, Inc., pending final legal and tax review;

—directed the development of appropriate documents to dissolve the Disaster Victims Emergency Loan Fund, transfer the Disaster Fund assets to the ADA Endowment and Assistance Fund, Inc. and file corporate papers to establish the entity prior to January 1, 1990;

—approved the development of *Administrative Rules* for the ADA Endowment and Assistance Fund, Inc., and directed further legal and tax review; and

—approved seeking a new charitable tax-exemption for the ADA Endowment and Assistance Fund, Inc.

Accordingly, the ADA Endowment and Assistance Fund, Inc. was chartered in Delaware on December 20, 1989 and Disaster Fund assets were transferred to the new corporation on December 29, 1989. Dissolution papers terminating the *Indenture of Trust* for the Disaster Fund were completed and signed effective December 31, 1989.

Financial Operations: The Endowment Fund received assets from the dissolved ADA Disaster Victims Emergency Loan Fund totalling $900,382 as of December 31, 1989. This was comprised of cash due to banks—$145,991; loans

receivable—$371,373; and Commercial Paper investments—$675,000. Liabilities included $107,494 due to the ADA Relief Fund; $29,074 to the American Dental Association and income taxes payable of $7,374. This resulted in an initial Endowment Fund balance of $756,440. All loans receivable from the Disaster Victims Emergency Loan Fund were assumed by the Endowment Fund. Loan recipients were so notified. The Board of Directors appointed Peat Marwick as auditors.

Investment Activity: The Board of Directors appointed the Lake Shore National Bank as the investment advisor and portfolio manager for the Endowment Fund assets. A very conservative investment philosophy of primarily short term financial instruments was chosen to allow the Board the flexibility to allocate the Fund's resources while developing its initial program activity. A short-term reserve was deemed appropriate since several disaster loan applications are expected.

Endowment Fund "Administrative Rules": The Board of Directors met February 16, 1990 to review the program activity intended for the Endowment Fund. After considerable discussion, the *Administrative Rules* governing program activity were approved, in principle, pending final legal review and approval by the Member. The *Rules* were then presented to the ADA Board of Trustees, as the sole Member, in a shareholder's meeting April 26, 1990. The Member approved the *Rules* with two minor editorial changes.

The approved *Rules* contain broadened charitable activity. However, in each of these categories, financial needs tests are included to determine the charitability of the applicant. A new tax exemption is unlikely to be obtained without such requirements. The four main areas approved for program activity are:

1. disaster victim loans with stricter financial needs criteria determinative of eligibility and more rigorous administrative procedures;
2. loans for uninsured in-patient medical costs for dentists who have chemical dependencies;
3. educational retraining loans to allow dentists and dental students to resume clinical practice after a disability; and
4. scholarship programs for needy dental, dental hygiene, dental assisting and dental laboratory technology students.

1989 Disaster Loan Activity Prior to Dissolution of the Disaster Victims Emergency Loan Fund: Prior to its dissolution, the Disaster Victims Emergency Loan Fund was active in assisting needy dentists who were affected by the natural disasters occurring in late 1989. Due to Hurricane Hugo and the earthquake in the San Francisco area, the Disaster Fund received and processed 32 loan applications. There were 24 loans made totalling $239,342. Table 1 shows the disaster loan activity in 1989.

Table 1

State/Territory	Number Submitted	Number Approved	Number Denied
South Carolina	2	0	2
Puerto Rico	6	5	1
Virgin Islands	7	6	1
California	17	13	4
Total	32	24	8

Endowment Fund Tax Exemption: The Endowment Fund intends to seek a tax exemption under Section 501(c)(3) of the Internal Revenue Code. This exemption application was filed after completion and approval of the *Rules.* It is believed that the changes to a disaster loan program along with broader programs in other areas of charitable activity will allow the Endowment Fund to secure this exemption. However, no guarantee can be made that the Fund will, in fact, receive such an exemption. Further modifications of proposed programs may be necessary to secure a favorable ruling. Tax counsel has advised that until a new tax exemption is granted, expansion of program activity into new areas should not be started.

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

Notes

Division of Education

Council on Dental Education and Commission on Dental Accreditation

Special Report of the Council on Dental Education

Joint Commission on National Dental Examinations

Notes

Council on Dental Education
Commission on Dental Accreditation

***Labadie, William L.**, Arizona, 1990, chairman, American Dental Association
***Formicola, Allan J.**, New York, 1991, vice-chairman, American Association of Dental Schools
***Babineau, T. Arthur**, New Hampshire, 1992, American Dental Association
***Barker, Ben D.**, North Carolina, 1992, American Association of Dental Schools
***Barnes, Wayne J.**, Iowa, 1991, American Association of Dental Examiners
***Biddington, W. Robert**, West Virginia, 1990, American Association of Dental Schools
Budnick, Steven D., Georgia, 1990, American Academy of Oral Pathology
Casko, John S., Iowa, 1991, American Association of Orthodontists
Harris, Sandra, Connecticut, 1992, public member
***Hasler, John F.**, Maryland, 1993, American Association of Dental Schools
Holmes, Everlena M., New York, 1990, public member
***Holt, Rene E.**, Texas, 1990, American Association of Dental Examiners
LoFrisco, Christopher J., Missouri, 1991, student member
Morr, Kathleen, Idaho, 1991, American Dental Hygienists' Association
Mumolo, F. Alan, New York, 1993, National Association of Dental Laboratories
Novak, Darlene, Kentucky, 1992, American Dental Assistants Association
***Roberson, Peter D.**, Illinois, 1993, American Dental Association
***Sweet, Thomas O.**, New York, 1991, American Dental Association
***Warren, Robert E.**, Alaska, 1993, American Association of Dental Examiners
***Yeager, Arthur L.**, New Jersey, 1992, American Association of Dental Examiners
Santangelo, Mario V., secretary
Bellanti, Neal D., manager
Davenport, Cynthia A., manager
Nix, Judith A., assistant secretary
Schuhrke, Lois L., assistant secretary

Meetings: The Council met in the Headquarters Building, Chicago, on December 8, 1989 and May 4, 1990. The Commission conducted its meetings on December 7, 1989 and May 3, 1990. Standing and advisory review committees, which provide comments and recommendations on policy and accreditation matters, met immediately prior to the scheduled meetings of the Council and Commission.

Personnel: The Council and Commission acknowledged with appreciation the many significant contributions made by Drs. W. Robert Biddington, Rene E. Holt and William L. Labadie upon completion of their tenure of service as Council and Commission members. Commendation and appreciation were also extended to Drs. Steven Budnick and Everlena Holmes who served as Commission members. The Council and Commission are pleased to report the appointment of Dr. Neal D. Bellanti as manager for dental education.

Commission on Dental Accreditation

Summary of Accreditation Actions: The Commission's accreditation actions from June 1989 through May 1990 are summarized in Table 1. At the December 1989 and May 1990 meetings, 324 accreditation actions were taken. These actions were based on site evaluation reports, progress reports submitted by educational institutions detailing the degree to which specific recommendations included in previous evaluation reports had been implemented, and applications for initial evaluation of education programs. As identified in Table 2, the total number of educational programs currently accredited is 1,305, representing a decrease of 11 programs from the previous reporting period.The Commission *Rules* stipulate that when the Commission anticipates denial or withdrawal of accreditation, it must inform the institution of its right to appeal the proposed action prior to final action being taken. There were no such appeals during the reporting period. Because accreditation is voluntary, accreditation may also be discontinued at the request of the sponsoring institution.

Enrollment: Enrollment in accredited dental and dental-related educational programs during the 1989-90 academic year and the number of 1989 graduates are reported in Table 3. The number of first-year students enrolled in predoctoral educational programs in 1989 decreased to 3,979, a 5.2% reduction from the previous academic year's enrollment of 4,196 students. The number of 1989 dental school graduates decreased by 5.9% from 4,581 to 4,312 during the previous year. The total enrollments in dental assisting and dental hygiene increased by 1.2% and 5.5% respectively, while the total enrollment in dental laboratory technology programs decreased by 11.5%. There was a 2.2% increase in dental specialty enrollment and a 3.3% decrease in general practice residency program enrollment. The total number of students enrolled in advanced education programs in general dentistry increased 16.2% from the previous reporting period. Currently, 37,243 students are enrolled in accredited dental and dental-related education programs in the United States. This represents a decrease of 0.6% from the previous academic year.

U.S. Department of Education's Continued Recognition of the Commission: The Commission's accreditation program, in the 14 disciplines for which it has accreditation recognition and authority, is reviewed and recognized by two

*Council on Dental Education Member

Table 1

Accreditation Actions
June 1989 -- May 1990

Accreditation Classification	Dental	Advanced Dental Specialties	General Practice Residency	General Dentistry	Dental Assisting	Dental Hygiene	Dental Laboratory Technology	Total
Accreditation Eligible		1				4		5
Preliminary Provisional Approval			2	11	4			17
Approval	11	74	22	9	36	36	6	194
Conditional Approval		23	15	5	8	5	2	58
Provisional Approval		7	5		1			13
Accreditation Denied or Withheld			1	2	1			4
Accreditation Withdrawn		2			2			4
Discontinued Program	2	8	6	1	11	1		29
Number of Accreditation Actions	13	115	51	28	63	46	8	324

Source: ADA Department of Educational Surveys

Table 2

Number of Accredited Programs: May 1990

Accreditation Classification	Dental	Advanced Dental Specialties	General Practice Residency	General Dentistry	Dental Assisting	Dental Hygiene	Dental Laboratory Technology	Total
Accreditation Eligible		10				4		14
Preliminary Provisional Approval			4	25	4		1	34
Approval	56	390	237	38	239	193	48	1,201
Conditional Approval		16	12	5	8	5	1	47
Provisional Approval		4	4		1			9
Number of Programs	56	420	257	68	252	202	50	1,305

Source: ADA Department of Educational Surveys

Table 3

Enrollment and Graduate Summary: October 1989

	Dental	Advanced Dental Specialties	General Practice Residency	General Dentistry	Dental Assisting	Dental Hygiene	Dental Laboratory Technology	Total
1st Year Enrollment	3,979	1,251	877	297	5,500	5,250	903	18,057
Percent Change	-5.2	0.5	-3.8	19.8	2.1	7.5	-15.9	0.6
Total Enrollment	16,412	3,012	952	352	5,719	9,309	1,487	37,243
Percent Change	-4.0	2.2	-3.3	16.2	1.2	5.5	-11.5	-0.6
Number of Graduates	4,312	1,144	922	241	3,960	3,904	722	15,205
Percent Change	-5.9	0.8	5.1	6.2	-7.7	0.3	-5.9	-3.6

Source: ADA Department of Educational Surveys

national agencies, the Council on Postsecondary Accreditation (COPA), a non-governmental agency, and the U.S. Department of Education (USDOE), every five years. As previously reported (*Reports* 1989:95), the Commission submitted its petition for renewal of recognition by USDOE in late January 1989. The USDOE National Advisory Committee on Accreditation and Institutional Eligibility met in June 1989 to take action on re-recognition of the Commission. The official notice of action was received from USDOE Secretary Lauro F. Cavazos in December 1989. It reflected full compliance with all *Criteria* and recognition for the maximum five-year period.

First Interim Report to COPA Submitted: As reported previously to the House (*Reports* 1989:95), final action of the Council on Postsecondary Accreditation on the continued recognition of the Commission included the requirement of an annual interim report on the revision of the accreditation standards for dental hygiene education programs. The Commission submitted its first interim report to COPA in November 1989 and will submit another report in 1990. The report was reviewed by COPA's Committee on Recognition and, in April 1990, by the COPA Board.

Adoption of Formal Mission Statement of the Commission on Dental Accreditation: The Commission adopted a formal statement of the Commission's long-standing concern with educational quality and protection of the public through its accreditation program. The newly adopted mission statement, which has been included in official Commission publications, states:

Mission Statement
Commission on Dental Accreditation

The Commission on Dental Accreditation's mission is to ensure the quality of dental and dental-related education by conducting accreditation reviews to determine the degree to which individual programs meet the Commission's published accreditation standards and their own stated goals and objectives. The Commission recognizes only those programs meeting the accreditation standards that are developed and agreed upon by the various communities of interest, including the public. The Commission's second purpose is to enhance and encourage improvement in the quality of its accredited educational programs.

The Commission's accreditation program ensures that quality education is available for dentists, dental specialists and allied dental personnel. Quality education ultimately leads to quality dental care for the public.

Thus, the Commission's voluntary accreditation program serves to ensure educational quality and to improve the quality of the educational programs in 14 dental and dental-related disciplines. These disciplines include: dentistry; dental assisting, dental hygiene, dental laboratory technology; dental public health, endodontics, oral pathology, oral and maxillofacial surgery, orthodontics, pediatric dentistry, periodontics, prosthodontics, general practice residency and advanced general dentistry.

Revision of Accreditation Standards: The Commission has *Bylaws* authority for the development and revision of educational standards for all programs falling within its accreditation purview. Accreditation standards are revised when there is a specific demonstrated need for a revision. Because of the significant impact of new standards on the resources of postsecondary institutions, the Commission considers the revisions with care and does not initiate the process unless the need for revision has been adequately documented. Currently, a number of activities related to standards revision are being conducted by the Commission.

As reported to the 1989 House (*Reports* 1989:96), the Commission initiated a study in December 1988 to determine whether there was need to revise any of the allied dental accreditation standards. During the December 1989 meeting, the Commission reviewed the results of studies conducted to determine whether changes have occurred in dental assisting and dental laboratory technology education and practice that are sufficient to require revision of the accreditation standards for these disciplines. The Commission considered the results of a comparable study that was conducted for the discipline of dental hygiene. In both instances, the Commission determined that changes occurring in allied dental education and practice would warrant changes in the accreditation standards for all three disciplines.

Ad hoc committees representing the dental assisting, dental hygiene and dental laboratory technology communities have been appointed to develop draft standards for consideration by the Commission. The Commission expects to review a progress report on the revision process at its December 1990 meeting; final revisions in the documents will be considered in December 1991. It is anticipated that the revised accreditation standards for dental assisting, dental hygiene and dental laboratory technology will become effective January 1, 1993.

In May 1990, revised accreditation standards for advanced education programs in general dentistry (AEGD) were adopted with a July 1, 1992 implementation date. Among the major changes is an expanded description of components of a two-year program and the requirement that program directors appointed after July 1, 1992 must have completed an accredited general practice residency or AEGD program.

The Commission adopted revised standards for advanced specialty education programs in oral pathology and established an implementation date of January 1, 1992. Significant changes in the new standards include: the time spent in residency-level anatomic pathology was changed from a minimum of six months to a minimum of three months; a requirement of 2,000 diagnostic accessions was established as a minimum number that the advanced program's laboratory must receive; and a requirement of 20

autopsies was specified as the number for which the resident must act as prosector or assistant.

The Commission endorsed in principle a proposed revision in the accreditation standards for advanced specialty education programs in prosthodontics. The revision incorporates implant prosthodontics into the curriculum as a required area of instruction. The revision will be distributed to the communities of interest for review and comment. An open hearing on the document will be scheduled during the 1991 annual meeting of the American Association of Dental Schools. A proposed implementation date of July 1, 1992 has been established.

Revisions of the accreditation standards for advanced specialty education programs in orthodontics, endodontics and periodontics have also been initiated based on documented need.

The Commission endorsed in principle a change in Standard Two of the general *Requirements for Advanced Specialty Education Programs* related to the qualifications of program directors. The change would require that directors of advanced specialty education programs be board certified. This proposed change will be circulated to the communities of interest for review and comment and presented at an open hearing during the 1991 American Association of Dental Schools' annual meeting. Final action by the Commission is anticipated in May 1991 with a proposed implementation date of January 1, 1994.

Closing of Georgetown University School of Dentistry: As reported to the House in 1989 (*Reports* 1989:97), the Commission has been informed of the closing of Georgetown University School of Dentistry. The school informed the Commission that its last class of dental students graduated in 1990. Sponsorship of the oral and maxillofacial surgery program was transferred to the Georgetown University Hospital.

Closing of Fairleigh S. Dickinson Jr. College of Dental Medicine: As reported to the 1989 House (*Reports* 1989:97), the Commission has been monitoring the phaseout of the Fairleigh S. Dickinson Jr. College of Dental Medicine. In May 1990, the Commisison was informed that the last class of dental students graduated in 1990.

Closing of Washington University School of Dental Medicine: In December 1989, the Commission reviewed a preliminary report outlining plans to discontinue the dental and advanced dental education programs sponsored by the Washington University School of Dental Medicine (St. Louis). The University, which plans to close the school no later than June 30, 1992, submitted a plan that addressed the first two years of the phaseout (1989-90 and 1990-91). The Commission concluded that the Washington University administration appears committed to an orderly phaseout of its dental education program and will monitor the phaseout through 1992.

Matters Related to Structure of the Commission and Other Concerns Raised by the Oral and Maxillofacial Surgery Community: As reported to the House in 1989 (*Reports* 1989:98), issues related to the Commission's structure have been raised by the American Association of Oral and Maxillofacial Surgeons (AAOMS) and the American Board of Oral and Maxillofacial Surgery (ABOMS), as well as the 1989 House of Delegates, through its referral of Resolution 86-1989 (*Trans.*1989:521). During its May 1990 meeting, the Commission reviewed comprehensive reports on possible changes in the structure of the Commission, on the composition of site visit teams for oral and maxillofacial surgery site visits, and on the process used for the review of advanced specialty education accreditation reports.

The Commission took actions to address concerns about the composition of site visit teams and the review of advanced education accreditation reports. When oral and maxillofacial surgery (OMS) education programs are site visited in conjunction with other dental programs, the Commission will send two OMS consultants for a one-day review, as it does when an OMS program is reviewed alone.

The Commission also agreed that members of the standing committee on advanced education programs will have input regarding accreditation of advanced and specialty programs sponsored by dental schools. Issues related to the accreditation of these programs will continue to be studied as part of the Commission's ongoing efforts to improve its processes.

Council on Dental Education

Specialty Recognition

The American Academy of Pediatric Dentistry's (AAPD) Application for Recognition of Pediatric Dentistry as a Dental Specialty: On June 30, 1989, the American Academy of Pediatric Dentistry submitted an application for re-recognition of pediatric dentistry as a dental specialty. The application included information and documentation relating to the sponsoring organization and to the five criteria for dental specialty recognition specified in the *Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists.*

In accordance with Council on Dental Education policy, notification of receipt of the application was transmitted to ADA constituent and component societies, recognized specialty organizations and certifying boards, the American Association of Dental Examiners and the American Association of Dental Schools through a letter from the Council Secretary dated July 13, 1989. A notice to the profession regarding receipt of the application was published in the August 7, 1989 issue of the *ADA News*. Comments on the application from interested individuals and organizations were invited.

The Council reviewed the application during a meeting held on December 8, 1989. The Council was of the

judgment that the AAPD application failed to provide sufficient information to demonstrate compliance with all criteria for recognition as specified in the *Requirements*. Following its consideration of the AAPD application, a detailed report was transmitted to the AAPD. In accordance with established protocol, the AAPD provided a written response dated February 15, 1990. The Council reviewed the additional written information during its May 1990 meeting. In its deliberations, the Council carefully considered two revised sections of the AAPD application for re-recogniton, additional references and appendices, and information presented during the special appearance by AAPD representatives on May 4, 1990. The Council's task was to review the application submitted by the AAPD, not the field of pediatric dentistry in a broader sense beyond that information provided in the application. Compliance with the criteria was assessed on the basis of the specific information submitted in the application and comments on the application.

The Sponsoring Organization: The recognition *Requirements* specify:

> In order for an area to be recognized as a specialty it must be represented by a sponsoring organization whose membership is reflective of the special area of dental practice and recognized by the profession at large for its contribution to the art and science of the discipline.

To demonstrate compliance with this requirement, the Council requires sponsoring organizations applying for recognition to submit specific information on the organization's founding and historical development, its officers, membership, bylaws, activities and the contributions of its members to the art and science of the discipline. The sponsoring organization is also requested to identify other national dental organizations with a primary interest in the same area of dental practice.

In 1947, a meeting was held to organize and create the American Academy of Pedodontics, which became the American Academy of Pediatric Dentistry in 1984. The original purpose for the organization was "to study and evaluate critically the various procedures employed in the treatment of children's dental problems." The articles of incorporation further clarify the Academy's purpose, "to achieve by mutual study and cooperative activities, a high and ethical standard of practice, teaching and research in the art and science of dentistry for children."

According to the application, in 1921, a group comprised of specialists and generalists was organized and, in 1928, became known as the American Society of Dentistry for Children (ASDC). It was from this group that a core group of specialists later created what is known today as the AAPD. Further, in 1940, the ASDC sponsored the American Board of Pedodontics (ABP). In 1964, the sponsorship of the ABP was transferred to the AAPD.

The AAPD's membership in the past decade has grown in each successive year from 2,394 in 1980 to 2,963 in 1989. Current statistics are provided for each membership category which include: active, fellow, life, associate, retired, student and honorary.

Annual scientific meetings are held and attendance at these meetings is approaching 33% of the membership. The Association also sponsors continuing education courses each year. The AAPD publishes *Pediatric Dentistry*, Journal of the American Academy of Pediatric Dentistry, four times each year and the *American Academy of Pediatric Dentistry Newsletter* eight times each year. The application details other publications periodically published by the AAPD.

The application includes a detailed listing of original research conducted by members and graduate students over the past decade which has subsequently been presented during the research section at the AAPD annual meeting. A comprehensive listing of the scientific contributions made by AAPD members from 1977-1987 is also included, as is information about the educational foundation established by AAPD in 1987.

The Council on Dental Education agreed that the sponsoring organization demonstrated compliance with this criterion.

> **Criterion:** A specialty must be a distinct and well-defined field which requires unique knowledge and skills beyond those commonly possessed by general practitioners.

To assess compliance with this criterion, the Council requires a sponsoring organization to provide its definition of the proposed specialty; to identify the areas of behavioral and/or biomedical science in which advanced knowledge (beyond that included in the predoctoral curriculum) is required for practice and is not commonly possessed by general practitioners. The specialty of pediatric dentistry as defined by the AAPD and as approved by the Council on Dental Education is as follows:

> The specialty of pediatric dentistry 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.

With regard to advanced knowledge, the application stated that advanced specialty education programs in pediatric dentistry provide an integrated postdoctoral experience of at least two years duration. Knowledge and skills beyond those attained in the predoctoral curriculum include in-depth instruction at an advanced level in both the basic sciences and the applied sciences. Specific areas of the curriculum included in advanced pediatric dentistry programs were provided, together with a general description summarizing the content included in each of the identified behavioral and basic science content areas. The areas identified include: psychology, anatomy/embryology including growth and development, physiology, pharmacology, microbiology and pathology. In addition, applied clinical science content areas are discussed.

With regard to level of skills, the application identifies the broad categories of advanced skills as delineated in the

Standards for Advanced Specialty Education Programs in Pediatric Dentistry in which the pediatric dentist is trained beyond that of the predoctoral student. The application acknowledges that the *Standards* do not address levels of skill as found in the *Accreditation Standards for Dental Education Programs* (revised 1988), but states that, in the AAPD's opinion, postdoctoral students are trained in the the advanced skills to a level of proficiency consistent with the definition of "proficiency" as contained in the predoctoral *Standards*. This definition of proficiency, which was not intended to apply to students in advanced education programs, reads as follows: "The level of skill beyond competency, generally acquired through advanced training leading to specialization."

The application described the clinical skills in pediatric dentistry of the dental graduate versus those of the pediatric dentist. The AAPD states that while the dental graduate has attained competence in the clinical skills related to pediatric dentistry, the pediatric dentist has achieved proficiency in these same clinical skills.

Based on the information contained in the written response and clarification presented during the special appearance, the Council determined that the AAPD demonstrated compliance with this criterion.

> **Criterion:** The scope of the specialty shall not be coincident with or readily subsumed within the scope of other recognized specialties.

To demonstrate compliance with this criterion, the Council requires sponsoring organizations to identify the advanced knowledge and skills required for practice of the proposed specialty that are not included within the scope of other recognized specialties and to identify and comment upon areas of perceived and actual overlap between the proposed specialty and one or more of the recognized specialties.

The application summarized the specific areas of advanced knowledge required for advanced education training in pediatric dentistry beyond those specified in the accreditation standards for other dental specialty training programs. In addition, the application summarized the advanced skills required by the pediatric dentistry accreditation *Standards* and not specified in the accreditation standards of other dental specialty training programs.

With regard to overlap in scope, the application states that pediatric dentistry is "an age-specific, not a technique-specific or disease-specific specialty, although it does include care for some individuals with special health care needs and disabilities beyond the age of adolescence." Further, a section was included on perceived and/or actual overlap with the other seven specialty areas.

Based on the information contained in the written response and clarification presented during the special appearance, the Council agreed that the AAPD demonstrated compliance with this criterion.

> **Criterion:** In order to be recognized as a specialty, substantial public need and demand for services which cannot be adequately met by general practitioners or specialists in other areas must be documented.

Need. To demonstrate need in relation to this criterion, the Council requires the sponsoring organization to: cite epidemiologic studies which indicate the incidence and/or prevelance of conditions diagnosed and/or treated by practitioners of the proposed specialty; cite data that indicate the severity of conditions diagnosed and/or treated by practitioners in the proposed specialty; and project the need for practitioners in the proposed specialty over the next ten years.

The response in this section of the document was based on the data provided from two activities commissioned by the American Academy of Pediatric Dentistry. One project, conducted by Dr. H. Barry Waldman, a public health dentist, indicates the projected current need and demand for pediatric dental services. The second project was a membership survey which reflected a 67% "usable" response rate.

The application cited national and statewide studies conducted over the last two decades regarding the prevalence of dental caries between the ages of five and 17 years confirming a general decline. Evidence indicated that certain populations of children have disproportionately higher levels of oral disease: children of recent U.S. immigrants, lower socioeconomic status groups, those in non-fluoridated areas, and breast or bottle-fed infants over extended periods of time. Dr. Waldman's conclusions are: (1) there has been a substantial decrease in the prevalence of dental disease in children, (2) significant treatment needs exist and demand for services has not decreased, (3) parents are aware of consequences of dental care and need for services and (4) great numbers of children live in poverty and thus are denied dental services.

With regard to public need, the application discussed another activity of the pediatric dentist—care for the "special patient." Special patients include exceptional, mentally retarded, crippled, as well as developmentally and medically compromised children, adolescents and adults. Data cited in this section were gathered from local and regional reports.

In analyzing the projected need for pediatric dentists over the next decade, this section concludes that:

1. The need for restorative and particularly preventive services will continue.
2. The number of pediatric dentists will increase in less populous states and communities for economic reasons.
3. Certain ethnic and socioeconomic groups of children have a higher need for care and will serve as a focus for future practice location.
4. As will be seen from data (in following sections of the AAPD application), the number of pediatric dentists in training has stabilized and would seem appropriate given the described patterns of need.

Demand. To demonstrate demand in relation to this criterion, the Council requires sponsoring organizations to indicate the number of dentists currently in practice who have received two or more years of advanced education; the number of advanced education programs of two years or

more in length and the number of graduates from these programs over the past five years; referral patterns; type and volume of services provided in the proposed specialty; and the projected demand for practitioners in the proposed specialty over the next ten years.

Based on data collected in a recent AAPD membership survey, 2,823 pediatric dentists practice pediatric dentistry full-time. The data indicate that the typical pediatric dentist is secondarily actively engaged in education. As of 1988, there are 55 accredited advanced education training programs in pediatric dentistry. Citing data over the past five years, in 1984, 59 accredited advanced training programs graduated 157 students; in 1988, 55 programs graduated 137 students.

With regard to referral patterns, the AAPD membership survey indicates that pediatric dentist referrals most frequently come from the parents of children already in the practice, with the second most frequent source being the pediatrician. Survey data regarding type and volume of services provided by pediatric dentists reflect a strong demand for restorative services followed by the need for pulp therapy and fluoride treatments. Provision of the full spectrum of behavioral management including nitrous-oxide and other forms of conscious sedation was also cited. In addition, according to the AAPD data, management of the developing occlusion and services for medically compromised or physically handicapped patients constitute services for which there is a high need and demand for the pediatric dentist. According to the application, the data collected also demonstrate that pediatric dentists are unusual in their level of involvement both in the hospital setting and on an outpatient basis.

This section concludes by noting that, according to the AAPD survey data, a strong need and demand continues for the pediatric dentist to provide patient care. Further, referral patterns indicate that there appears to be an acute awareness of the unique ability of the pediatric dentist.

Literature references contained in the application supporting the need and/or demand for pediatric dentists include the 1984 ADA report, *Special Committee on the Future of Dentistry,* revised (1988) Commission on Dental Accreditation, *Accreditation Standards for Dental School Accreditation* and the Waldman study.

The Council on Dental Education concluded that the sponsoring organization demonstrated compliance with this criterion.

> **Criterion:** A specialty must incorporate some aspects of clinical practice, that is, individuals in the specialty must provide health services for the public.

To demonstrate compliance with this criterion, the Council requires sponsoring organizations to identify the principal health services provided and to identify the setting in which these services are customarily provided.

According to the AAPD, pediatric dentists provide comprehensive services to patients from birth to 21 years of age and to patients of all ages with special health care needs. Practice settings, as reflected on a detailed chart, include private (solo) practice, group practice, hospitals, governmental clinics, residential facilities and advocacy, and church-operated clinics.

The Council on Dental Education agreed that the sponsoring organization demonstrated compliance with this criterion.

> **Criterion:** Formal advanced education programs of at least two years beyond the predoctoral curriculum must exist to provide the special knowledge and skills required for the practice of the specialty.

To assess compliance with this criterion, the Council requires sponsoring organizations to identify all currently operational advanced education programs in the proposed specialty, to provide a description of the minimum curricular requirements for advanced education programs in the specialty and to provide a representative sample of curricula used in several existing advanced education programs in the proposed specialty.

The sponsoring organization provided a list of 55 advanced pediatric dentistry education programs accredited by the Commission on Dental Accreditation. Of these, 37 programs are sponsored by dental schools; 18 are sponsored by non-dental schools. The list includes program length, name and board status of the program director, as well as type of certificate or degree awarded by the program.

The minimum curricular requirements for an advanced education program in pediatric dentistry are those stated in the Commission on Dental Accreditation's *Standards for Advanced Specialty Education Programs in Pediatric Dentistry* which was appended to the application. The last major revision of this document was approved by the Commission in May 1984 and became effective in January 1985. The Council on Dental Education agreed that the sponsoring organization demonstrated compliance with this criterion.

Summary: Following careful review of the application for re-recognition of pediatric dentistry as a dental specialty, the Council on Dental Education determined that:

> The AAPD had demonstrated compliance with Association requirements for the sponsoring organization.
>
> The AAPD had demonstrated that pediatric dentistry is a distinct and well-defined field which requires knowlege and skills beyond those commonly possessed by general practitioners.
>
> The AAPD had demonstrated that the scope of pediatric dentistry is not coincident with or readily subsumed within the scope of other recognized specialties.
>
> The AAPD had demonstrated public need and demand for pediatric dentistry services that could not be adequately met by general practitioners or specialists in other areas.
>
> The AAPD had demonstrated that pediatric dentistry incorporates some aspect of clinical practice, that is, individuals in the field provide health services for the public.
>
> The AAPD had demonstrated that formal advanced education programs of at least two years beyond the predoctoral curriculum exist to prepare individuals for the practice of pediatric dentistry.

For these reasons, the Council approved the following resolution for transmittal to the Association's 1990 House of Delegates:

20. Resolved, that the American Academy of Pediatric Dentistry's request for continued recognition of pediatric dentistry as a dental specialty be approved.

Content Areas of the AAPD Application with which the Council takes Exception: While reaching the conclusion that the AAPD has demonstrated compliance with the previously unmet criteria, the Council takes exception to certain statements contained in several revised sections of the application. The Council understands that the statements contained in the document belong to the AAPD and do not imply concurrence by the American Dental Association. However, the Council believes that the document could serve as a reference for other uses, including third-party carriers in determining who is reimbursed for certain procedures and by hospital credentialing committees for hospital voting privileges. For these reasons, the Council takes exception to certain content areas.

The Council was especially concerned about statements with regard to postdoctoral pediatric dentistry students receiving "in-depth experience in the teaching services of the Department of Anesthesia..." A later statement reads, "Pediatric dentists are required to be proficient in the provision of comprehensive oral health care for pediatric in-patients in the hospital setting and the treatment of patients in the operating room. Achievement of proficiency in this area requires a minimum of four weeks rotation in anesthesiology service." During a special appearance before the Council, AAPD representatives stated that the intent of the statements referenced above was to indicate that through a required minimum one-month rotation on the anesthesia service, postdoctoral pediatric dentistry students would learn about assessment and drugs used to assist in the management of patients in and out of the operating room. According to the AAPD representatives, by virtue of their advanced training, pediatric dentists are proficient in conscious sedation but not in the administration of general anesthesia. While the Council accepts the clarification provided by the AAPD representatives, the Council believes the statements as contained in the application are misleading.

The Council believes much of the content failed to recognize the generally acknowledged overlap in the scope of practice of other specialties. The application failed to acknowledge the advanced knowledge and skills of the dental public health dentist, the endodontist, the orthdontist, the oral and maxillofacial surgeon, and the prosthodontist in the treatment of the primary and mixed dentition, as well as in the provision of care for children in general. Further, the application failed to acknowledge the advanced knowledge and skills of other dental specialists in areas of interpersonal skills and behavior management in the treatment of infant, child, adolescent and handicapped patients.

Also, the AAPD notes, "The following advanced skills are *required* for the practice of pediatric dentistry; however, these skills are not specified in the *Requirements for Advanced Specialty Education* in other recognized special areas of dental practice:... (item 6) space management, (item 7) pulpal therapy for the primary and immature dentition (and item 10) early management of the occlusion of patients with congenital oral anomalies." These are widely recognized as skills required of orthodontists (items 6 and 10) and endodontists (item 7) whether included in the education *Standards* for these disciplines or not.

With regard to behavior management, the AAPD states, "Pediatric dentists, by virtue of their education and experience are able to prevent, assess or intercept aberrant behavior in infants, children and adolescents, as well as employ successful strategies for managing that behavior." The Council believes this statement is very broad and questions the specialty's ability to accomplish what is implied by this statement and therefore believes this statement could be misleading. Clarification of this statement was provided during the AAPD's special appearance when the AAPD representatives stated that the intent of the statement was to indicate that pediatric dentists "prevent, assess or intercept aberrant behavior..." in the dental office.

The section titled, "Comprehensive Restorative Dentistry..." states: "The unique services available from the specialist in pediatric dentistry in restorative dentistry come as a result of achieving advanced clinical proficiency during training and practice and the ability to provide extensive and comprehensive restorative treatment in an efficient and psychologically comfortable environment." The Council believes that these skills can also be found in an advanced prosthodontic program.

In addressing the overlap in scope between this specialty and other recognized specialties, AAPD states that "no overlap in scope exists between these two specialties with regard to dental public health." The Council takes issue with this statement because it believes that there is obvious overlap between pediatric dentistry and dental public health as it relates to the two specialties' studies of disease patterns.

Although the Council believes that it is important to state its reservations regarding these sections of the AAPD application, it also believes that AAPD has demonstrated compliance with all of the criteria for re-recognition. This belief is reflected in the resolution presented to the House in the preceding section of this report.

Establishment of Disclaimer Statement for Applications for Specialty Recognition: During the past year questions have been raised concerning the Council's endorsement of or concurrence with statements contained in applications for recognition of dental specialties. In view of concerns expressed by some external organizations, the Council has taken the position that is not within its purview to require an organization to delete or revise any statements contained in an application on the basis that the Council does not endorse or support those statements. In addition, the Council believes that recognition of a specialty does not in any way connote concurrence with all of the statements contained in the sponsoring organization's application. To clarify this issue, the Council developed the following disclaimer

statement for inclusion in the specialty recognition application:

> Material provided in the application for specialty recognition contains statements which represent conclusions of the sponsoring organization. Recognition (continued recognition) of this specialty by the American Dental Association is based on compliance with established criteria and does not imply concurrence with all of the statements presented in the sponsoring organization's application.

Plans for Comprehensive Review of the Specialty Recognition Process: The eight recognized dental specialties are scheduled to complete the specialty re-recogniton process in 1990. In this regard, the Council determined that there was a need to conduct a comprehensive review of the specialty recognition process and directed that proposed plans for the study be initiated in 1990. The Council's Committee on Specialty Recognition has been charged with evaluating the profession's current system of recognition and re-recognition of dental specialties approved by the 1983 House of Delegates and initated in 1985 (*Trans.*1983:527).

Plans for the study have been developed. While the study is underway, the Council plans to delay action on any new applications it receives during 1991 from groups requesting recognition as a dental specialty. Notice of this decision was published in the March 5, 1990 issue of the *ADA News*.

Dental Education

Dental Admission Testing Program Trends: During the past decade, the total number of Dental Admission Test (DAT) candidates had been decreasing at a steady rate of 9-10% annually. For the class to be enrolled in 1990, the number of candidates taking the DAT has increased.

The total number of candidates taking the DAT in the 1989-90 academic year includes those taking the fall 1989 and spring 1990 tests. Although the number of candidates taking the fall test did not increase, the relatively large increase in those taking the spring test resulted in a 3.7% increase as compared to the previous year, 1988-89. The candidates taking the spring 1990 DAT numbered 2,479, a 9.4% increase as compared to the spring 1989 DAT.

DAT Research Activities: Programmatic research on the DAT is being conducted in three areas. The first area is related to the validity of the DAT in predicting performance in dental school theory and technique courses. The results of this research suggest that the academic portion of the DAT is the best single predictor of first- and second-year dental school theory grades and that the perceptual ability test (PAT) portion is the best single, nationally available, predictor of technique performance.

The second area of research also relates to validity. Specifically, this research focuses attention on those characteristics of PAT items that tend to enhance the validity of the PAT in the prediction of performance. The final area of research activity identifies test items that exhibit bias related to gender or ethnicity.

Goal-Setting Activities Initiated: During 1989, the Council took steps to initiate long-range planning activities that would allow examination of its duties as outlined in the Association's *Bylaws*. It will also assess their continued relevance to the future. The Council appointed Dr. Ben Barker to clarify the goals and establish a process to achieve them. Plans for an August 1990 Council retreat to conduct goal-setting activities were reviewed in May 1990. It is anticipated that it will take 2-3 years to implement the proposals that emerge from this activity.

Forum to Address Issues Related to Dental Education, Accreditation and Licensure: The 1989 House adopted Resolution 34H-1989 (*Trans.*1989:527) which was directed to the Council for implementation. To address this resolution, the Council convened a forum of examiners and educators in June 1990 to discuss matters related to dental education and dental licensure. The issues of outcome assessment and minimal competency level referred to in Resolution 34H were also addressed by the forum. The Council will inform the House of progress and/or the results of the meetings held to address this resolution.

CDE/ADSA Cosponsored Workshop on Conscious Sedation, Deep Sedation and Anesthesia: A workshop to expand educational opportunities for dentists in conscious sedation, deep sedation and anesthesia was held in March 1989, in a continuing response to Resolution 25H-1985 (*Trans.*1985:576). The Council referred the recommendations of the workshop to the Council on Dental Therapeutics, the American Association of Dental Schools and the American Dental Society of Anesthesiology. The Council also established a Steering Committee on Dental Anesthesia. The committee will: (1) review all three parts of the *Guidelines for Teaching the Comprehensive Control of Pain and Anxiety in Dentistry,* (2) evaluate the need for the steering committee to meet at established intervals, (3) review issues relating to outpatient anesthesia requirements in the oral and maxillofacial surgery accreditation standards and (4) undertake other duties as assigned by the Council and/or established by the steering committee based on identified need.

Advanced Dental Education

Revision of Definition of the Specialty of Oral and Maxillofacial Surgery: The Council considered a proposed revised definition of oral and maxillofacial surgery submitted by the American Association of Oral and Maxillofacial Surgeons. The current definition was adopted by the House in 1978 (*Trans.*1978:518). The specialty has requested the revision to ensure that the definition more accurately describes the specialty's role in esthetics, as well as the treatment of the functional aspects of the hard and soft tissues of the oral and maxillofacial region.

Because of the unique interprofessional relations between medicine and dentistry, approval of a revised definition for oral and maxillofacial surgery has, since 1966, required House action. In its consideration of this matter, the Council noted that the current *Standards for Advanced Specialty*

Education Programs in Oral and Maxillofacial Surgery support the revised definition. For this reason, the Council agreed that the proposed revised definition of oral and maxillofacial surgery should be approved and transmits the following resolution to the 1990 House.

21. Resolved, that the following definition of the specialty of oral and maxillofacial surgery be adopted:

> Oral and maxillofacial surgery is the specialty of dentistry which includes the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects involving both the functional and esthetic aspects of the hard and soft tissues of the oral and maxillofacial regions.

and be it further

Resolved, that Resolution 14H-1978 (*Trans.*1978:518) defining the specialty of oral and maxillofacial surgery be rescinded.*

Study of Real or Perceived Overlap in Orthodontic/ Pediatric Dentistry Scope of Practice: The Council considered a request from the American Association of Orthodontists (AAO) that the Council study the real or perceived overlap in scope between orthodontics and pediatric dentistry.

A committee representing the communities of interest was appointed to conduct an in-depth study of pertinent issues. The committee met in March 1990 and reviewed comprehensive background information and approved a protocol for study of the issues. The committee's next meeting is scheduled for October 30-31, 1990. The Council expects to receive the committee's report for consideration at its December 1990 meeting.

Dental Auxiliary Education

Shortage of Allied Dental Personnel: The Council has undertaken a wide variety of activities to address the ongoing shortage of dental assistants, dental hygienists and dental laboratory technicians available for employment in dental practices. The Council on Dental Education and the Council on Dental Practice co-sponsored the National Conference on Recruitment and Retention of Dental Team Members on October 2-3, 1989 at the ADA Headquarters Building in Chicago. The Conference provided the 237 attendees with an understanding of the underlying issues that have contributed to dental personnel shortages and an opportunity to exchange information on recruitment and retention strategies that have proven successful.

Subsequent to the National Conference, the 1989 House adopted Resolutions 73H and 90H (*Trans.*1989:534;533) that signaled the dental profession's ongoing concern about the continued shortages of allied dental personnel in some regions of the country. To address this concern, as well as to follow through on the National Conference, the Council on Dental Education (CDE) and the Council on Dental Practice (CDP) met jointly on December 4, 1989, in conjunction with the regularly scheduled meetings of both councils. An extensive list of recommendations was developed at that meeting for the councils' future consideration and, as feasible, implementation. At its May 1990 meeting, CDE reviewed a report on the progress made to date in implementing the directives of the House and the joint councils.

Recommendations related to the flexibility inherent in the accreditation standards for allied dental education programs and the need to encourage nontraditional programs are being met through several activities. The CDE has approved development of a publication on innovative education programs. In addition, a number of articles have been published in Association media on nontraditional education programs and the special needs of nontraditional students. Finally, the Commission on Dental Accreditation will address the need to ensure flexibility to accommodate innovation during the current revision of the accreditation standards which was described in the Commission's annual report (see page 101).

In response to a recommendation from the joint council meeting, CDE developed and adopted working definitions of non-traditional allied dental students and programs at its May 1990 meeting. The definitions state:

> *Nontraditional Allied Dental Student:* any individual who does NOT fit a profile that includes the following characteristics: being between the ages of 18-23, Caucasian, female (for dental assisting and dental hygiene), economically advantaged and/or college-prepared.
>
> Nontraditional students may be drawn from one or more of the population groups listed below; however, other groups/populations could be included as well:
>
> - older than traditional college-age students, e.g., approximately between the ages of 23 and 65;
> - members of minority population groups;
> - men, particularly in dental assisting and dental hygiene;
> - persons changing careers;
> - persons with full-time job and/or family responsibilities;
> - economically disadvantaged individuals;
> - individuals less academically prepared for college; and
> - recent immigrants or those from culturally diverse backgrounds.
>
> *Nontraditional Allied Dental Education Program:* any program that meets the *Accreditation Standards* for the specific discipline and is NOT offered full-time, during the day and/or on one campus site.
>
> Nontraditional curricula have one or more of the following characteristics; however, other designs could be included as well:
>
> - alternate site arrangements, e.g., branch/extended campus, branch clinical facility, cooperative, one plus one and mobile programs;

*Note: As the volume of policy being proposed for rescission is significant, this report will only provide the appropriate citations. Copies of the policies to be rescinded will be provided to the House of Delegates prior to its meeting and to all other individuals upon request.

- flexible scheduling, e.g., part-time, evening and weekend programs;
- extended completion dates, e.g., part-time and expanded-time curricula; and
- efficient and intensified presentation, e.g., advanced standing and credit transferability, credit for career experience, challenge and place-out credits, self-paced or modular learning, career ladders, core courses, competency-based or contract learning and articulation agreements.

The Council has transmitted these definitions to appropriate Association agencies as well as allied dental education programs for use in future discussions, surveys and reports.

The joint meeting resulted in several recommendations related to licensure by credentials for dental hygienists. During its consideration of these recommendations, the Council on Dental Education noted that the 1989 House revised the Association's guidelines for licensure by credentials for dentists (*Trans.*1989:529). The Council believed that constituent dental societies that are interested in promoting freedom of movement for dental hygienists should follow similar guidelines for dental hygienists as for dentists. Accordingly, the Council recommends adoption of the following resolution:

22. Resolved, that constituent dental societies, in concert with state boards of dentistry, be urged to address their state's need for dental hygienists by developing mechanisms through which dental hygienists licensed in another state may be licensed by their state using a performance record in place of examinations, and be it further
Resolved, that constituent dental societies and state boards of dentistry be urged to use the eligibility requirements established by Resolution 38H-1989 (*Trans.*1989:529) as a model for developing similar requirements and criteria for dental hygienists, and be it further
Resolved, that Resolution 8H-1959 (*Trans.*1959:203), Licensing of Dental Hygienists, be rescinded.*

The Council considered a recommendation that the charge to the ADA/AADE Licensure Examination Comparability Committee established by Resolution 14H-1988 (*Trans.*1988:494) be expanded to include a study of the comparability of clinical licensure examinations for dental hygienists. The Council concurred that such a study might assist in efforts to address freedom of movement issues. Additional information on this matter is provided in another section of this report (see page 112).

Throughout the past year, the Council has continued its efforts to provide consultation and information on the allied dental personnel shortages to constituent dental societies and educational institutions. Interest in establishing new programs in dental hygiene, especially, continues at a high level. The Council was pleased to note that eight new dental hygiene education programs have been accredited during the previous three years and at least six additional programs are in various stages of development.

Activities to Address Resolution 73H-1989: Resolution 73H-1989 (*Trans.*1989:534) directs appropriate agencies of the Association to develop a plan of action for providing direct assistance to constituent and component dental societies in their efforts to address the current shortages of allied dental personnel. Such assistance would be provided on a cost-sharing basis and might include programs for recruitment and retention of personnel, as well as development of traditional and nontraditional education programs that are consistent with the accreditation standards of the Commission on Dental Accreditation.

As a first step in implementing this resolution, the Association has initiated a pilot project to work directly with several states that have specific manpower needs and concerns. Appropriate Association agencies are providing consultation and support to these constituent societies, to assist in developing strategies and resource materials that will support their efforts and can be adapted to the needs of other states as well. This demonstration project will permit the Council to assess realistically the financial and staff support that may be needed to continue and expand direct assistance programs in the future.

Three states—Massachusetts, Pennsylvania and Virginia—were selected to participate in the pilot project based on their expressed interest in the allied dental personnel manpower issue. Each of these states had already taken some steps to identify and address specific manpower concerns. Further, these states had demonstrated that they could provide substantial resources and the leadership needed to implement potential solutions to the problem. If there appears to be sufficient need for direct assistance at the state level, the demonstration project will be continued and expanded in 1991. To assess the ongoing need for the program, the chairmen of the Council on Dental Education and Council on Dental Practice sent a letter to all constituent dental societies in early April 1990, requesting input as to the states' level of interest and the kinds of resources and/or expertise that might be beneficial. The comments received from constituent societies will be considered by the Council on Dental Education and Council on Dental Practice in developing future program plans and budget requests.

The Council's second major project designed to address Resolution 73H, as well as several of the recommendations of the joint council meeting, is publication of an informational brochure on innovative programs in allied dental education that meet the Commission on Dental Accreditation's accreditation standards. By supporting innovative approaches to education, this publication may assist in easing access for nontraditional students. Brief descriptions of nontraditional dental assisting and dental hygiene programs, such as evening schedule, extended campus, career ladder and modular curriculum programs, will be included. It is anticipated that the publication will be available for distribution in late 1990 or early 1991.

Activities to Address Resolution 90H-1989: Resolution 90H-1989 (*Trans.*1989:533) requests the Council to consider the feasibility of developing a "model curriculum" that will

foster career growth opportunities for allied dental personnel by "integrating and coordinating" dental assisting and dental hygiene education programs. If the Council determines that such an integrated curriculum is feasible, then the resolution directs that a model be developed and reported to the 1990 House.

The Council believed that the intent of this resolution is: (1) to ease access to the educational system, and thus broaden the market of available applicants to allied dental education programs, by providing multiple training sites, more part-time programs and programs designed for currently-employed workers, and (2) to improve retention of employees in the dental workforce by encouraging and supporting these individuals' efforts to move from one occupational role to another with minimal repetition and redundancy in the required education.

The Council reviewed a comprehensive report on this matter and concluded that development of educational programs to achieve the intent of the resolution is feasible. Models that are already available could be adapted to create the kind of flexible, articulated curriculum that the resolution suggests. Therefore, the Council determined that it is neither feasible, nor realistic, to develop a full-blown "model curriculum" with specific educational objectives, content, and clinical competencies for each identified achievement level.

There is significant variability from state to state, or region to region, in the duties and responsibilities allied dental team members are expected to fulfill in practice, as reflected by state practice acts. Given the differences among states, not only in practice patterns, but also in manpower needs and educational resources, the Council believed that attempting to design a single generic curriculum to meet the needs of all states/regions would be impractical and unrealistic. It would be more useful to provide descriptions of those materials and/or programs that are already available and could be adapted to create a career advancement program. If a state dental society wishes to pursue development of such a program, it will be important to work with the educational community to design a program that is appropriate to the state's unique needs, goals and resources.

Available Options to Support Career Development Programs: Several program models already exist that are specifically designed to encourage movement from one allied dental career field to another with minimal loss of class time or academic credits. Examples of these programs include:

- The career ladder programs offered by several U.S. and Canadian colleges, which include an accredited one-year program in dental assisting followed by an optional second year of dental hygiene. These programs have been fairly successful in permitting students some flexibility in breaking up their education into shorter segments, thus adapting to their family and financial needs.
- Curricula designed around "core courses" in which dental assisting and dental hygiene students take the same courses in several subject areas common to both career fields (e.g., dental anatomy, dental radiography, dental materials). If a dental assisting graduate wishes to change career fields and enter dental hygiene, she/he need not repeat these core courses, thus reducing the time required to complete the dental hygiene program. A number of states, such as Florida, have begun to expand this concept to include all accredited programs within the state, so that students who have completed a core course in one institution may transfer credit for that course to any other program/institution in the state.
- Articulation agreements that permit students to apply general education and basic science prerequisite courses taken in any institution in the state toward completion of a dental hygiene or dental assisting program. These transfer of credit arrangements, like evening schedules, part-time enrollment and awarding of advanced standing, minimize the amount of time a student may need to be in residence, or in full-time study, to complete the program.

Because nontraditional students are sometimes less academically prepared, intensified or shortened programs may not serve their needs as well as a curriculum that permits a slower pace. States attempting to develop programs that utilize these articulation arrangements and flexible scheduling options need to be aware of the trade-offs that may have to be accepted in some areas in order to achieve their goals in other areas.

In its review, the Council identified another approach to flexible curricula using instructional modules, which permit the required curriculum content to be broken up into smaller units so that students can adapt the program to their individual schedules. Such modular programs are often *competency-based,* in that the curriculum content is designed around specific skills needed in order to perform the expected functions in a dental office. The advantages of modular instruction include not only flexibility of scheduling, but also of delivery method and setting. The use of instructional modules also permits flexibility in adapting the curriculum easily to changing employment needs.

The Council noted that the primary drawback of modular-based instruction is the time and cost involved in developing instructional materials. Considerable expertise is required to identify the competencies to be taught, develop the theoretical content, and create appropriate learning exercises and skill evaluations. However, material is already available that can be used or adapted for allied dental education programs—either alone or in combination with other modes of educational delivery.

This report has summarized the extensive information on available program options considered by the Council. Individuals wishing additional information may contact the Council for specific details.

Broader Considerations Related to Development of Flexible Curricula: The Council concluded that the educational tools are available to support the design and implementation of integrated and coordinated dental career

programs. State dental societies that believe such programs offer an effective approach to meeting their allied dental personnel needs can use a combination of these options to fit their unique circumstances. In this effort, however, states need to be aware of several broader considerations that may influence the planning process.

Career ladder programs are generally designed to encourage trained dental assistants to change career fields and enter dental hygiene, thus retaining a qualified individual in the dental workforce. While this goal is laudable, it ignores the fact that the current shortage of trained dental assistants is probably more acute than the shortage of dental hygienists. The number of accredited programs in dental hygiene has increased during the past two years, as have the number of students enrolled and the number of graduates. On the other hand, nearly 40 dental assisting programs have been discontinued since 1985, largely due to lack of enrollment, and the number of graduates has declined significantly. The shortage of trained dental assistants has raised fewer concerns for the dental profession, perhaps because of the availability of untrained personnel for employment as dental assistants. However, because career ladder programs are usually designed for dental assistants who have received formal training in an accredited program, the widespread development of these programs may exacerbate the current drain on the pool of trained dental assistants.

The Council was aware of the widespread assumption that dental assistants, given easily accessible training in dental hygiene, are eager to make this career change. However, in the Council's opinion, these career fields are quite different and thus may appeal to different individuals, as has been demonstrated by focus group research conducted by the Council on Dental Practice. Before considerable resources are devoted to development of a career ladder educational program, states may be well advised to study the market demand for such a program within the target audience.

The previous discussion of available curriculum models has essentially ignored the issues of licensure and/or credentialing for allied dental personnel. If the integrated career ladder program will result in the creation of categories of dental personnel other than those currently recognized in a state, however, then these issues cannot be set aside. A curriculum with multiple entry and exit points, as envisioned by Resolution 90H may result in new categories of personnel that require new occupational titles and credentials. The Council recognized that such changes in the licensure and credentialing process can be accomplished through revision of state dental practice acts. However, any attempt to revise long-accepted occupational titles and credentials will undoubtedly raise concerns about adequate protection of the public, as well as issues related to interstate portability of these credentials for the individuals who have earned them.

The relationships between accreditation of education programs and the educational requirements for credentialing and/or employment are key issues that need to be considered carefully in designing new curriculum models. The accreditation standards of the Commission on Dental Accreditation were designed to evaluate programs that prepare individuals for the traditionally recognized practice roles of dental assistants and dental hygienists. If states elect to create categories of personnel that depart significantly from those recognized roles, then the education programs designed to prepare these individuals for employment may not be eligible for accreditation at this time.

The Council reiterated its philosophy that accreditation of any career-entry program should reflect and be based on the needs of employers for well-prepared individuals to fulfill existing employment roles. If new categories of allied dental personnel are created and widely accepted within the dental practice arena, the Commission may need to consider developing accreditation standards for these new education programs, as has occurred frequently within the allied health career fields.

Finally, the Council emphasized that any state wishing to develop a coordinated career ladder program will need to seek the active involvement and support of the educational community. Forging an effective partnership between educators and practitioners will in most cases be an essential first step toward development of new and creative allied dental education curricula.

Continuing Dental Education

Continuing Education: It is the Council's responsibility to "monitor and desseminate information on continuing dental education and to encourage the provision of and participation in continuing dental education" in accordance with the Association's *Bylaws.* In this regard the Council was involved in the following activities related to continuing dental education.

Surveys of Need for Remedial Education Related to Clinical Competency. The Council conducted two surveys to determine the extent of the need for educational intervention or remediation programs for dentists. One survey was sent to state dental examining boards regarding the need for remedial continuing education activities related to competency. The other survey was sent to dental schools to determine their willingness and ability to provide such remediation to those practitioners identified as needing this kind of assistance. Data collected through these surveys should be helpful in assessing the scope of competency-related problems. The results of these surveys will be considered by the Council at its December 1990 meeting.

Continuation of the Program Planners Workshops. As reported to the 1989 House (*Reports* 1989:104), the Council, in conjunction with the Academy of General Dentistry (AGD), developed a Program Planners Workshop (PPW) designed for professionals who plan and produce continuing dental education courses. The PPW provides information on the practical skills and resources essential to effective program planning and includes a detailed resource manual that is provided to participants. The PPW has been presented five times to date and two PPW sessions are scheduled for 1990.

The Council agreed with AGD's Council on Continuing Dental Education that continuing education sponsors have

an ongoing need for information about program planning and that the workshops should be continued. However, the workshop content should be modified to increase its attractiveness to a repeat audience desiring information at a more advanced level. The updated PPW will be offered twice during 1991.

Consideration of a Proposed Continuing Dental Education Quality Assurance Program. The Council reported to the 1989 House (*Reports* 1989:104) on its efforts to determine the amount of interest among relevant organizations in exploring mechanisms to monitor the quality of continuing education (CE) in dentistry. Because sufficient interest was expressed, a task force meeting was hosted at the Headquarters Building in September 1989 to consider the feasibility of developing a new program for continuing dental education quality assurance, which would be modeled after a similar program offered by the Accreditation Council for Continuing Medical Education (ACCME). Groups represented at the meeting included the recognized specialties, the Academy of General Dentistry, the American Association of Dental Schools, the American Association of Dental Examiners, the Eastern Conference for Continuing Dental Education, the Continental Congress for Continuing Dental Education and the American College of Dentists.

The ADA Board of Trustees signaled its support for development of a quality review program of some type by adopting a resolution at its August 1989 session urging the Council to "consider the feasibility of implementing a mechanism to evaluate the institutions and organizations that offer CE and approve those that meet established standards" (*Trans.*1989:485). The number of states that require CE for dentists' licensure renewal has grown considerably since 1983 (from 9 to 18), which may indicate that the need for a national provider evaluation program has grown.

The Council's Committee on Continuing Dental Education reviewed and modified the program proposal which had been developed by the task force. The proposal was presented to the Council for review in December 1989. The Council endorsed in principle the proposal for a Continuing Dental Education Quality Assurance Program and directed that the proposal be disseminated widely within the communities of interest for review and comment.

In January 1990, the Council's program proposal was distributed to ADA constituent dental societies, the American Association of Dental Examiners, American Association of Dental Schools, Academy of General Dentistry, the eight recognized specialty organizations and the Officers and Trustees of the ADA. In May 1990, the Council reviewed the comments received from the communities of interest. The Council noted a consensus among the respondents that the ADA is the appropriate organization to sponsor and conduct such a program. The Council also recognized that the majority of the organizations and institutions that commented on the proposal appear supportive of the program concept, but are not fully satisfied with the program's proposed governance, target audience or evaluation methods.

Based on the comments received, the Council determined that there is interest in and need for a continuing education evaluation program, but concluded that the current proposal should be modified. The Council therefore referred the proposal and the comments received back to its standing committee for additional review and modification. The Council anticipates that the proposal will undergo additional revision and will again be circulated to the communities of interest for review and comment, and that another report on the proposed program will be presented to the House in 1991.

Licensure Committee

Report of the ADA/AADE Licensure Committee to Study ADA Resolution 14H-1988 and Possible Expansion of Work: Resolution 14H adopted by the 1988 House (*Trans.*1988:494) called for a study of matters related to licensure with a preliminary report to the 1989 House and a final report to the 1990 House. The first part of the resolution directed that the comparability of clinical examinations used for dental licensure be studied. The second part of the resolution required a study of the feasibility of identifying reliable standards for evaluating clinical competency. The findings of the study are presented as a Special Report of the Council to the House (see page 117).

The Council reviewed a recommendation that emerged from a joint meeting of the Council on Dental Education and the Council on Dental Practice held in December 1989 which recommended that the Board of Trustees be requested to expand the charge to the Licensure Examination Comparability Committee established by Resolution 14H to include consideration of comparability of dental hygiene licensure examinations. Because of the already established expertise of the committee, the Licensure Comparability Committee agreed to take on this additional responsibility if requested to do so. In May 1990, the Council determined that such a study of the comparability of dental hygiene licensure examinations is a priority, and adopted a resolution requesting Board authorization for the study.

The Council believed that the ADA/AADE licensure committee is the best group to assist with the implementation of the work required by Resolution 32-1989 (*Trans.*1989:523) which involves development of guidelines to assess equivalency of clinical examinations. This group will also review the results of a forum to be held with dental educators and dental examiners to discuss outcomes and minimal competency and other matters related to Resolution 34H-1989 (*Trans.*1989:527).

Recognition of Certification Board for Dental Assistants

Dental Assisting National Board's Application for Recognition as the Certification Board for Dental Assistants: The 1989 House of Delegates approved *Criteria for Recognition of a Certification Board for Dental Assistants*

(*Trans.*1989:520). On March 1, 1990, the Dental Assisting National Board, Inc. (DANB) submitted an application for recognition as the certification board for dental assistants. The application included information and documentation relating to the certification agency and the criteria for recognition.

In accordance with Council policy, component and constituent dental societies were informed of the receipt of the application. The American Dental Assistants Association, American Association of Dental Schools, National Association of Dental Assisting Directors and American Association of Dental Examiners were also notified. A notice to the profession was published in the April 9, 1990 issue of *ADA News*. Comments on the application from interested individuals and organizations were invited.

The Council reviewed the DANB application at its May 1990 meeting. All submitted information was evaluated in light of the House-established criteria for the recognition of a certification board. The Council evaluated the application to determine the extent to which compliance with the criteria had been demonstrated.

Organization of the Board. The *Criteria for Recognition* specify that the certification board's membership must be composed of representation from the dental assisting communities of interest and that all dental assistant members shall be currently certified by the Board. The Board must provide evidence of adequate financial support to conduct its program of certification. It must also provide evidence that the American Dental Assistants Association, as well as other groups within the communities of interest, are supportive of the Board. The Council found DANB's application to be in compliance with these requirements.

Appropriate dental assisting organizations and communities of interest are represented on the DANB Board of Directors. Financial statements appended to the application demonstrated sound finances that support the operation of the certification program. The application included letters of support from the American Dental Assistants Association, American Association of Dental Schools and the American Association of Dental Examiners.

Operation of the Board. The *Criteria* require the certification board to issue certificates to individuals who have provided evidence of competence in dental assisting. The Board must submit to the Council its plan for renewal of certificates currently held by certified persons. Further, the Board must maintain and make available a current list of all persons certified. A copy of the certificate that is awarded to individuals who have passed the certification examination, the renewal information packet that is provided annually to certificants, and a listing of currently certified dental assistants were appended to the application. The Council believed that the DANB's application demonstrated compliance with these criteria.

The *Criteria* require that proposals for important changes in the certification examination eligibility criteria or the Board's procedures and policies be circulated in advance of consideration to affected communities of interest for review and comment. Because the DANB Bylaws state that "DANB shall circulate proposed relevant changes in policies, rules, regulations, and requirements to organizations represented on the Board at least 60 days prior to the meeting at which the Board will vote on the proposed changes for review and comment," the Council believed that this requirement was met.

Granting Certificates and Waivers. In the evaluation of its candidates for certification, the Board is required to use standards of education and clinical experience approved by the Commission on Dental Accreditation. The *Criteria for Recognition* specifies that the Board must require for eligibility for certification the successful completion of a dental assisting education program accredited by the Commission on Dental Accreditation. However, the Council has also realized that there may be a need to recognize candidates who do not meet the established eligibility criteria on educational training. Therefore, the Board may provide the Council with evidence regarding the need for specific types of waivers that it believes to be essential for certification and/or certification renewal.

The current eligibility pathways for DANB's certification examination include graduation from a dental assisting program accredited by the Commission or high school graduation and two years of full-time work experience (3,500 hours) as a dental assistant. The Council noted that DANB's application provided adequate justification for the work experience pathway and further noted that this pathway is supported by the dental assisting communities of interest and the organizations represented on the Board. In the Council's judgment, these sections of the *Criteria for Recognition* have been met.

During the review process, the Council also gave consideration to comments received from the American Academy of Oral and Maxillofacial Radiology, an individual member of the American Dental Association and an administrator of a community college which offers an accredited dental assisting program. Each of these letters was in support of the need for a recognized certification board for dental assisting and the recognition of DANB as that certification board.

Following careful review of the application for recognition as the certification board for dental assistants, the Council determined that the DANB meets the *Criteria for Recognition of a Certification Board for Dental Assistants* and should be recognized by the Association as the certification board for dental assistants. For these reasons, the Council approved the following resolution for transmittal to the 1990 House:

23. Resolved, that the Dental Assisting National Board, Inc.'s request for recognition as the certification board for dental assistants be approved, and be it further

Resolved, that the Association's policy that "acknowledges" the Dental Assisting National Board, Inc. as the national agency to certify dental assistants (*Trans.*1980:565) be rescinded.*

***Note:** As the volume of policy being proposed for rescission is significant, this report will only provide the appropriate citations. Copies of the policies to be rescinded will be provided to the House of Delegates prior to its meeting and to all other individuals upon request.

Rescission of Policy Related to Dental Assistants Certification Requirement: In reviewing Association policies related to a certification board for dental assistants, the Council noted that a previous policy (*Trans.*1978:520) related to eligibility criteria for the certification examination administered by the Certifying Board of the American Dental Assistants Association (predecessor to the Dental Assisting National Board) adopted in 1978 is outdated and inappropriate. The policy states that the requirement of graduation from an educational program accredited by the Commission on Dental Accreditation be waived for the certification examination until December 31, 1981 and that the Certifying Board report its findings on results of the waiver period to the Council on Dental Education in 1982. The Certifying Board did report the results to the Council and the Council subsequently reported to the House in 1982 (*Trans.*1982:49). Further, it should be noted that the Certifying Board of the ADAA became the Dental Assisting National Board, Inc., in 1980. Therefore, as a housekeeping measure, the Council recommends adoption of the following resolution:

24. Resolved, that the policy statement "Dental Assistants Certification Requirement" (*Trans.*1978:520) be rescinded.*

Department of Career Guidance/SELECT

The Department of Career Guidance/SELECT supports the activities of the Council on Dental Education through its efforts to recruit individuals to careers in the dental profession. Since the report to the 1989 House (*Reports* 1989:101), SELECT distributed more than 500,000 pieces of career guidance information to state and local dental societies, dental and allied dental education programs, and to individuals requesting information from the ADA or the American Association of Dental Schools. Materials distributed included brochures, fact sheets, videos, TV and radio spots, and related publications.

In addition, SELECT continued to provide consultation services to support the development of dental society programs to recruit traditional and nontraditional students to careers in dentistry, dental assisting, dental hygiene and dental laboratory technology. SELECT's orientation seminars and manuals assisted dental society efforts to involve members of the profession in student recruitment activities.

SELECT also sponsored, in part, several pilot projects designed to encourage nontraditional students to consider careers in the dental profession. Information from these projects, including copies of new TV, radio and print materials, will be sent to all SELECT coordinators for use in dental society recruitment activities.

During 1989, SELECT developed and distributed radio and TV spots designed to encourage traditional and nontraditional students to consider careers in dental assisting, dental hygiene and dental laboratory technology. Preliminary reports from state dental society SELECT coordinators and dental society executive directors indicate that these materials are being utilized in many component dental society recruitment programs.

In 1990, SELECT will implement a series of orientation seminars that will prepare several teams of dental practitioners and educators to provide on-site consultation for the development of state and local dental society recruitment programs. This activity, and other related projects, are part of SELECT's response to Resolution 73H-1989 (*Trans.*1989:534).

Responses to Assignments from the 1989 House of Delegates

Continued Recognition of Orthodontics as a Dental Specialty: In response to Resolution 18H-1989 (*Trans.* 1989:519), the American Association of Orthodontists was notified via certified mail of the resolution adopted by the 1989 House approving continued recognition of orthodontics as a dental specialty.

Approval of "Criteria for Recognition of a Certification Board for Dental Assistants": In response to Resolution 19H-1989 (*Trans.*1989:520), the communities of interest were notified of the House action. The Council developed and adopted procedures for considering an application for the recognition of the certification board. These procedures were announced to the dental assisting communities of interest, as well as in the *ADA News.* This matter is discussed further in a separate section of this report (see page 112).

Guidelines for Assessing Equivalency of Clinical Examinations: In response to Resolution 32-1989 (*Trans.*1989:523), a memorandum was sent to the American Association of Dental Examiners (AADE) and the presidents and administrators of the state boards of dentistry advising these groups that the CDE, AADE and the special ADA/AADE Licensure Comparability Committee formed to study the comparability of licensure examinations have agreed that the Licensure Committee would be the appropriate group to assist the Council in addressing Resolution 32-1989. In May 1990, the Council acted to expand the scope of work of the Licensure Comparability Committee. This is addressed in a separate section of this report (see page 112).

Mutual Exploration of New Methods of Determining Current Clinical Competency: In response to Resolution 33H-1989 (*Trans.*1989:525), this resolution was transmitted to the American Association of Dental Examiners and the presidents and administrators of the state boards of dentistry for their information. The memorandum noted that a constituent society must initiate the process with an invitation and that, if such invitations are received, the dental boards will be contacted immediately.

Resolution 33H-1989 was also forwarded to the presidents and executive directors of constituent societies; presidents and administrators of state dental boards; members of the

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***Note:** As the volume of policy being proposed for rescission is significant, this report will only provide the appropriate citations. Copies of the policies to be rescinded will be provided to the House of Delegates prior to its meeting and to all other individuals upon request.

ADA Council on Dental Practice (CDP); and presidents and executive directors of dental specialty organizations. These communities were encouraged to contact the ADA or the Council if they have an interest in pursuing mutual exploration of issues related to competency and mobility.

Perceived Problems Related to Assessment of Educational Outcomes and Minimal Level of Competence of Graduates to Practice in Any State: To implement Resolution 34H-1989 (*Trans.*1989:527), correspondence was sent to the presidents of the American Association of Dental Examiners (AADE) and the American Association of Dental Schools (AADS) informing them of the Council's December 1989 decision to convene a forum in which matters related to dental education and dental licensure could be discussed. The letters listed specific issues thought to be of interest to both communities.

The AADE and AADS each selected five individuals to participate in the forum which was held on June 26, 1990. In May 1990, the Council approved an agenda and a three-step procedure for this important consensus-building activity. Details of this forum are discussed in a separate section of this report (see page 107).

Encouragement of More Effective Communication Among Boards of Dentistry and Increased Availability of Disciplinary Actions: The American Association of Dental Examiners (AADE) and the presidents and administrators of the state boards of dentistry were notified of the adoption of Resolution 35H-1989 (*Trans.*1989:527). The Council encouraged AADE and the state boards of dentistry to review this resolution for implementation and to develop a mechanism to provide disciplinary information to an inquiring dental board since such a mechanism would contribute to making appropriate licensure decisions.

Encourage Development of Mutually Acceptable Continuing Competency Criteria: Resolution 36H-1989 (*Trans.*1989:527) was provided as information to the American Association of Dental Examiners (AADE) and the presidents and administrators of the state boards of dentistry. The memorandum reiterated the Council's belief that mutually acceptable criteria are of utmost importance whether the criteria relate to determining initial or continued competency. The identification and use of such criteria relate directly to issues of public protection and accountability. The council reminded these communities of interest of the special ADA/AADE Licensure Committee to study ADA Resolution 14H-1988 and the possibility that this committee's efforts might relate to work required to implement this resolution.

Development of Licensure Examination Assistance Programs: Resolution 37H-1989 (*Trans.*1989:527) was addressed by the 1989 Reference Committee on Dental Education but was referred to the Commission on the Young Professional (CYP) for implementation (see page 38). The Council has informed CYP that the forum which the Council agreed to convene in response to Resolution 34H-1989 (see detailed report on page 107) might be an additional avenue for responding to Resolution 37H.

Amendments to the "Licensure by Credentials" section of the ADA's Guidelines for Licensure: Resolution 38H-1989 (*Trans.*1989:529) authorized several amendments to the section of the Association's *Guidelines for Licensure* entitled, "Licensure by Credentials." The policy statement, as amended, was transmitted to presidents and executive directors of constituent dental societies; presidents and executive secretaries of component dental societies; presidents and administrators of state boards of dentistry; and the AADE for their information.

Continued Recognition of Endodontics as a Dental Specialty: In response to Resolution 56H-1989 (*Trans.*1989:521), the American Association of Endodontists was notified via certified mail of the resolution adopted by the 1989 House approving continued recognition of endodontics as a dental specialty.

Support for the Continued Existence of Private and Public Dental Schools in the United States: The Council communicated adoption of Resolution 65H-1989 (*Trans.*1989:522) to all accredited dental schools. Other groups, including the Association of Academic Health Centers, the American Association of Dental Schools and the American Association of Dental Examiners, also received correspondence from the Council. In addition, this issue was addressed in the June 1990 issue of *Communications Update*, a newsletter whose primary audience is the accredited dental and dental-related educational programs.

Strategies in Response to Auxiliary Personnel Shortages: The Council initiated a number of activities in response to Resolution 73H-1989 (*Trans.*1989:534). These activities are discussed in detail in a separate section of this report (see page 109).

Accreditation Process for Advanced Oral and Maxillofacial Surgery Programs: The Commission responded to Resolution 86-1989 (*Trans.*1989:521), by taking a number of specific steps to address the concerns expressed about the composition of site visit teams and the process used to review accreditation reports. Details of the Commission's actions are included in a separate section of this report (see page 102).

Development of Model Curriculum for a Continuum of Dental Auxiliary Education: Based on a comprehensive report, the Council concluded that development of educational programs to achieve the intent of the Resolution 90H-1989 (*Trans.*1989:533) is feasible. Models already exist that could be readily combined or adapted to create the kind of flexible, articulated curriculum that the resolution suggests. A detailed explanation of the Council's position is included in another section of this report (see page 109).

Summary of Resolutions

New Policy/Directive:

20. Resolved, that the American Academy of Pediatric Dentistry's request for continued recognition of pediatric dentistry as a dental specialty be approved.

Amendment/Rescission of Current Policies:

21. Resolved, that the following definition of the specialty of oral and maxillofacial surgery be adopted:

> Oral and maxillofacial surgery is the specialty of dentistry which includes the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects involving both the functional and esthetic aspects of the hard and soft tissues of the oral and maxillofacial regions.

and be it further

Resolved, that Resolution 14H-1978 (*Trans.*1978:518) defining the specialty of oral and maxillofacial surgery be rescinded.

22. Resolved, that constituent dental societies, in concert with state boards of dentistry, be urged to address their state's need for dental hygienists by developing mechanisms through which dental hygienists licensed in another state may be licensed by their state using a performance record in place of examinations, and be it further

Resolved, that constituent dental societies and state boards of dentistry be urged to use the eligibility requirements established by Resolution 38H-1989 (*Trans.*1989:529) as a model for developing similar requirements and criteria for dental hygienists, and be it further

Resolved, that Resolution 8H-1959 (*Trans.*1959:203), Licensing of Dental Hygienists, be rescinded.

23. Resolved, that the Dental Assisting National Board, Inc.'s request for recognition as the certification board for dental assistants be approved, and be it further

Resolved, that the Association's policy that "acknowledges" the Dental Assisting National Board, Inc. as the national agency to certify dental assistants (*Trans.*1980:565) be rescinded.

24. Resolved, that the policy statement "Dental Assistants Certification Requirement" (*Trans.*1978:520) be rescinded.

Special Report of the Council on Dental Education

ADA/AADE Committee to Study Licensure Issues—A Response to Resolution 14H-1988

Background: Resolution 14H adopted by the 1988 House calls for a study of matters related to licensure with a preliminary report to the 1989 House and a final report to the 1990 House (*Trans.*1988:494). The first part of the resolution directs that the comparability of clinical examinations now used for dental licensure be studied. The second part of the resolution requires a study of the feasibility of identifying reliable standards for evaluating clinical competency.

The Council wishes to acknowledge with appreciation the support received from the American Association of Dental Examiners (AADE) and its General Assembly which endorsed the study at its April 1989 meeting. AADE was also instrumental in obtaining information, provided with the understanding that it would be treated as confidential, from all regional dental testing agencies and from all but one of the state dental boards that are not affiliated with a regional testing agency. The information submitted by 21 of the 22 testing agencies was critically important to the success of this study.

The committee's report to the Council includes the following sections:

I. Background information and a chronology of events for the study, including the charge to the committee, members of the Committee, meeting dates;

II. Methodology used to conduct the study, analysis of data, summary statistics and findings of part one of the study (i.e., comparability);

III. Methodology, data analysis and findings for part two of the study (i.e., feasibility);

IV. Conclusions as developed by the Committee at the February 1990 meeting, including agreed upon recommendations for any additional study that might be approved by the appropriate bodies.

It should be noted that the information contained in sections two and three of this report was prepared by the psychometrician affiliated with the study. Members of the Committee reviewed drafts of the information in these sections as the study progressed.

I. Chronology of Events Related To the Study of ADA House Resolution 14H-1988

October 1988: ADA House adopts Resolution 14H-1988 which calls for a study of matters related to licensure with a preliminary report to the 1989 House and a final report to the 1990 House (*Trans.*1988:494) as follows:

> **Resolved,** that the appropriate agencies of the ADA, in cooperation with the American Association of Dental Examiners, study (1) the comparability of clinical examinations in use for dental licensure and (2) the feasibility of identifying reliable standards for evaluating clinical competency, and be it further
>
> **Resolved,** that a preliminary report be provided to the 1989 House of Delegates and a final report be submitted to the 1990 House of Delegates.

February 27-28, 1989: Initial meeting of the ADA/AADE nine-member committee formed to study Resolution 14H. Members of the committee include: Drs. Wayne Barnes, Edward Carlson, Richard Chichetti, W. V. Kittleman, Michael Koufos, David Low, Henry Pollard, and William VanDyk. Dr. Ben Barker is chairman of the committee.

Information from 21 of the 22 testing agencies which was submitted confidentially through the AADE; current ADA policies espousing the principle of dental licensure at the state level (*Trans.*1975:187;718); validity, reliability and currency of the licensing examination process are reviewed.

A psychometrician, a test and measurements expert, who is also a professor of research methodolgy in the Department of Counseling and Educational Psychology at Loyola University of Chicago, joins the committee to provide insight into those forces external to dentistry which impact on the study. The committee is provided with the results of his preliminary analysis of the confidential data and agrees that a structured telephone interview will be conducted of all agencies to clarify and obtain certain additional data.

The committee anticipates formulating recommendations related to future projects which might include development of specific material that could assist examining boards.

April 1989: AADE General Assembly formally endorses the study.

May 4-5, 1989: The Council on Dental Education reviews the results of the initial ADA/AADE Licensure Committee meeting and directs that additional analyses be conducted using materials already provided.

The Council concurs with the committee that the study's results and information will be shared with appropriate audiences as the study progresses and expresses its gratitude to AADE for its role in gathering the initial data.

The Council receives a report from AADE and is pleased to note that AADE's executive council has adopted a resolution to continue to work with the ADA in the study directed by Resolution 14H. The Council also notes that AADE anticipates holding a workshop to help disseminate the results of this study after it has been completed.

August 1989: Committee members are contacted by AADE and in turn contact testing agencies to encourage them to participate in a telephone survey soon to be conducted by AADE. This survey is designed to clarify and add to information already submitted.

September 1989: AADE conducts a telephone survey of each testing agency to clarify information already received and to gather additional information to further assist in the study of comparability.

September 14, 1989: Second meeting of the ADA/AADE Licensure Committee.

The committee reviews grids that summarize data in four main categories: (1) information about the examination furnished to the applicant, (2) content and format of the examination, (3) calibration (training) of examiners and the information provided to them, and (4) other test practices, especially those related to the validity and/or reliability of the examination.

The psychometrician notes that he used the *Guidelines for Clinical Examinations,* adopted in 1985 by the AADE, and current professional testing standards as a framework and baseline for his review of the material provided for the committee's use.

The committee considers what additional statistics and analyses are needed and notes that comparability can be considered from two points of view: (1) among the various testing agencies and (2) between each agency and some predetermined standards. The analyst is asked to focus on both.

With regard to the study of feasibility, the committee recognizes that reliable standards could be developed using methods widely accepted for establishing content validity and agrees to a program of work to be followed in order to accomplish the feasibility study. The program includes consideration of the following:

- the process used to achieve content validity of examinations (including degree of input from the communities of interest and appropriate test construction techniques);
- standards for evaluating clinical competency that are reliable and therefore should be in all examinations;
- standards for examination practice (e.g. administrative procedures related to orientation and calibration of examiners, information provided to candidates, etc.);
- supplemental examination aids (such as calibration exercises), pointing out what should be included and common problems;
- security issues (related to the exam itself and to the professional conduct and ratings of the examiners);
- grading process;
- environmental circumstances; and
- content of the examinations in relation to validity (issues: currency, community acceptability, commonly used procedures, equivalency).

October 1989: AADE sends a survey, at the committee's request, to administrators of all state and regional testing agencies requesting statistics regarding the number of candidates who were examined during the 1988 calendar year. The survey includes questions on numbers of candidates who were foreign graduates versus U.S. graduates, and the number of candidates who were repeating the examination versus taking it for the first time.

November 1989: Preliminary report goes to the 1989 ADA House of Delegates.

December 7-8 1989: The Council on Dental Education reviews the additional analyses it had requested and information which was obtained through the telephone surveys of the 22 licensing agencies. The Council stresses the importance of sharing specific information from this study with the state and regional testing agencies and other groups, such as the American Association of Dental Schools (AADS), at a later date.

February 1990: At its third meeting, the committee reviews the additional analyses and makes specific requests for refinement. The committee then outlines the structure of its report as it will be presented to the Council in May 1990 prior to its inclusion in the Council's annual report to the ADA House. The report will have the four sections listed previously in the introductory background section of this report.

The committee adopts final conclusions related to its charges and recommends expansion of its work to include specified additional charges to be discussed at the next meeting scheduled for June 1990.

II. Methodolgy Used to Conduct the Study of the Comparability of Licensure Examinations

The following sections summarize the related outcomes of the meetings from the ADA/AADE Licensure Committee on Resolution 14H. Three meetings of the committee were held as indicated in the chronology of events of the study. Data, statistical analyses and reports concerning the dental licensure examination processes in the United States and its territories were reviewed at each committee meeting. At the first meeting in February 1989, an initial review of testing practices for dental licensure examinations was given. Based on that review, the committee requested the development of a "grid" to uniformly examine each agency's testing practices according to recognized testing standards. In addition, further information concerning testing practices and examiner training was to be gathered from each testing agency.

At the second meeting in September 1989, the committee reviewed the grid and a statistical analysis of its contents. The ADA/AADE committee requested further analysis and identified a specific program of work as outlined in the chronology of events above. The further analysis and the topics noted in the program of work were addressed in the third meeting in February 1990. This report is a synthesis of all the foregoing information.

Methodology for the Initial Review and Development of the Grid: Initially, some preliminary distinctions were made

to avoid confusion in the analysis of the data. In this analysis, the term "testing agency" was defined to correspond to the definition used in the American Association of Dental Examiners' *Guidelines for Clinical Examinations,* approved in 1985. In that document, a state board of dentistry is considered to be a testing agency only if it conducts its own clinical examination. If a state board participates in a regional clinical testing service, the regional agency is the testing agency.

Data for this analysis were collected from 21 of the 22 testing agencies and thus represent 52 out of 53 licensure jurisdictions in the United States and its territories. Oklahoma is the only state testing agency that chose not to participate in the study. Consequently, this analysis includes data from the four regional testing agencies and 17 state testing agencies. The data used in this study come from all materials submitted through October 17, 1989. The committee makes special note of the fact that clinical testing is a dynamic process that constantly changes; the most current operating procedures/practices of a testing agency may not be reflected in this report if changes were made subsequent to October 17, 1989.

The following information is provided as a context for some of the data and analysis included in this report. The four regional testing agencies and the states participating in each are:

Central Regional Dental Testing Service, Inc. (CRDTS): Colorado, Illinois, Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota, Wisconsin, Wyoming;

Northeast Regional Board of Dental Examiners, Inc. (NERB): Connecticut, District of Columbia, Illinois, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, Ohio, Pennsylvania, Rhode Island, Vermont, West Virginia;

Southern Regional Testing Agency, Inc. (SRTA): Arkansas, Kentucky, Tennessee, Virginia;

Western Regional Examining Board (WREB): Alaska, Arizona, Idaho, Montana, New Mexico, Utah.

The state and U.S. territory testing agencies that participated in this study are: Alabama, California, Delaware, Florida, Georgia, Hawaii, Indiana, Louisiana, Mississippi, Nevada, North Carolina, Oregon, Puerto Rico, South Carolina, Texas, Virgin Islands and Washington.

The number of dental schools located in each testing agency's regional or state area is as follows:

CRDTS - 12*	NERB - 23*
SRTA - 5	WREB - 0
Alabama - 1	California - 5
Florida - 1	Georgia - 1
Indiana - 1	Louisiana - 1
Mississippi - 1	North Carolina - 1
Oregon - 1	South Carolina - 1
Texas - 3	Washington - 1
Puerto Rico - 1	

*Note: The four dental schools from Illinois are included in the totals for both CRDTS and NERB. Delaware, Hawaii, Nevada and the Virgin Islands do not have a dental school.

In addition to the testing information supplied by 21 of the 22 testing agencies, more detailed information was requested by the ADA/AADE committee. Consequently, a survey interview format was developed and telephone interviews were conducted in August and September of 1989. Information was gathered concerning changes in the examination, examiner calibration, test scoring and post examination analysis. All 22 testing agencies participated in the telephone survey. The information gathered from this survey was incorporated into the grid.

The format for the initial review of the materials provided and the development of the grid was derived from the *Guidelines for Clinical Examinations* adopted in 1985 by AADE. Issues reviewed were also examined in regard to current professional testing standards used by organizations such as the American Educational Research Association, the American Psychological Association and the National Council on Measurement and Evaluation. This study examined the entire range of testing practices and procedures from the application process through the utilization of the examination results.

Initial Review: The following analysis is based upon the information that was supplied by 21 of the 22 state and local testing agencies.

I. Application—At the time of application, initial information is sent to the candidates along with the application form. Review of this material yielded the following conclusions.

   A. Candidate Requirements—The requirements to qualify for testing vary considerably. In general all boards require:

      1. graduation from a Commission on Dental Accreditation-accredited school, and
      2. evidence of malpractice insurance.

   B. Application information—The information required for application varies considerably. Most agencies require documentation of educational training. Some applications consist of a few pages, while others require certified statements such as character references, statements from deans of the schools from which the candidates graduated and/or statements from practicing dentists.

II. Test Information Provided—AADE Guideline I specifies the type of information that needs to be sent to candidates prior to testing. Agencies may send this information along with the application materials or it may be sent after the candidate has returned the completed application materials.

A. Overview of Jurisdiction and Purpose of the Board—Eight of the 21 agencies list some type of initial statement concerning the purpose and legal jurisdiction of the licensure test.

B. General Information Concerning the Test—All of the agencies send information that reviews the testing procedure, content and testing schedule. However, the information from three of the 21 agencies is so general and limited that it appears that candidates may not be sufficiently informed. Information concerning the schedule, test content, and candidates' requirements are inadequate for these agencies.

C. Test Content—The information sent to candidates prior to testing varies considerably.

   1. All of the agencies send information outlining the content of the examination, i.e., written-jurisprudence, clinical-restorative, periodontics.
   2. Specific, detailed information outlining the test content which details the procedures along with the performance expected of examinees is furnished to candidates by only eight of the 21 agencies.

D. Scoring

   1. Only 11 of the 21 agencies furnish general information concerning how the candidates will be scored on the examination.
   2. Six agencies furnish candidates detailed information as to how they will be scored on each component of the examination.

E. Passing Criteria—The pass/failure criteria is not furnished by eight agencies.

F. Examination Schedule/Site

   1. Time schedules submitted by four of the agencies listed dates only or gave inadequate information.
   2. Ten agencies furnished very detailed, thorough descriptions of the schedule and site for testing.

G. Materials to be Furnished—The information sent to candidates concerning the materials that they must furnish is either missing or inadequate for five agencies.

III. Testing Procedures—Testing procedures vary greatly in terms of test content, test length, scoring procedures, and test calibration. Due to the vast amount of information provided for this study concerning testing procedures, only general findings and concerns are reported.

A. Test Content—The content of all the examinations and the clinical procedures required vary. It is clear that the tests generally include examination of clinical skills in diagnosis and treatment planning, operative dentistry, prosthodontics and periodontics.

   1. Written Examinations—Twenty agencies require written examinations. The written portion consists of an examination on jurisprudence for five of these agencies. The written content covered by the other 15 agencies varies considerably. The length of time for the written examinations varies from two hours to two days, with one day being most common.
   2. Clinical Examinations—The content of these examinations is reviewed in detail in conjunction with the further analysis requested. The length of time for these examinations varies from one day to four days.

B. Test Length—Review of the materials submitted shows the following time concentration on the written and clinical areas for 20 agencies:

   5 agencies, 3 days clinical; 4 agencies, 1 day written, 3 days clinical; 2 agencies, 1 day written, 2 days clinical; 2 agencies, ½ day written, 2 days clinical; 2 agencies, 4 days clinical; 1 agency, 3½ days clinical; 1 agency, 2 days written, 2 days clinical; 1 agency, 2 days written, 1 day clinical; 1 agency, 2 days clinical, ½ day written; 1 agency, 1 day clinical, 1 day written; and 2 agencies, no specified time.

C. Scoring—The scoring methods used in many instances are very difficult to determine, since the information furnished does not adequately explain how scores are assigned. Consequently, only a general description of the procedures used is reported.

   1. Ten agencies give no evidence of any scoring system. Five use a five-point system with 3.0 as satisfactory. A deductive system is used by three agencies. Both a deductive and additive system is used by one agency. One agency uses both a 1-3 and 1-5 system and another agency uses a 0-7 system, while another uses pass/fail.
   2. Scoring forms may not exist for at least two agencies.
   3. The criteria for passing is not furnished by eight agencies.

D. Passing Criteria—Seventy-five percent is generally accepted as passing on written examinations and some clinical examinations.

E. Examiner's Manual—Examiner's manuals differ in specificity and complexity. They are designed to guide the examiners in all aspects of the testing procedure. Ten of the testing agencies have examiner's manuals to assist in testing. Twelve agencies do not have a manual.

F. Calibration Procedures—Establishing inter-rater agreement according to predefined standards in clinical testing is known as calibration. It is essential to establish test reliability. A test that is unreliable will also be invalid.

1. Six of the 22 agencies report that they use calibration procedures. The remainder report no formal procedures.
2. Of the six agencies that use calibration procedures, it is not always clear whether these procedures are carried out prior to each test or every few years.
3. Those agencies reporting the use of calibration procedures are not always clear about the actual procedure involved. From a technical and statistical perspective, inter-rater reliability (calibration) must be established empirically through specific exercises. Viewing a videotape, listening to a presentation, and/or participating in a discussion do not constitute adequate empirical calibration of examiners. Based on the information furnished, only five agencies established calibration of examiners using solid, empirical techniques.

G. Technical and Statistical Information From the Examinations—Nationally-accepted standards specify how technical information is to be used and disseminated. The information generally concerns test norms, pass/failure rates, scoring procedures and indices of reliability, among others. This information can be based upon testing information gathered from year to year and is generally consolidated in a technical manual which may be available for dissemination.

1. Based on the information furnished, only three agencies use testing data to review examiners, examinees, failure rates, subtests, test items and related matters.
2. This technical information could be used to substantiate the reliability and validity of a clinical examination.

IV. Other Considerations—After reviewing all of the information, some additional considerations for conducting licensure examinations emerge.

A. A patient acceptability manual would assist candidates in the selection of appropriate patients.

B. A complaint review procedure for candidates should be furnished to all candidates prior to testing.

C. Information concerning the release of examination results should be furnished to the candidate.

A Grid for the Comparison of Clinical Examinations: A grid was developed in order to compare the vast volume of information provided by the 21 testing agencies participating in the study. The basic areas of information reflected on the grid concerned the information that was furnished to the test applicant, the examination format and content, the examiner calibration/manual, and other testing practices. Within each of these broad areas, specific standards, as adopted by AADE and other national associations, were uniformly applied to all 21 testing agencies. The grid is in Appendix I of this report.

A General Statistical Summary of Selected Data from the Grid: Selected portions of the grid were reviewed in order to develop summary statistics concerning the testing practices for dental licensure of the 21 testing agencies participating in the study. As noted previously, the grid contains the information that was gathered from the information provided to the AADE and the results of the telephone survey.

In establishing the grid, the information sent to candidates prior to testing was reviewed to determine the amount of information being furnished. The number of agencies furnishing information in each category is summarized below:

	Number of Agencies		
Test Information:	**Complete Information**	**Partial Information**	**No Information**
Application Forms-requirements	21	0	0
Overview of Jurisdiction	17	3	1
General Information	18	2	2
Content and Format	15	3	3
Specific Information	5	0	16
Content	5	0	16
Grading and Scoring	4	1	16
Schedule—site, date	14	3	4
Materials to be Furnished	13	2	6
Insurance Requirements	13	1	7
Patient Acceptability	8	2	11
Release of Results	10	1	10
Appeals Procedure	8	0	13
Retesting Policy	11	0	10
Candidate Orientation Guide	7	4	10

Written Content: The written sections of the different licensure examinations emphasize different content. The content covered and the number of agencies testing that content are listed below:

Content Area:	**Number of Agencies Requiring Content Area**
Anatomic sciences	1
Asepsis	1
C.P.R./Life Emergencies, etc.	2
Dental Anatomy	1
Jurisprudence	13
Operative Dentistry	1
Oral Diagnosis/Treatment Planning	9
Oral Pathology	3
Oral Surgery	2
Periodontics	6
Pharmacology	1
Prosthetics	4
Prosthodontics	4
National Board—Part 2	1
National Board—Part 1 and 2	1
Radiation Safety	1

Clinical Content: The content of the clinical examinations from the 21 state and regional agencies are summarized according to the number of agencies requiring specific procedures.

The restorative section of the examinations is the most difficult to summarize since the procedures vary and some agencies allow selected options and combinations of options. The number of agencies requiring each procedure is as follows:

Procedure:	Number of Agencies Requiring Procedure
1. Class II amalgam	16
2. M.O.D. or D.O. amalgam only	1
3. Complex amalgam (minimum 1 pin)	2
4. Class III and IV composite on a mannequin	1
5. Class II amalgam or Class II, III or IV gold foil	1
6. Class II, III or IV gold foil	4
7. Class III composite	5
8. Class III or IV composite	6
9. Class V gold foil	3
10. Casting (inlay or crown)	2
11. Class II onlay on a mannequin	1
12. Class II onlay	1
13. One gold crown	2
14. Class I gold foil or Class V gold foil	1
15. Class II gold restoration	1
16. Pin amalgam preparation and restoration on a mannequin cast gold—inlay, onlay	1
17. M.O.D. ¾ or ⅞ crown	4
18. An amalgam restoration and a gold foil restoration Class II, III, IV or V	1
19. Crown and bridge (full or ¾ crown on a mannequin)	1
20. Cast restoration (M.O.D. onlay or full crown on a mannequin)	1
21. Gold casting—¾ crown or M.O.D. onlay	3
22. Class II M.O., D.O., or M.O.D. onlay or ¾ crown (molar)	2

The remaining clinical requirements for licensure vary. They are summarized as follows:

Procedure:	Number of Agencies Requiring Procedure
Periodontics (scaling and polishing on at least two molars)	11
Prophylaxis	1
Prosthetics	13
Endodontics	6
Endodontics (mannequin)	1
Extraction of a molar tooth	2
Radiology	1
Treatment planning	2
Complete dentures	1
Radiographs—periapical and bite-wing	1

Selected summary information from the "Other Test Practices" and "Post-test Analysis" portions of the grid is summarized as follows:

Other Test Practices:	Number of Agencies Specified	Not Specified
Scoring and Grading	10	11
Pass/Failure Criterion	10	11

Of the 21 agencies responding, only seven reported any use of post-test analysis. Appropriate test analysis was conducted by the number of agencies specified in the following categories:

Post-test Analysis:	Number
(1) Empirical review of test content	5
*(2) Item analysis/level of difficulty	5
(3) Examiner consistency/scoring	5
(4) Analysis used for test revision	4
(5) Analysis used for examiner selection or remediation	5

*Note: Five additional agencies reported that they performed item analysis on the written portion of the test.

Methodology Used for the Further Analysis: At the request of the ADA/AADE committee, a further analysis of the clinical examinations was completed. This analysis focused only on the clinical or practical portions of the licensure examinations. From the grid and prior analysis, the various requirements for the written portions were reviewed. In most instances, these examinations concerned jurisprudence, oral diagnosis, oral medicine, radiology and treatment planning.

In order to gather information concerning the number of candidates tested by each agency from January through December of 1988, a survey was sent to each testing agency in October 1989. Follow-up telephone contacts were made to each agency not responding to the survey by December 31, 1989. Information was obtained from all four of the regional agencies and from 15 of the 17 state agencies. Two of the state agencies not responding were U.S. territories which represent only a small number of candidates. The data gathered indicated that a total of 8,536 candidates were tested from January through December 1988. Of these candidates, 7,725 are graduates of accredited U.S. dental schools.

Results of the Further Analysis: The following is a detailed description of the clinical requirements of state and regional

testing agencies. The investigation of the comparability of dental licensure requirements for state and regional agencies is summarized in Charts I-III (Appendix II) and Tables 1-4 (Appendix III).

Chart I breaks down the restorative clinical procedures for each of the 21 testing agencies participating in the study. The remaining clinical requirements from the state and regional agencies are outlined in Chart II. Chart III depicts the restorative requirements for those agencies testing more than 300 subjects. Tables 1 and 2 indicate the number of agencies that require each procedure by state and regional agencies. Tables 3 and 4 show the number of candidates tested in each clinical area. The content of each chart and table is reviewed sequentially. It should be noted that for this analysis, it was necessary to list all of the clinical procedures that were offered as options by certain agencies. These agencies are noted in each of the charts.

Chart I: The restorative clinical procedures depicted in Chart I indicate that there is a good deal of agreement that a Class II or more complex amalgam restoration should be performed. For the 21 agencies, 19 require this procedure. Of the two agencies that do not require it, one agency has it as an option. It also should be noted that of the 19 agencies requiring an amalgam restoration, two require a restoration that is more complex than a Class II amalgam. There is clear agreement that a Class II amalgam (or more complex) is a necessary test requirement. No other requirement has this same degree of similarity across all testing agencies.

State and regional agencies also have similar requirements in the area of a composite restoration. Eleven of the 21 agencies require a Class III or IV composite restoration. A Class II, III or IV gold foil restoration is a requirement for 5 of the 21 agencies with 1 agency also offering a Class V as an option. The remaining restorative procedures depicted in Chart I, listed sequentially from a Class V gold foil to a Class II M.O., D.O., or M.O.D. onlay or ¾ crown, show significant disparities among the requirements for dental licensure.

Chart II: The remaining clinical procedures for each of the 21 agencies are listed on Chart II. This chart reflects more general agreement on requirements than was evident for the restorative procedures. Twelve of the 21 agencies require a periodontal procedure (scaling and polishing on at least two molars). Candidates are tested on prosthetics in 13 of the 21 agency examinations. An endodontic requirement exists for 7 of the 21 agencies. One agency has the candidate perform the endodontic procedure on a mannequin. Extraction of a molar tooth is required by two agencies. One agency lists a radiology section as a part of the clinical procedure. Treatment planning is required by two agencies. Complete dentures is required by only one agency, as is radiographs (periapical and bite-wing radiographs).

Overall, it is clear that some comparability exists in the requirements of the 21 agencies participating in this study. From a testing perspective, candidates are required to perform different clinical procedures from state to state. These procedures are not uniform through the U.S. and its territories.

Chart III: The restorative clinical areas in which large numbers of the candidates are being tested and the comparability of these requirements are depicted on Chart III. This chart depicts the requirements of state or regional agencies testing over 300 candidates per year. As with all 21 agencies, there is agreement that a Class II or more complex amalgam restoration is a necessary clinical procedure since all seven have this requirement. A composite restoration (Class III or IV) is required by four of the seven agencies. One of the agencies has the composite restoration performed on a mannequin, however. The remaining restorative procedures differ. One agency has a Class II, III, IV or V gold foil as an option. A cast gold inlay, onlay, M.O.D. ¾ or ⅞ crown is required by four of the seven agencies. A Class II, III, IV or V compact gold restoration and amalgam restoration is required by one agency. One agency uses a mannequin for an M.O.D. onlay or ¾ or full crown. Two of the seven agencies require a Class II M.O., D.O., or M.O.D. onlay or ¾ crown. A casting (inlay or crown) is also an option for one agency. Although greater similarity exists between the agencies who test 300 or more candidates each year, there are still differences in test requirements for the restorative clinical portion of the examinations. It should be noted that there is more similarity among the procedures tested by these agencies than among all agencies in general.

Table 1. In Table 1, the restorative clinical procedures required by testing agencies are categorized by regional and state agencies. The number of agencies requiring each procedure is given and the frequency of each required procedure for state agencies testing over 300 candidates per year is also noted. The frequency breakdown yields results that are similar to those noted for Charts I and III. The restoration of a Class II amalgam is required by all four regional agencies while 12 of the 17 state agencies have that same requirement. Two of the state agencies require a more complex amalgam.

It should be noted in Table 1 that a Class II, III, IV or V gold foil is required by one regional agency. A casting (inlay or crown) is also an option. A Class III or IV composite is required by two regional agencies. Two regional agencies require a cast gold onlay or inlay which may be an M.O.D., ¾ or ⅞ crown. One regional agency requires a Class II M.O., D.O., or M.O.D. onlay or ¾ crown on a molar. Finally, one regional agency requires a gold foil restoration and an amalgam restoration (Class II, III, IV or V).

The requirements of the state testing agencies, other than for the amalgam restoration, vary considerably. Nine state agencies have a composite restoration requirement (Class III or IV). Four state agencies require a cast gold inlay or onlay (M.O.D., ¾ or ⅞ crown). A gold casting of a ¾ crown, M.O.D. onlay is required by three state agencies. As can be seen from the table, the remaining required procedures for the state agencies vary considerably with several different procedures being required by only one or two state agencies. Consequently, the results from Table 1 indicate that both state and regional agencies require an amalgam restoration. As for the remaining restorative requirements, there are some similarities among the required procedures for both regional and state agencies, as well as many differences.

Table 2: The frequency of the remaining clinical procedures required by state and regional agencies is shown on Table 2. Three of the four regional agencies have a periodontal section on their examination while nine of the 21 state agencies have such a requirement. Prosthetics is a requirement for two of the regional agencies and 11 of the state agencies. Endodontics is required by one regional agency and six state agencies. Extraction of a molar tooth, treatment planning, complete dentures and radiographs are required by one or two state agencies. The results here yield the same picture as for Chart II.

Table 3: The total number of candidates tested on each clinical procedure during 1988 is depicted in Table 3. The number tested in each area by regional agencies, state agencies and state agencies testing 300 or more candidates is also provided. This breakdown gives a somewhat different perspective from the previous results. Clearly an amalgam restoration is performed by the vast majority of candidates being tested. Of the 8,593 candidates tested in 1988, 8,353 (or 97.2%) performed a Class II or more complex amalgam procedure. A composite restoration was performed on a patient or mannequin by 45.9% or 3,942 candidates. There were 2,650 candidates (30.8%) who performed a Class II, III, or IV gold foil restoration. A cast gold inlay or onlay M.O.D., ¾ or ⅞ crown requirement impacted on 3,918 candidates (45.6%), or on somewhat less than one-half of all candidates tested. A gold foil restoration (Class II, III, IV or V) affected 2,170 candidates (25.3%) while another 1,748 (20.3%) performed a Class II M.O., D.O. or M.O.D. onlay or ¾ crown. Note that 2,246 (or 26.1%) could have performed a casting (inlay or crown), since it was an option for one large regional agency. Thus, 71.7% or 6,164 candidates could have been tested on a casting procedure.

The remaining restorative procedures affected a comparatively small number (less than 1%) of the candidates being tested. For example, Class V gold foil affected 16 candidates, casting (inlay or crown) affected 73, etc. It should be noted that 7,717 candidates were tested in periodontics and 5,525 in prosthetics. In endodontics, 1,746 (or 20.3%) were tested. The remaining non-restorative procedures were performed by very few candidates.

When the number of candidates being tested for each procedure is considered, greater similarity among clinical requirements is reflected. As can be seen from the breakdown in Table 3, this similarity is due to the similarity between the regional agencies and the large state agencies testing more than 300 candidates per year. Clinically speaking, there appears to be a good deal of similarity for most of the candidates taking the state and regional agency examinations. From a strict testing perspective, the requirements are quite different since the actual procedure(s) performed vary considerably. Overall, the clinical examinations are certainly not parallel from testing agency to testing agency.

Table 4: Table 4 yields results that are similar to those in Table 3.

III. Study of the Feasibility of Identifying Reliable Standards for Evaluating Clinical Competency

The following section of this report addresses selected aspects identified by the ADA/AADE Licensure Committee in September 1989 in relation to the second part of Resolution 14H-1988. In order to accomplish the feasibility study, a program of work was identified which included consideration of the following:

- the process used to achieve content validity of the examinations (including degree of input from the communities of interest and appropriate test construction techniques);
- standards for evaluating clinical competency that are reliable and therefore should be in all examinations;
- standards for examination practice (e.g., administrative procedures related to orientation and calibration of examiners, information provided to candidates, etc.);
- supplemental examination aids (such as calibration exercises), pointing out what should be included and common problems;
- grading process;
- environmental circumstances; and
- content of the examinations in relation to validity (issues: currency, community acceptability, commonly used procedures, equivalency).

Since these topics have been identified, this section will examine each in regard to current standards and practices in testing. This is not intended to be a complete description of all aspects that have been identified. It focuses on critical issues that directly influence the validity and reliability of clinical examinations.

The Process Used to Establish Content Validity

The content of a clinical examination should consist of the procedures that are required for minimal competency to practice in the dental profession. Prior studies indicate that testing agencies differ in the procedures required for state licensure.

In order for a testing agency to establish valid standards for evaluating clinical competency, a single set of clinical procedures for testing candidates would need to be developed. Specifically, such a set of clinical procedures should reflect the content validity of the licensure examination. In order for any examination to possess "content" validity in determining candidate competence, the test must adequately sample the responsibilities, subresponsibilities and activities identified in a professional role. In addition, the clinical procedures and responsibilities which are identified should relate to the importance, frequency, criticality, or representativeness of those procedures performed by a practicing professional.

An initial step in developing a clinical examination with the foregoing characteristics should be a representative sampling from the dental community throughout the

United States. Constituencies consisting of practicing dentists, professors in dental schools, dental students, dental patients, dental hygienists, and any other relevant groups would be included in the sample. Information from the sample could consist of surveys, documented discussion and empirical feedback from local, state, regional and national dental organizations.

The data could be consolidated and presented to a representative panel from the dental community for its consideration. The charge would be to arrive at a set (or subsets) of clinical procedures that constitute the "content" of the clinical examination. The selection of procedures would need to take into account those that can be appropriately measured, consistently and reliably and according to current testing practices. A number of different techniques in identifying the required clinical procedures such as a Q-sort, the Delphi technique, or other recognized techniques could be used.

Once the content of the clinical examination had been established, constituencies from the dental community should attempt to replicate the results. Lee J. Cronbach (*Essentials of Psychological Testing*, 3rd Edition, NY: Harper and Row, 1970) has suggested this replication technique for achievement testing and it could be extended to establish content validity for clinical examinations. Content validity established by the foregoing procedure would ensure that the content of clinical examinations would consist of procedures that are widely accepted by the vast majority of those in the dental profession.

Criterion-Related Validity

Another form of validity that is commonly established for standardized tests is criterion-related validity. Criterion-related validity indicates the effectiveness of a test in predicting an individual's performance in specified situations. For this purpose, performance on the test is checked against a criterion which is a direct and independent measure of that which the test is designed to predict. For example, the ability of the DAT to predict success in dental school can be assessed by using the grade point average at the end of the first year as the assessment criterion.

Two forms of criterion-related validity are concurrent validity and predictive validity. Concurrent validity is established when the criterion measure against which the test scores are validated is obtained at approximately the same time that the test is taken. If the criterion measure is obtained some time after the administration of the test, then the validity is predictive rather than concurrent. The term "prediction" can be used in a broader sense, to refer to prediction from the test to any criterion situation, or in a more limited sense of prediction over a time interval.

In establishing criterion-related validity, it is essential to select criteria measures that are also reliable and valid. A test may be validated against as many criteria as there are specific uses for the test. Any method for assessing performance in a clinical setting could provide a criterion measure for some particular purpose. In terms of clinical testing, it would be difficult to establish valid criterion measures. Such criterion measures would need to be based on the actual job performance of practicing dentists. A critical subgroup, those failing the examination, are excluded from practice and thus their performance could not be used in this context.

Establishing criterion-related validity for clinical testing is time consuming and costly. The nature of clinical performance involves multifaceted practical criteria. Several indicators of job proficiency must be used to validate a clinical test. Because of criterion complexity, validating a test against a composite criterion of job proficiency may be of questionable value because the ability to generalize is limited. It is, however, a procedure that is recommended in the *Standards for Educational and Psychological Testing* for use when feasible.

Standards for Evaluating Clinical Competency

Guidelines for testing have been adopted by the AADE and standards are also available from organizations such as the American Educational Research Association, the American Psychological Association, and the National Council on Measurement and Evaluation. These guidelines and standards constitute the basis for the construction, publication, application and use of tests in the U.S. and its territories. Departures from standards by testing agencies are subject to legal scrutiny.

In reviewing 21 of the 22 testing agencies of the United States and its territories, test standards were uniformly applied to the data supplied to the ADA/AADE committee. These standards can be used to delineate the characteristics of a quality clinical examination. They are briefly outlined here. More detailed information is available from the *Standards for Educational and Psychological Testing* and the AADE *Guidelines for Clinical Examinations.*

The process of testing can be traced from the time that an initial application is made through the use of the candidate's final test score. A quality examination will meet the following standards.

1. Application

At the time a candidate makes application, information must be provided concerning all requirements for qualifying for the licensure examination. This includes information such as: graduation from an accredited dental school, CPR certification, National Dental Examination scores, and citizenship status. Candidates should also be informed as to what type of insurance they are required to possess.

The application forms should be self-explanatory or include specific directions in order to avoid confusion. They should be available to the candidate so that sufficient time is available to obtain any required documents such as certified statements or character references. Candidates must be clearly informed concerning deadlines for application and testing dates.

2. Testing Information Provided to the Candidate

Candidates must be given sufficient information concerning

the clinical examination. This information must be specific and clear. The information sent to candidates must include some statement about the purpose and jurisdiction of the agency. The dates, location, materials to be furnished, and general information concerning the testing procedure must be provided.

In addition to general information concerning the test, candidates must be furnished specific examination information prior to the exam so that they are adequately prepared for the test situation. This information must clearly describe the test content and required clinical procedures. The scoring procedure upon which clinical procedures are graded must be specified along with the criteria for passing or failing the examination. The materials that candidates must furnish must be clearly delineated. If the candidate must perform a procedure on a patient provided by the candidate, then a clear, detailed outline of patient acceptability must be given.

Candidates also need to be informed about how and when the results of the examination will be released. An appeals procedure for each testing agency must exist. Information concerning that procedure should be furnished to the candidates prior to testing. The agency's retesting policy must be clearly delineated. Prior to taking the clinical examination, candidates must be given some type of test orientation The test orientation information or a Candidate Orientation Guide that gives detailed information concerning the testing procedures must be provided. This Guide must indicate such things as: what a candidate cannot do, where grading will take place, the proper behavior of the monitors, etc. This information must be furnished early enough to give the candidate sufficient time to comprehend and comply with all requirements.

3. Test Content

Testing agencies are responsible for ensuring that their tests are valid for the stated purposes of the tests. Consequently, the clinical procedures that a candidate must perform need to be representative of those procedures that a practicing professional would minimally need to possess. Testing agencies must provide evidence of test validity.

Testing standards also state that the test must be reliable. For clinical examinations, reliability presents a greater problem than for written examinations. Grader variability, patient variability and other confounding sources may make it difficult, if not impossible, to assess certain clinical procedures reliably. Thus, a testing agency may be limited as to the type of procedures it chooses on an examination. Testing agencies are responsible for choosing procedures that can be reliably evaluated.

4. Testing Procedures

A complete delineation of an appropriate testing procedure is beyond the scope of this report. There are, however, a number of standards concerning clinical examinations that need to be emphasized. In order for an examination to be comparable for all candidates, it must be administered in exactly the same manner to all candidates. The time allotted for each procedure must be the same. The facilities, available materials and the setting must be very similar. The candidates must be treated exactly the same. Excellent, detailed descriptions of testing procedures addressing these issues are available from a number of testing agencies.

Since clinical examinations involve test examiners, it is clear that selection of examiners is very important. The criteria are important no matter what process of selection is used. Written examiner selection criteria and procedures should exist for each testing agency. The training or calibration of these examiners is a crucial aspect of clinical testing. In order for a clinical test to be reliable, inter-rater reliability in accordance with well defined standards must be established. Examiner calibration should be conducted just prior to each clinical examination. It must include discussion and review of test objectives, criteria and scoring procedures.

Examiner calibration must include simulated grading and exercises that will empirically establish inter-rater reliability. From a legal perspective, examiner calibration cannot be established unless empirical evidence of inter-rater agreement (perhaps 85-90%) exists. An Examiner's Manual should exist to lend consistency to the process of examiner training. In addition to calibration exercises, examiners should review written rules of professional conduct and security issues. They must know how they will proceed with the examination if security problems are identified.

Systems of Grading and Test Analysis

It would appear that there is little difference in whether a 1-5 point or 1-7 point or additive or deductive scoring system is used. Any grading system used must not be so complex that graders will not be able to differentiate or so simple that errors or deficiencies will be masked. If some type of point awarding (or point deductive) system is used, the criteria must be specified clearly and succinctly. A pass/fail grading system is also a viable alternative as long as the criteria are delineated and operationalized in a manner that allows for consistent assignment of scores. It cannot be overemphasized that the scoring procedure must be applied in a manner that is both valid and reliable.

As a part of the scoring process, examiners must use a system which ensures that scoring will be done without racial or sexual bias. Some agencies grade at the operatory, while some grade in a separate location. Regardless of the procedure used, the intent must be to ensure that prejudice cannot enter into the assignment of a score.

At the completion of a clinical examination, all test scores need to be analyzed carefully. The scores on all sections of the examination need to be included in the analysis. One analysis is similar to an item analysis where the level of difficulty of each section of the test is assessed along with each section's characteristics. The relative contribution of each aspect of the test to the total test is determined. Review of test content, scoring and testing procedures should also be conducted with the post-test data. Scoring patterns and examiner consistency also need to be investigated. This data may indicate the need for additional training of examiners, examiner remediation, removal of examiners, future test revisions and improved examiner selection criteria.

Summary: The foregoing discussion is an attempt to address salient aspects of clinical examinations as they relate to current professional testing standards. It is not intended to be a guideline for testing. Such "guidelines" are available in the testing and measurement literature and are too extensive for listing here. They have, however, been applied to the identified program of work outlined by the committee.

IV. Conclusions of the Committee for Presentation to the Council on Dental Education

Following discussion at its third meeting, held in February 1990, the committee unanimously agreed to the following conclusions and directed that they be included in the committee's report to the Council.

In response to the first part of the resolution, which states:

> **Resolved,** that the appropriate agencies of the ADA, in cooperation with the American Association of Dental Examiners, study 1) the comparability of clinical examinations for dental licensure...

the committee adopted the following conclusion:

1. Resolution 14H: Part I—Comparability of Clinical Licensure Examinations: The study initiated jointly by the ADA Council on Dental Education and the American Association of Dental Examiners to address the comparability of the clinical examinations used for dental licensure included 21 of the 22 dental testing agencies in the United States and its territories. Numerous similarities exist between and among the several clinical examinations, especially within the regional testing agencies. However, there is also wide variation among all the testing agencies when examined in relation to a predetermined set of testing standards. This analysis provides persuasive evidence supporting the conclusion that clinical examinations for licensure are not, in their present form, comparable.

In response to the second part of the resolution which states:

> **Resolved,** that the appropriate agencies of the ADA, in cooperation with the American Association of Dental Examiners, study...2) the feasibility of identifying reliable standards for evaluating clinical competency...

the committee adopted the following conclusion:

2. Resolution 14H: Part II—Feasibility of Identifying Reliable Standards: It is acknowledged that reliable standards for evaluating clinical competency can be developed. Using widely accepted methods from the field of tests and measurements, two broadly gauged activities would be required:

a) adopting an agreed upon set of clinical procedures and a common set of related criteria for evaluation, and
b) employing methods to establish content validity and test reliability, as well as adopting accepted testing standards and practices.

In addition, this goal is attainable at the individual jurisdictional level, among and between several states or among all dental licensure jurisdictions.

Council's Action on the Committee's Report: The Council discussed the report of the special committee and recognized that the study is an important assessment of the licensure processes addressed by this resolution. The Council concurred with the conclusions of the study related to (1) comparability of clinical licensure examinations and (2) feasibility of identifying reliable standards as cited in the report. The Council approved the report for transmittal to the 1990 House.

In addition, the Council noted that the special committee has acquired valuable expertise. For this reason, the Council agreed that this committee should provide input to the Council in implementing the following resolutions adopted by the 1989 House:

1. Resolution 32H-1989—development of guidelines to assess equivalency of clinical examinations (*Trans.*1989:523);
2. Resolution 34H-1989—issues related to outcome assessment and minimal competency (*Trans.*1989:527).

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

Definition of Terms

Calibration—The process of establishing consistency of agreement or inter-rater reliability among examiners where ratings are set according to predefined criteria.

Comparability—A term not limited to the field of testing. To **compare,** according to Webster, is to examine the character or qualities of, especially in order to discover resemblances or differences. For the purpose of this study, a test is comparable when the same procedures and the same criteria are used for evaluation.

Content Validity—A systematic examination of the test content to determine whether it covers a representative sample of the domain of behavior to be measured.

Criterion-Related Validity—The degree to which a test is successful in predicting an individual's behavior in specific situations. For this purpose, performance on the test is checked against a criterion, e.g., how well does performance on the DAT predict grade point average at the end of one year in dental school.

Inter-Rater Reliability—The consistency of agreement among raters or examiners. It can be empirically established by finding an intraclass correlation coefficient which varies between 0 and 1. It is interpreted like an ordinary correlation coefficient.

Reliability—The consistency or accuracy of a test measuring whatever it measures.

Validity—The degree to which a test measures what it was designed to measure.

Q-Sort and Delphi Technique—Rating procedures that can be used to determine how different individuals perceive the relative importance of clinical procedures.

Appendix 1

Dental Licenser Board 01

APPLICANT TEST INFORMATION	EXAM FORMAT AND CONTENT	EXAMINER CALIBRATION/MANUAL	OTHER TEST PRACTICES
Application Forms - Requirements Jurisdiction - stated in state code (not materials) General Information Concerning Test Content - General Grading Criteria (not specific) General Schedule - site, dates, materials to be furnished, insurance requirements No Specifications For: Patient acceptability Release of results Appeals Procedure Retesting policy	<u>1/2 Day Written Consisting Of:</u> 1) Jurisprudence 2) Oral diagnosis 3) Dental anatomy <u>3 Days Clinical Consisting Of:</u> 1) One MOD, or DO amalgam restoration (molar or bicuspid) 2) One complex amalgam restoration requiring a minimum of one pin 3) One Class III composite restoration 4) One full gold crown (molar or bicuspid) 5) Prosthetics - upper and lower master impression 6) Discussion of a diagnosis and treatment plan for his/her patients	No Examiner's Manual No written Examiner's Orientation New Examiners must be trained Examiner Calibration - one day prior to each test by Board members Calibration includes: 1) No formal written orientation 2) Lecture and discussion 3) Examples Calibration is missing: 1) Simulated grading 2) Exercises to empirically establish inter-rater reliability	Passing Criteria-minimum 70% on at least of the three clinical procedures Test grades are given by three examiners Scoring Criteria - pass/fail Patient is escorted out for grading No post-analysis of test results for revision No review of examiners

Dental Licenser Board 02

APPLICANT TEST INFORMATION	EXAM FORMAT AND CONTENT	EXAMINER CALIBRATION/MANUAL	OTHER TEST PRACTICES
Application Forms - requirements Overview of Jurisdiction - contained in state law but not sent to the candidates General Information Concerning Test Format and Content General Information Concerning Grading - specific information concerning "0" grades. General schedule - date, site, guidelines No Indication Concerning - Insurance requirements Release of results Appeals procedure Retesting policy Limited Information Concerning - patient acceptability, materials to be furnished.	<u>1/2 Day Written Consisting Of:</u> 1) Jurisprudence 2) Periodontics 3) Prosthodontics (discrimination test) <u>3-1/2 Days Consisting Of:</u> 1) Operative Dentistry - Class II amalgam (must be in occlusion) and a Class V restoration on a patient. Class II onlay on a manikin. 2) Removable Prosthodontics - construction of a maxillary wax model opposed by a minimum of 12 teeth. 3) Periodontics - plaque and calculus removal. 4) Endodontics (one permanent molar embedded in plaster)	No formal written examiner grading and standardization procedure A consultant (dentist) and new examiners have conducted standardization exercises prior to the exam (1 day) Calibration consists of: 1) Lecture and discussion 2) Grading simulation 3) Simulation No empirical calibration exists Three examiners for each clinical section are used. No Examiner's Manual Three examiners for each clinical section are used. No indication of examiner selection procedure	Scoring - 0 through 5 system with an average of "3" being passing. No indication of how test scores relate to licensure Grades are assigned away away from the operatory Post analysis of test results used to: 1) Review candidate's performance 2) Review written test items No post analysis of test results used for: 1) Test revision 2) Clinical difficulty and discrimination 3) Examiner consistency and scoring 4) Test revision

Dental Licenser Board 03

APPLICANT TEST INFORMATION	EXAM FORMAT AND CONTENT	EXAMINER CALIBRATION/MANUAL	OTHER TEST PRACTICES
Application Forms - Requirements Overview of Jurisdiction General Information Concerning Test Content and Format - grading Specific Information Concerning Test Content - grading criteria, scoring system Schedule - site, date Materials to be furnished Insurance requirements Specifications for: Patient acceptability Release of results Appeals procedure Retesting policy Candidate Orientation Guide - very detailed	1/2 Day Written Consisting Of: 1) Prosthodontics (1-3/4 hr.) 2) Periodontics Diagnosis (1-1/4 hr.) 3) Emergencies/Basic Life Support (1 hr.) 2 Days Clinical Consisting Of: 1) Operative Clinical a) Class II silver amalgam restoration b) Cast restoration (precious or semi-precious metal- DO, MO, MOD inlay or onlay, or 3/4 crown) c) Composite restoration (Class III or IV) 2) Periodontics - (periodontal measurements, scaling, polishing - 6 teeth with at least 2 molars with proximal contact) Scoring Sheets - very detailed	Examiner Manual - very detailed procedural and scoring instructions Examiner Calibration - one day prior to each test administration Calibration includes: 1) discussion and review of objectives 2) discussion and review of criteria 3) discussion and review of scoring 4) Simulated grading 5) Exercises to empirically establish inter-rater reliability No written examiner selection procedures Examiners do not observe candidates - only their completed work.	Scoring - both an additive and deductive system based on 100 points (complicated) A 70% average is passing with no less than 60% on any exam. Reviews are conducted once the exam has been completed on: 1) Test content 2) Item analysis 3) Level of difficulty 4) Examiner consistency and scoring patterns Test data are used to suggest upcoming test revisions and examiner selection procedures. Data are used in school reports

Dental Licenser Board 04

APPLICANT TEST INFORMATION	EXAM FORMAT AND CONTENT	EXAMINER CALIBRATION/MANUAL	OTHER TEST PRACTICES
Application Forms - Requirements Overview of Jurisdiction General Information Concerning Content and Format No Information Concerning: Specific test content Grading criteria Scoring system Schedule - site, date Materials to be furnished Patient acceptability Release of results Appeals procedure Retesting policy Candidate orientation	2-1/2 Hours Written Consisting Of: 1) Jurisprudence, law and ethics 2) Radiation safety 3-1/2 Days Clinical Consisting Of: 1) Prosthetics (vertical and centric relations and mounting on an articulator on a model - constructed prior to exam) 2) Endodontics (one anterior and one molar mounted in an acrylic block - non-specific) 3) Prophylaxis 4) Operative Dentistry a) Class II amalgam (or more complex) b) Class III or IV composite c) One casting (inlay or crown - non-specific)	No written examiner selection procedure No Examiner's Manual Examiner's Calibration conducted by outside consultant Examiner Calibration (at the time written exams are given) consisting of: 1) Lecture and discussion 2) Films/slides/models 3) Simulated rating exercises No exercises to empirically establish inter-rater reliability Two examiners score (if they disagree a third is brought in) Examiners don't see candidates	No written information concerning scoring Use a 1-5 scoring system Post test analysis consisting of: 1) Item analysis 2) Level of difficulty 3) Examiner rating and consistency Analysis may be used for examiners.

Dental Licenser Board 05

APPLICANT TEST INFORMATION	EXAM FORMAT AND CONTENT	EXAMINER CALIBRATION/MANUAL	OTHER TEST PRACTICES
Application Forms - Requirements Jurisdiction in State Statutes General Information Concerning Test - (quite limited) - passing criteria listed Schedule - (General Only) - Site - Dates No Information Concerning: Specific test content Grading criteria Scoring system Materials to furnish Insurance requirements Patient acceptability Release of results Appeals procedure Retesting policy Candidate orientation information	1 Day Written Consisting Of: 1) Anatomy 2) Physiology 3) Pathology 4) Microbiology 5) Oral Surgery 6) Periodontics 7) Anesthesia 8) Pharmacology 9) Pedodontics 10) Prosthetic Dentistry 11) Operative Dentistry 12) Radiology 13) Biochemistry 14) Dental Materials 15) Other Subjects (comprehensive treatment plan) 1 Day Clinical Consisting Of: 1) Option I - Class II, III or IV gold foil Class II amalgam Option II - Class V Gold Foil and 3 - surface Class II amalgam Option III - 3 - surface Pin - Amalgam and Class III or IV composite 2) Prosthetics - full upper and lower final impressions, bite blocks	No examiner selection procedures No Examiner's Manual New Board members are trained by Board members No formal calibration of examiners	No indication of scoring or pass/fail criteria Grading completed away from operatory Candidate escorts patient to be graded No post-test analysis

Dental Licenser Board 06

APPLICANT TEST INFORMATION	EXAM FORMAT AND CONTENT	EXAMINER CALIBRATION/MANUAL	OTHER TEST PRACTICES
Applicant Forms - Requirements Overview Of Jurisdiction General Information Concerning Test Schedule - site, date Materials to be furnished Insurance requirements Retesting policy (in state statutes) Release of results Candidate Orientation Information (general information only) Content and format - (general description only) No specifications for: Specific grading procedure Scoring system (state statutes indicate 80% passing - information is not given to the candidate) Appeals procedure	1 Hour Written Consisting Of: 1) Jurisprudence 3-1/2 Days Consisting Of: 1) Complete dentures a) Fully festooned dentures b) Adjusted and fitted to patient 2) Amalgam Restoration - a) Gold casting (tooth has two contacts and is in occlusion - 3/4 crown, MOD onlay or similar restoration) b) Cementing of restoration on patient	Examiner Selection - specified in state statutes - consists of the State Board - (7 dentists and 1 consumer) No Examiner's Manual Examiner calibration (one-half day prior to each exam conducted by dental consultants) consisting of: 1) Lectures and discussion 2) Films/slides/models 3) Review of scoring procedures 4) Scoring and grading simulations/role playing exercises No evidence of empirically establishing inter-rater reliability Three examiners grade at operatory - candidate is not present - all must agree	80% passing No written information concerning grading and scoring No post-test analysis Examiners informally evaluated by president of the Board

Dental Licenser Board 07

APPLICANT TEST INFORMATION	EXAM FORMAT AND CONTENT	EXAMINER CALIBRATION/MANUAL	OTHER TEST PRACTICES
Application Forms - Requirements Overview of Jurisdiction General Information Concerning Test Content - passing/failure Schedule - site, dates (no day-by-day schedule) Materials to be furnished Insurance requirements Release of results Appeals procedure Retesting policy No specific information concerning scoring system No candidate orientation manual or guide (limited orientation information)	4 Days Consisting Of Written Examinations in: (Cannot be broken down without a time schedule) 1) Jurisprudence 2) Periodontics - planning and treatment 3) Prosthetics Clinical Examinations in: 1) Periodontics - (scaling and stain removal - 5 teeth in each of 2 quadrants - each quadrant must have a molar) 2) Prosthetics - prepare a maxillary central incisor (porcelain bonded to metal crown) - Complete wax-up, casting and finish of a 3/4 gold crown on premolar - set teeth for full maxillary denture against cast 3) Restorative (Operative) Dentistry a) Option I - Class I gold foil or Class V gold foil and Class III resin restoring proximal contact b) Option II - Class II, III or IV gold foil c) Option III - prepare, cast and cement a 2- or 3-surface inlay, a 3/4 crown or a full crown	No written examiner selection procedure Examiner's Manual Examiner Calibration (two days before test; conducted by Board members) consisting of: 1) Discussion of grading criteria 2) Reading grading criteria aloud 3) Noting changes in manual No simulated grading No exercise to empirically establish inter-rater reliability Examiner begins clinical test (may question candidate) Examiner's Score - (average (score is assigned) Candidates inform examiners when procedure is completed and grading is done in operatory	75% passing on all tests 1-4 point system Additive scoring procedure - weights specified on score sheets Post test analysis (on written only) consisting of: 1) Item analysis 2) Level of difficulty No post test analysis of clinical test

Dental Licenser Board 08

APPLICANT TEST INFORMATION	EXAM FORMAT AND CONTENT	EXAMINER CALIBRATION/MANUAL	OTHER TEST PRACTICES
Application Forms - Requirements Overview of Jurisdiction General Information Concerning Test Content and Format - Grading Specific Information Concerning Test Content No Specific Information Concerning 1) Grading criteria 2) Scoring system Schedule - sites, date Materials to be furnished Insurance requirements Specifications for: Patient acceptability Release of results Appeals procedures Retesting policy Candidate orientation guide	1/2 Day Written Consisting Of: 1) Oral Pathology 2) Prosthetics 3) Oral diagnosis and treatment planning 2 Days Clinical Consisting Of: 1) Amalgam preparation (at least a Class II) (posterior tooth) 2) Amalgam Restoration (at least a Class II) (posterior tooth) 3) Cast gold preparation (two surface inlay, MOD onlay, 3/4 or 7/8 crown) 4) Periodontics (scaling and polishing - 8 teethd with moderate pocket depth of 5mm or more and at least 8 teeth with moderate subgingival calculus) 5) Cast gold finish (two surface inlay, MOD only, 3/4 or 7/8 crown) 6) Endodontics (performed on an extracted tooth) 7) Periodontal diagnosis 8) Periodontal treatment	Written examiner selection procedures Examiner's Manuals - very detailed procedural and scoring instructions Examiner Calibration - one day prior to each test administration - Calibration includes: 1) Discussion and review of objectives 2) Discussion and review of criteria 3) Discussion and review of scoring 4) Simulated grading 5) Exercises to empirically establish inter-rater reliability There are two floor examiners observing candidates There are three examiners who rate completed work as to pass/fail	Scoring - pass/failure from 3 graders from the 7 clinical exams. Pass/ Failure based upon specific criteria. Pass/ Failure on each of the 3 written exams. Failure on the total exam occurs when 8 or more failures are recorded. Reviews are conducted once the exam has been completed on: 1) Test content 2) Item analysis 3) Level of difficulty 4) Examiner consistency and scoring patterns Test data are used to suggest future test revisions and examiner selection procedures

Dental Licenser Board 09

APPLICANT TEST INFORMATION	EXAM FORMAT AND CONTENT	EXAMINER CALIBRATION/MANUAL	OTHER TEST PRACTICES
Application Forms - Requirements Overview of Jurisdiction General Information Concerning Test Content and Format Schedule - date, site Retesting policy No information concerning: Materials to be furnished Insurance requirements Patient acceptability Release of results Appeals procedure Test scoring system Grading criteria Passing criteria No Candidate Orientation Guide (limited candidate orientation information)	2-1/2 Hours Written Consisting Of: 1) Jurisprudence 2) Office emergencies 3) Oral surgery 4) Periodontics 2-1/2 Days Clinical Consisting Of: 1) Amalgam restoration - Class II (in natural occlusion) 2) Composite restoration - Class III 3) Prosthetics - maxillary and mandibular impressions, mounting of occlusal rims 4) Onlay procedure - Class II 5) Endodontic Access Preparation - premount an extracted maxillary central incisor and mandibular first or second molar	No written examiner selection procedure No Examiner Calibration No Examiner's Manual When clinical procedures are completed, examiners go to operatory	No written information concerning scoring and pass/failure criteria Post-test analysis on written examination concerning: 1) Item analysis 2) Level of difficulty No post-test analysis on: 1) Clinical exams 2) Examiner consistency No post-test analysis used for test revisions or examiner selection

Dental Licenser Board 10

APPLICANT TEST INFORMATION	EXAM FORMAT AND CONTENT	EXAMINER CALIBRATION/MANUAL	OTHER TEST PRACTICES
Application Forms - Requirements Overview of Jurisdiction General Information Concerning Content and Format No information concerning: Specific test content Grading criteria Scoring system Pass/Failure criteria Schedule - site, date Materials to be furnished Insurance requirements Patient acceptability Release of results Appeals procedure Retesting policy Candidate orientation guide	2 Hours Written Consisting Of: 1) Operative Dentistry 2) Pharmacology 3) Prosthodontics 4) Oral Surgery and Pain Control 5) Oral Pathology and Radiology 6) Endodontics - Periodontics 7) Anatomic Sciences 8) Dental Anatomy 3 Days Clinical Consisting Of: 1) Operative Dentistry a) Class II amalgam 2) Surgical a) Extraction of a maxillary or mandibular first or second molar 3) Periodontics (scaling on 5 teeth, two of which are molars) 4) Radiology - non-specific	No written examiner selection procedures No Examiner's Manual No Examiner Calibration Board sets its own standards Five examiners review clinical procedure - team must agree as to pass/failure Patient is taken from operatory for grading	No written scoring or pass/failure criteria No post-test analysis

Dental Licenser Board 11

APPLICANT TEST INFORMATION	EXAM FORMAT AND CONTENT	EXAMINER CALIBRATION/MANUAL	OTHER TEST PRACTICES
Application Forms - Requirements Overview of Jurisdiction General Information Concerning Test Specific Information Concern Test, format and content - grading criteria, scoring system, pass/ failure criteria Schedule - site, date Materials to furnished Insurance requirements Patient acceptability Release of results Appeals procedures Retesting policy Candidate orientation information (very detailed)	1/2 Day Written Consisting Of: 1) Law 2) Oral diagnosis, treatment planning, dental materials 3) Prosthodontics Discrimination Examination 2 Days Clinical Consisting of: 1) Class II amalgam (bicuspid or molar) 2) Class III or IV composite 3) Crown and bridge - full crown and 3/4 crown (performed on a mannequin) 4) Endodontics (mounting one anterior and one molar - non-specific)	Examiner's Manual Examiner selection procedures Examiner Calibration (one day prior to each exam conducted by dental consultant) consisting of: 1) Lecture and discussion 2) Slides/models/mannequins 3) Simulated grading 4) Inter-rater reliability must be established (13% critical difference) Three graders must agree or minority grade is discarded Examiners grade in the operatory - they don't see the candidates	Grading and scoring criteria not specified Post-exam analysis to be conducted by outside agency for the next 3 years using current testing procedures - (court ordered) - must establish test validity and reliability

Dental Licenser Board 12

APPLICANT TEST INFORMATION	EXAM FORMAT AND CONTENT	EXAMINER CALIBRATION/MANUAL	OTHER TEST PRACTICES
Application Forms - Requirements Overview of Jurisdiction General Information Concerning Test Content and Format - grading criteria and scoring system Specific information available for: Schedule - site, date Materials to be furnished Insurance requirements Patient acceptability Release of results Appeals procedure Retesting policy Candidate Orientation Information No specific information concerning grading criteria and scoring system	1/2 Day Written Consisting Of: 1) Diagnosis and treatment planning 2) Jurisprudence 3) Asepsis 4) Prosthetics - non-specific - clinical 2 Days Clinical Consisting of: 1) Class II amalgam 2) Class II cast gold restoration (MOD) 3) Condensed gold (Class II, III or V) 4) Periodontics - non-specific 5) Prosthodontics - model - furnished to design removable partial denture that requires writing a prescription to laboratory	Examiner's Manual Examiner calibration (conducted by testing experts and board one day prior to exam) consisting of: 1) Lecture and discussion 2) Role playing 3) Slides/films/models 4) Inter-rater reliability empirically established 5) Remediation of examiners is given after calibration Examiners grade patients in grading area - they don't see candidates	Deductive scoring system is used - information being sent No post-test analysis for: 1) Exam revision 2) Examiner scoring and rating 3) Item difficulty 4) Item analysis

Dental Licenser Board 13

APPLICANT TEST INFORMATION	EXAM FORMAT AND CONTENT	EXAMINER CALIBRATION/MANUAL	OTHER TEST PRACTICES
Application Forms - Requirements General Information Concerning Test Partial Listing of Materials to be Furnished Partial Listing of Schedule No information concerning: Test content - grading criteria and scoring criteria Insurance requirements Patient acceptability Release of results Appeals procedure Retesting policy Candidate orientation	2 Days Written Consisting of: 1) National Board Examination (Part 2) 2 Days Clinical Consisting Of: 1) Prosthetics (impressions of maxillary and mandibular teeth) 2) Gold crown inlay or onlay - non-specific 3) Composite restoration (Class II) 4) Extraction of a molar tooth	No Examiner Calibration Manual No Examiner Selection procedure No Examiner Calibration Examiner grading is completed away from the operatory - candidate is not seen	No written scoring or grading criteria No pass/failure criteria No post-test analysis

Dental Licenser Board 14

APPLICANT TEST INFORMATION	EXAM FORMAT AND CONTENT	EXAMINER CALIBRATION/MANUAL	OTHER TEST PRACTICES
Application Forms - Requirements Overview of Jurisdiction General Information Concerning Test Content and Format Schedule - site, date Partial Information: Release of results Insurance requirements No Information Concerning: Specific information concerning grading criteria and scoring system Patient acceptability Appeals procedures Retesting policy Candidate orientation (limited)	1-1/2 Hours Written Consisting Of: 1) Jurisprudence 3 Days Clinical Consisting Of: 1) Gold foil (Class II, III or V) 2) Cast gold preparation (onlay, overlay or 3/4 crown) 3) Periodontics - non-specific 4) Amalgam Class I and II preparation	Examiners selected by governor No Examiner's Manual No Examiner Caliabration Examiner only sees patient Three examiners per procedure working individually - average score is assigned Patient is escorted to grading area by clerk	Both additive and deductive systems are used 75% is passing for each procedure No post-test analysis Informal discussion at a meeting after the exam to account for changes

Dental Licenser Board 15

APPLICANT TEST INFORMATION	EXAM FORMAT AND CONTENT	EXAMINER CALIBRATION/MANUAL	OTHER TEST PRACTICES
Application Forms - Requirements Overview of Jurisdiction General Information Concerning Test Content and Format Schedule - site, date Materials to be furnished Insurance requirements Release of results No Information Concerning: Specific test information - Content, grading criteria, Scoring system, pass/failure criterion Patient acceptability Appeals procedures Retesting policy Candidate Orientation Information (quite limited)	1 Hour Written Consisting Of: 1) Jurisprudence 3 Days Clinical Consisting Of: 1) Operative Dentistry a) Two Class II amalgams b) One Class III anterior non-metalic restoration 2) Prosthetics (maxillary and mandibular impressions) 3) Periodontics - (scaling and polishing - patient with significant subgingival calculus - quadrant must have at least 6 teeth having pocket depth of 4mm or greater - at least 2 posterior teeth must be in proximal contact) 4) X-rays - periapical and bite-wing radiographs	No Examiner's Manual Examiner Calibration (conducted 4-6 months prior to exam by dental consultant) consisting of: 1) Lecture and discussion 2) Role play 3) Simulated rating exercises using slides No exercise to empirically establish inter-rater reliability Three examiners per team - if there is disagreement concerning a failure, the entire Board reviews procedure Double-blind scoring system - grading at operatory without candidates present	Scoring and grading system - being sent No post-test analysis

Dental Licenser Board 16

APPLICANT TEST INFORMATION	EXAM FORMAT AND CONTENT	EXAMINER CALIBRATION/MANUAL	OTHER TEST PRACTICES
Application Forms - Requirements Overview of Jurisdiction General Information Concerning Test Content and Format Specific information for: Schedule - site, date Materials to be furnished Insurance requirements Patient acceptability No information concerning: Specific test information - Grading criteria, scoring system, Pass/failure criterion Release of results Appeals procedure Retesting policy Candidate orientation information (very limited)	2 Hours Written Consisting Of: 1) Jurisprudence 2) Disease control 3) Periodontal diagnosis and treatment planning 3 Days Clinical Consisting Of: 1) Two gold onlays - MOD, 3/4 or 7/8 crown - at least one onlay on a molar tooth 2) One two-surface alloy restored with mesial and distal contact (molar or bicuspid) 3) Composite restoration - Class III or IV 4) Periodontics - one quadrant to be assigned by examiner - minimum of 5 teeth, one of which is a molar with mesial and distal contacts	Examiners appointed by governor Examiner's Manual No formal Examiner Calibration - Board meets 1-1/2 day prior to exam. Meeting consists of: 1) Discussion with Board by the President of the Board 2) Lectures and a film No simulated grading exercise No procedures to empirically establish inter-rater reliability Examiner grades in operatory - candidates are not present	75% passing criteria No written information concerning grading and scoring Post-test analysis consists of pass/failure rates and subjective evaluation of examiners No empirical post-test analysis

Dental Licenser Board 17

APPLICANT TEST INFORMATION	EXAM FORMAT AND CONTENT	EXAMINER CALIBRATION/MANUAL	OTHER TEST PRACTICES
Application Forms - Requirements Overview of jurisdiction General Information Concerning Test Format and Content Specific information for: Test content and grading criteria Schedule - site, date Materials to be furnished Insurance requirements Patient acceptability Release of results Appeals procedure Retesting policy Candidate Orientation guide - very detailed No explanation of pass/failure criteria	1/2 Day Written Consisting Of: 1) Diagnosis, oral medicine and radiology 2) Comprehensive Treatment planning 2 Days Clinical Consisting Of: 1) Restoration Dentistry a) Cast restoration and an amalgam restoration (gold Class II, Class III, IV, V or crown or onlay or inlay - Class II) b) Compacted gold restora- and an amalgam restoration (Gold Class II, III, IV, V) and an amalgam restoration: Class II - in contact with at least proximal surface and tooth must be in occlusal contact. If MOD is selected both proximal surfaces must be untreated lesions 2) Periodontics - segment selected by examiner consisting of a minimum of 6 natural teeth including 4 posterior with a minimum of 3-5mm pocket depth - at least 2 posterior teeth must be in proximal contact 3) Prosthodontics (maxillary anterior teeth) non-specific)	Examiner Manual-detailed with scoring instructions Examiner Calibration - held once each spring Calibration includes: 1) Discussion of objectives 2) Viewing of videotapes 3) Discussion of how the exam will be conducted 4) Simulated grading No exercises to empirically establish inter-rater reliability are conducted No written examiner selection procedures	Scoring - deductive system (no clear explanation of pass/ failure criteria)

Dental Licenser Board 18

APPLICANT TEST INFORMATION	EXAM FORMAT AND CONTENT	EXAMINER CALIBRATION/MANUAL	OTHER TEST PRACTICES
Application Forms - Requirements Overview of Jurisdiction General Information Concerning Test Format and Content Schedule - site, date Materials to be furnished No information concerning: Test content - grading and scoring system Insurance requirements Patient acceptability Release of results Appeals procedure Retesting policy No Candidate Orientation Guide (limited orientation information)	2-1/2 Hours Written Consisting Of: 1) Jurisprudence 2) Oral medicine, oral pathology and periodontics 1-1/2 Days Clinical Consisting Of: 1) Diagnosis, treatment, planning and periodontics - non-specific 2) Class III - composite restoration 3) Class II - amalgam restoration (molar or upper bicuspid) 4) Cast gold onlay or inlay or 3/4 cast gold crown (molar or upper bicuspid) 5) Removable and Fixed prosthodontics (at least one gold restoration) 1-1/2 days laboratory (includes 2-1/2 hours written)	Examiners selected through a political process No Examiner's Manual Examiner's Calibration (1-1/2 day - held every couple of years conducted by the Board members) consisting of: 1) Discussion and lecture 2) Simulated rating exercises (models are utilized) No process to empirically establish inter-rater reliability Examiner grades in operatory - candidate is not present	Information concerning testing scoring not available No post-test analysis

Dental Licenser Board 19

APPLICANT TEST INFORMATION	EXAM FORMAT AND CONTENT	EXAMINER CALIBRATION/MANUAL	OTHER TEST PRACTICES
Application Forms - Requirements Overview of Jurisdiction General Information Concerning Test Form and Content - grading and pass/failure criteria Schedule - general only Specific information for: Materials to be furnished Insurance requirements Patient acceptability Release of results Appeals procedure Retesting policy No specific information concerning grading and rating procedure Candidate Orientation Information - no manual, but extensive	1/2 Day Written Consisting Of: 1) Oral diagnosis and treatment planning 2) Periodontal diagnosis and treatment planning 2 Days Clinical Consisting Of: 1) Amalgam restoration - Class II restoration on a posterior tooth 2) Cast restoration (7/8 or 3/4 crown) 3) Periodontics - Scaling Requirements - Patient with at least 20 teeth - at least one molar; bicuspid and anterior tooth which are free of conditions to interfere with evaluation - interproximal probing depth of 3-6mm - subgingival calculus present on 50% of the teeth -quadrant is selected by examiner 4) Restorative Laboratory: Removable prosthodontics/ dentures (articulated dentoform typodant - 32 maxillary and mandibular teeth) - (full maxillary and mandibular wax-up)	Examiner Selection Procedure Examiner's Materials - Equivalent to a manual Examiner Calibration (conducted by professional consultant - one day prior to each exam) consisting of: 1) Lecture and discussion 2) Role playing exercises 3) Slides/models No evidence of empirical calibration to establish inter-rater reliability Examiners grade patients at a facility away from the operatory - they do not see the candidate	Scoring system - additive 0-7 rating system 3 = passing and translates to a 75%. Two examiners grade - if they disagree, a third grader is assigned Post-test analysis on written test consisting of: 1) Item analysis 2) Level of difficulty, etc. Post-test analysis on clinical to evaluate examiners Little post-test analysis on clinical test content

Dental Licenser Board 20

APPLICANT TEST INFORMATION	EXAM FORMAT AND CONTENT	EXAMINER CALIBRATION/MANUAL	OTHER TEST PRACTICES
Application Forms - Requirements General Information Concerning Test Content and Format Specific information concerning: Grading criteria, scoring system, pass/failure criteria Schedule - site, dates Materials to be furnished Insurance requirements Patient acceptability Release of results Appeals procedures Retesting policy Candidate Orientation Guide - very detailed - well done	2 Days Written Consisting Of: 1) Jurisprudence 2) Diagnostic skills 3) Dental Prosthetics 2 Days Clinical Consisting Of: 1) Periodontics (scaling and polishing 5 teeth with subgingival calculus) with at least one deep-rooted molar) 2) Class II amalgam restoration with distal contact 3) Class III Composite - preparation and Class IV restoration (performed on a mannequin) 4) Endodontic procedure - perform on maxillary right first bicuspid and maxillary left first bicuspid (performed on a mannequin) 5) Pin amalgam preparation and restoration - Preparation of a maxillary model (detailed explanation - Pin amalgam (type and number chosen at candidate discretion) - (performed on a mannequin) 6) Cast restoration - MOD onlay or 3/4 crown or full crown (all metal or porcelain to metal) - (performed on a mannequin)	Examiner selection procedure Examiner and Monitor Manuals (very detailed) Examiner Calibration (prior to each examination conducted by testing expert and dental consultants) includes: 1) Discussion and review of objectives 2) Discussion and review of criteria 3) Discussion and review of scoring 4) Simulated grading 5) Use of slides/models 6) Exercises to empirically establish inter-rater reliability Examiners do not observe candidates - only their completed work	75% = passing on written exams Scoring on clinical 1-5 point system. Ratings are averaged with a score of 3.0 as passing Reviews are conducted after the exam on: 1) Test content 2) Item analysis 3) Level of difficulty 4) Examiner consistency and scoring patterns 5) Test reliability Test data are used to suggest test revisions and examiner selection procedures

Dental Licenser Board 21

APPLICANT TEST INFORMATION	EXAM FORMAT AND CONTENT	EXAMINER CALIBRATION/MANUAL	OTHER TEST PRACTICES
Application Forms - Requirements Overview of Jurisdiction General Information Concerning Test Format and Content - scoring and passing criteria Schedule - sites, dates Materials to be furnished Insurance requirements Release of results Appeals procedure Retesting policy No specifications for patient acceptability Candidate Orientation Information (limited) No detailed information concerning grading and scoring	1/2 Day Written Consisting Of: 1) Jurisprudence 2) Oral pathology 3) Oral diagnosis 3 Days Clinical Consisting Of: 1) Restorative Dentistry a) Class II, MO, DO, or MOD onlay/inlay or 3/4 crown (molar) b) Class II amalgam (molar) c) Class III or IV non-metalic restoration 2) Prosthetics (maxillary and mandibular impressions, full denture setup)	No written examiner selection criteria Examiner's Manual Examiner Calibration (prior to examination conducted by chief examiner) consisting of: 1) Lecture and discussion 2) Information on scoring process No simulated rating exercises No process to empirically calibrate to establish inter-rater reliability Two examiners grade - if they don't agree, the chief examiner makes final decision Grading is completed at the operatory - candidate is not present	Deductive system - 100 points total on each exam - 75% passing Post-test analysis (on written) consisting of 1) Item analysis 2) Level of difficulty, etc. Post-test analysis on clinical to evaluate examiners (peer review only) No quantitative post-test analysis on clinical

Appendix 2

Chart I
RESTORATIVE CLINICAL PROCEDURES FOR EACH TESTING AGENCY

	Procedure	Testing Agency																				
		01	02	03	04	* 05	06	* 07	08	09	10	11	12	13	14	15	16	* 17	18	19	20	21
1	Class II amalgam		X	X	X	X			X	X	X	X	X		X	X		X	X	X	X	X
2	M.O.D. or D.O. amalgam only	X																				
3	Complex amalgam (minimum, 1 pin)	X															X					
4	Class III and IV composite on a mannequin																				X	
5	Class II amalgam or Class II, III, or IV gold foil					X																
6	Class II, III or IV gold foil							X					X		X			X				
7	Class III composite	X								X				X		X			X			
8	Class III or IV composite			X	X	X						X					X					X
9	Class V gold foil		X			X												X				
10	Casting (inlay or crown)				X													X				
11	Class II onlay on a mannequin		X																			
12	Class II onlay									X												
13	One gold crown	X												X								
14	Class I gold foil or Class V gold foil							X														
15	Class II gold restoration												X									
16	Pin amalgam preparation and restoration on a mannequin																				X	
17	Cast gold - inlay, onlay M.O.D., 3/4 or 7/8 crown								X								X		X	X		
18	An amalgam restoration and a gold foil restoration Class II, III, IV or V																	X				
19	Crown and bridge (full or 3/4 crown) on a mannequin											X										
20	Cast restoration (M.O.D. onlay or full crown on a mannequin)																				X	
21	Gold casting - 3/4 crown, or M.O.D. onlay						X	X							X							
22	Class II M.O., D.O., or M.O.D. onlay or 3/4 crown (molar)			X																		X

An asterisk (*) denotes an agency that offers options or alternatives relative to the listed procedures.

Chart II
CLINICAL PROCEDURES FOR EACH TESTING AGENCY (OTHER THAN RESTORATIVE)

	Procedure	Testing Agency																				
		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21
1	Periodontics (scaling and polishing on at least two molars)		X	X				X	X				X		X	X	X	X		X	X	
2	Prophylaxis				X																	
3	Prosthetics	X	X		X	X		X		X			X	X		X		X	X	X		X
4	Endodontics		X		X	X			X	X		X										
5	Endodontics (mannequin)																				X	
6	Extraction of a molar tooth										X			X								
7	Radiology										X											
8	Treatment planning	X																	X			
9	Complete dentures						X															
10	Radiographs - periapical and bite-wing radiographs															X						

Please note that treatment planning and radiology as denoted here are listed as part of the clinical examination and are not part of the written examination.

Chart III
RESTORATIVE CLINICAL PROCEDURES FOR AGENCIES EXAMINING MORE THAN 300 CANDIDATES PER YEAR

	Procedure	Agency						
		A	B	C	D	E	F	G
1	Class II amalgam	X	X	X	X	X	X	
2	Complex amalgam (minimum, 1 pin)							X
3	Class III or IV composite	X			X			X
4	Class III and IV composite on a mannequin					X		
5	Class II, III, IV or V gold foil		X					
6	Cast gold - inlay, onlay M.O.D., 3/4 or 7/8 crown	X		X			X	X
7	Compacted gold restoration and amalgam restoration (Class II, III, IV, or V)		X					
8	Cast restoration (M.O.D. onlay or 3/4 or full crown) on a mannequin					X		
9	Class II M.O., D.O., or M.O.D. onlay or 3/4 crown (molar)	X			X			
10	Casting (inlay or crown)		X					

Appendix 3

Table 1
RESTORATIVE CLINICAL PROCEDURES: REGIONAL VS. STATE TESTING AGENCIES

Procedure	Regional Agencies (n = 4)	State Agencies (n = 17): All State Agencies	State Agencies (n = 17): State Agencies Examining over 300 Candidates
Class II amalgam	4	12	2
M.O.D. or D.O. amalgam only	0	1	0
Complex amalgam (minimum, 1 pin)	0	2	0
Class III and IV composite on a mannequin	0	1	1
Class II amalgam or Class II, III, or IV gold foil	0	1	0
Class II, III or IV gold foil	1	3	0
Class III composite	0	5	0
Class III or IV composite	2	4	0
Class V gold foil	1	2	0
Casting (inlay or crown)	1	1	0
Class II onlay on a mannequin	0	1	0
Class II onlay	0	1	0
One gold crown	0	2	0
Class I gold foil or Class V gold foil	0	1	0
Class II gold restoration	0	1	0
Pin amalgam restoration on a mannequin	0	1	1
Cast gold - inlay, onlay M.O.D., 3/4 or 7/8 crown	1	3	2
An amalgam restoration and a gold foil restoration Class II, III, IV or V	1	0	0
Crown and bridge (full or 3/4 crown) on a mannequin	0	1	0
Cast restoration (M.O.D. onlay or full crown) on a mannequin	0	1	1
Gold casting - 3/4 crown, M.O.D. onlay	0	3	0
Class II M.O., D.O., or M.O.D. onlay or 3/4 crown (molar)	1	2	1

Table 2
CLINICAL PROCEDURES (OTHER THAN RESTORATIVE):
REGIONAL AND STATE TESTING AGENCIES
NUMBER OF AGENCIES REQUIRING EACH PROCEDURE

Procedure	Regional Agencies (n = 4)	State Agencies (n = 17)
Periodontics (scaling and polishing on at least two molars)	3	8
Prophylaxis	0	1
Prosthetics	2	11
Endodontics	1	5
Endodontics (mannequin)	0	1
Extraction of a molar tooth	0	2
Radiology	0	1
Treatment planning	0	2
Complete dentures	0	1
Radiographs - periapical and bite-wing radiographs	0	1

Table 3
NUMBER OF CANDIDATES TESTED IN EACH CLINICAL AREA
FROM JANUARY THRU DECEMBER 1988*

Procedure (Restorative)	Regional Agencies	State Agencies	Large State Agencies**	Total
Class II amalgam	4,290	3,597	3,184	7,887
M.O.D. or D.O. amalgam only	0	47	0	47
Complex amalgam (minimum, 1 pin)	0	419	372	419
Class III and IV composite on a mannequin	0	1,071	1,071	1,071
Class II amalgam or Class II, III, or IV gold foil	0	16	0	16
Class II, III or IV gold foil	2,173	480	0	2,653
Class III composite	372	233	0	605
Class III or IV composite	1,748	518	372	2,266
Class V gold foil	2,170	124	0	2,294
Casting (inlay or crown)	2,173	73	0	2,246
Class II onlay on a mannequin	0	108	0	108
Class II onlay	0	106	0	106
One gold crown	0	47	0	47
Class I gold foil or Class V gold foil	0	236	0	236
Class II gold restoration	0	149	0	149
Pin amalgam restoration on a mannequin	0	1,071	1,071	1,071
Cast gold - inlay, onlay M.O.D., 3/4 or 7/8 crown	1,697	2,221	2,113	3,918
An amalgam restoration and a gold foil restoration Class II, III, IV or V	2,170	0	0	2,170
Crown and bridge (full or 3/4 crown) on a mannequin	0	57	0	57
Cast restoration (M.O.D. onlay or full crown) on a mannequin	0	1,071	1,071	1,071
Gold casting - 3/4 crown, M.O.D. onlay	0	337	0	337
Class II M.O., D.O., or M.O.D. onlay or 3/4 crown (molar)	1,748	0	0	1,748

Procedure (Non-Restorative)	Regional Agencies	State Agencies	Large State Agencies**	Total
Periodontics (scaling and polishing on at least two molars)	3,867	3,850	3,184	7,717
Prophylaxis	0	73	0	73
Prosthetics	2,593	2,932	1,741	5,525
Endodontics	372	360	0	732
Endodontics (mannequin)	0	1,071	1,071	1,071
Extraction of a molar tooth	N/AV	0	N/AV	0
Radiology	N/AV	0	N/AV	0
Treatment planning	0	155	0	155
Complete dentures	0	46	0	46
Radiographs - periapical and bite-wing radiographs	0	78	0	78

* Total examined for all Testing Agencies was 8,593
** Large State Agencies are defined by having examined over 300 candidates each
N/AV Denotes "not available", candidates were tested in these areas but information was not returned.

Table 4
NUMBER OF UNITED STATES TRAINED CANDIDATES TESTED IN EACH CLINICAL AREA FROM JANUARY THRU DECEMBER 1988*

Procedure (Restorative)	Regional Agencies	State Agencies	Large State Agencies**	Total
Class II amalgam	4,274	2,801	2,398	7,074
M.O.D. or D.O. amalgam only	0	47	0	47
Complex amalgam (minimum, 1 pin)	0	918	371	918
Class III and IV composite on a mannequin	0	847	847	847
Class II amalgam or Class II, III, or IV gold foil	0	16	0	16
Class II, III or IV gold foil	2,173	473	0	2,646
Class III composite	372	232	0	604
Class III or IV composite	2,170	515	371	2,685
Class V gold foil	2,170	73	0	2,243
Casting (inlay or crown)	0	73	0	73
Class II onlay on a mannequin	0	108	0	108
Class II onlay	0	106	0	106
One gold crown	0	47	0	47
Class I gold foil or Class V gold foil	0	236	0	236
Class II gold restoration	0	149	0	149
Pin amalgam restoration on a mannequin	0	847	0	847
Cast gold - inlay, onlay M.O.D., 3/4 or 7/8 crown	1,681	1,657	1,550	3,338
An amalgam restoration and a gold foil restoration Class II, III, IV or V	2,170	0	0	2,170
Crown and bridge (full or 3/4 crown) on a mannequin	0	55	0	55
Cast restoration (M.O.D. onlay or full crown) on a mannequin	0	847	847	847
Gold casting - 3/4 crown, M.O.D. onlay	0	337	0	337
Class II M.O., D.O., or M.O.D. onlay or 3/4 crown (molar)	1,741	0	0	1,741

Procedure (Non-Restorative)	Regional Agencies	State Agencies	Large State Agencies**	Total
Periodontics (scaling and polishing on at least two molars)	3,851	3,055	2,397	6,906
Prophylaxis	0	73	0	73
Prosthetics	2,593	2,369	1,179	4,962
Endodontics	363	358	0	721
Endodontics (mannequin)	0	847	847	847
Extraction of a molar tooth	0	N/AV	0	N/AV
Radiology	0	N/AV	0	N/AV
Treatment planning	0	155	0	155
Complete dentures	0	46	0	46
Radiographs - periapical and bite-wing radiographs	0	78	0	78

* Total examined for all Testing Agencies was 7,780

** Large State Agencies are defined by having examined over 300 candidates each

N/AV Denotes "not available", candidates were tested in these areas but information was not returned.

Joint Commission on National Dental Examinations

Goldblatt, Lawrence I., Indiana, 1991, chairman, American Association of Dental Schools
Piacine, Mark J., Pennsylvania, 1990, vice-chairman, American Dental Association
Bachman, Lillian H., New York, 1991, American Association of Dental Examiners
Carlson, Edward C., Arizona, 1993, American Association of Dental Examiners
Elzay, Richard P., Minnesota, 1992, American Association of Dental Schools
English, Leon J., Wisconsin, 1992, American Association of Dental Examiners
Looper, Joseph W., Georgia, 1991, American Dental Association
Malvitz, Dolores M., Georgia, 1990, American Dental Hygienists' Association
Minatra, Randolph D., Texas, 1992, American Association of Dental Examiners
Ogata, Randall H., Nebraska, 1990, American Student Dental Association
Palmer, John E., Oregon, 1993, American Dental Association
Reed, Michael J., Missouri, 1993, American Association of Dental Schools
Rupp, Roger P., Kansas, 1993, American Association of Dental Examiners
Simpson, Claude S., Jr., South Carolina, 1990, public member
Sullivan, Dennis M., Maryland, 1990, American Association of Dental Examiners
De Marais, David R., Manager, Department of Testing Services

Meetings: The Joint Commission on National Dental Examinations met in the Headquarters Building, Chicago, on March 29, 1990. Most of the topics considered by the Joint Commission were initially reviewed by one of three committees. The Committees on Administration, Dental Hygiene and Examination Development met on March 28.

The annual National Dental Examiners' Advisory Forum, sponsored by the Joint Commission, met in Chicago on March 27, 1990. Approximately 120 dental and dental hygiene examiners and educators from over 40 states attended the Forum. The program was devoted to an overview of the National Board Examinations, including content determination, test item development, performance standards and trends in candidate performance.

Sixteen test constuction committees met during the year to develop new editions of National Board Dental and Dental Hygiene Examinations. Three special committees also met to revise and implement the plan to restructure Part II of the National Board Dental Examinations and to develop examination content pertaining to dental public health, occupational safety and behavioral sciences for the restructured examination.

Acknowledgments: The Joint Commission acknowledges with appreciation the contributions made by Dr. Dolores Malvitz, Mr. Randall Ogata, Dr. Mark Piacine, Mr. Claude Simpson, Jr. and Dr. Dennis Sullivan, who complete their service on the Joint Commission this year.

Trends in Test Candidates and Failure Rates: The number of candidates for the National Board Dental and Dental Hygiene Examinations increased for the first time in several years. The number of Part I candidates (foreign-trained candidates included) increased from 5,697 in 1988 to 6,173 in 1989. Part II candidates remained stable in number, 5,472 in 1988 and 5,470 in 1989. Candidates for the National Board Dental Hygiene Examination increased from 4,383 in 1988 to 4,463 in 1989. These increases, in general, resulted from a greater number of candidates repeating the test and an increase in foreign-trained dental candidates.

The failure rates of the total group of candidates, both foreign- and U.S.-trained, taking National Board Dental Examinations have increased. During 1989, approximately 25% of the candidates failed one or more sections of the Part I Examination, and approximately 18% failed one or more sections of the Part II Examination. The failure rate for U.S.-trained candidates on the Part I Examination has increased from 8.8% in 1981 to 14.0% in 1989, while their failure rate on the Part II Examination has increased from 8.0% in 1982 to 13.4% in 1989. The failure rate for candidates taking the National Board Dental Hygiene Examination, typically 9-10%, increased to 12.1% in 1989.

Pilot of Restructured Part II, National Board Dental Examinations: At its March meeting, the Joint Commission on National Dental Examinations reviewed the plan to pilot-test the restructured Part II Examination scheduled in November 1990. Fifty schools have indicated their willingness to participate in the pilot-test. The Joint Commission is restructuring the Part II Examination to provide state boards of dentistry with the most reliable evaluation possible. The intent of the Joint Commission is to incorporate more test content based on cases, with a patient-oriented approach to problems. The objective is to improve the evaluation of the candidate's understanding of the relevant basic and clinical sciences. Results of the pilot-test will govern the implementation of the restructured examination.

Selection of Full-Time Practitioners for National Board Test Construction: During its recent meeting, the Joint Commission selected 11 full-time practitioners for its dental test construction committees. These practitioners will join the 64 other dental test constructors in 1991. Each year the Joint Commission contacts constituent dental societies, dental schools and state boards of dentistry requesting applications for test constructors. Although 15 to 20 applications are usually received for each vacancy, few had been received from full-time practitioners or dental examiners. This year, however, more than 90 applications were submitted by full-time practitioners. The Joint Commission, while supporting the traditional criteria for selecting test constructors, had been concerned that full-time practitioners were not well-represented on test construction committees. Therefore, the Joint Commission approved a pilot program that called for the addition of one

full-time practitioner to each dental test construction committee. The Joint Commission approved this program for a three-year period. In 1993, the Joint Commission will evaluate the effectiveness of this pilot program and will determine whether the change should become permanent.

During the selection of all test constructors, the Joint Commission gave special attention to any states or schools that appeared to have been under-represented in the National Board test construction process. Expertise in specific disciplines, however, was the primary criterion considered.

Assistance to Other Agencies: One of the duties of the Joint Commission is to serve as a resource for the dental profession in the area of developing written examinations. During the past year, staff continued to provide this support to the American Board of Periodontology. Assistance is provided in the development of new examinations, as well as in revising used test items and in reviewing examination procedures. This service is offered only if staff time is available and only for a fee to cover costs.

Special assistance is also provided to state boards of dentistry upon request. The Joint Commission is pleased to provide secure examinations to state boards for their internal use. Effective May 1, 1990, a $50 service fee per candidate is charged for this special assistance.

Informational Services Pertaining to Licensure: The staff assigned to work with the Joint Commission continues to respond to numerous requests for information pertaining to licensure. Because the National Board Dental and Dental Hygiene Examinations are part of the licensure qualification process, the staff becomes a frequent liaison between the state boards of dentistry and dentists or dental hygienists seeking licensure or relicensure. Although many of the requests come from dentists from other countries, numerous requests for information regarding state board requirements, licensure by credentials or reciprocity are received from U.S. dentists considering relocation of their practices.

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

Divisions of Legal Affairs and Legislative Affairs

Council on Ethics, Bylaws and Judicial Affairs

Council on Governmental Affairs and Federal Dental Services

Notes

Council on Ethics, Bylaws and Judicial Affairs

Feldman, Roddy N., California, 1990, chairman
Muller, Carl H., Illinois, 1991, vice-chairman
Burch, Robert H., Arkansas, 1992
Cartwright, O. V., Texas, 1992
Cooley, David F., Michigan, 1992
Fanno, James T., Ohio, 1993
Giuliani, Richard L., Maryland, 1993
Hamrick, Fitzhugh N., South Carolina, 1990
Lange, Karl W., Kentucky, 1991
Lavalla, Gaetan J., Pennsylvania, *ad interim,* 1991
Lawson, William, Alabama, 1990
Matis, John A., Utah, 1993
Plihal, James, Washington, 1991
Sewright, James R., South Dakota, 1992
Slagle, Charles J., Connecticut, 1990
Wentworth, Edward T., Jr., New York, 1993
Boerschinger, Thomas H., secretary

Meetings: The Council met on January 21-22, 1990 and May 6-7, 1990 in the Headquarters Building.

Dr. James H. Gaines, trustee, Sixteenth District, served as liaison to the Council for the Board of Trustees for 1990. Dr. Gaines monitored the proceedings of the Council during 1990 and attended its January meeting.

Vice-chairman: Dr. Carl H. Muller was elected vice-chairman at the January meeting.

Appreciation: The 1990 annual session will mark the retirement of Dr. Roddy N. Feldman, who served as the Council's chairman in 1990. Also retiring are Drs. William Lawson and Charles J. Slagle. Doctors Feldman, Lawson and Slagle each served four years on the Council. The Council expresses its gratitude to these individuals for their leadership, contributions and dedication during their tenure.

In Memorium: Dr. Eugene Czarnecki of the Third Trustee District died on March 18, 1990. Dr. Czarnecki brought to the Council a professional lifetime of service in organized dentistry. Dr. Czarnecki was a valued member of the Council and his colleagues mourn his passing.

Judicial Procedures

Appeal of Dr. Harrison: Dr. J. D. Harrison, a member of the Iowa Dental Association, appealed the denial of his attempt to transfer membership to the California Dental Association. The Council heard the appeal at its May meeting. The Council's decision on this appeal is being written at the time of this writing. The decision will be reported in a supplemental report to the House of Delegates.

Response to Assignments from the 1989 House of Delegates

ADA "Constitution and Bylaws" Revised: The current edition of the ADA *Constitution and Bylaws,* revised as of January 1, 1990, reflects the amendments approved by the 1989 House of Delegates. An addendum to the current edition also sets forth the dues equity amendments enacted by the 1989 House of Delegates which become effective January 1, 1991.

Council Activities

New Council Publications: During 1990, the Council continued to work toward its primary goal of encouraging constituent and component societies to increase emphasis in the area of professionalism and ethics. One of the steps taken toward this end in 1989 was the publication of a revised edition of the Council's *Guidelines for Disciplinary Hearings.* The *Guidelines* outline the appropriate procedures that must be followed when a society institutes a disciplinary proceeding against a member. It also gives practical advice on the conduct of mediation and negotiation which in some cases can be successful in avoiding the necessity of a disciplinary proceeding. Because there will be those instances where a disciplinary hearing is unavoidable, practical advice is also given in the *Guidelines* with respect to the conduct of such a hearing. Key legal points such as the essential steps which must be taken to afford a member due process and suggestions on how to avoid allegations of bias and interest on the part of the trial panel are set forth. Perhaps most importantly, there is a strong suggestion from the Council in this book that constituent societies revise their disciplinary proceedings so that disciplinary hearings are held only at the constituent society level. This recommendation is made because the Council believes constituent societies are in a better position to allocate appropriate resources in the form of staff, legal services and logistic support for the conduct of a disciplinary hearing than are most components.

This year, the Council also issued two new publications to complement its *Guidelines for Disciplinary Hearings.*

The publication *Official Summary, Appellate Disciplinary Decisions of the American Dental Association's Council on Ethics, Bylaws and Judicial Affairs* contains a synopsis of every

appellate decision issued by the Council since the *ADA Principles of Ethics and Code of Professional Conduct* was revised in 1979. While the cases are presented in abbreviated form, care was taken to assure that each synopsis contains the pertinent facts and circumstances of the case together with the controlling ethical principles.

The synopsized decisions provide significant insight into the issues on which a constituent society can take effective action under the *ADA Principles of Ethics and Code of Professional Conduct.* Also, with respect to proper procedure for a disciplinary proceeding, use of the *Official Summary,* with its discussion of various instances where the procedures of a particular case were determined to be either appropriate or inappropriate, should help to insure that the manner in which any proceeding is conducted protects the interests of both the society and the accused. The *Official Summary* is published in looseleaf form and will be updated with the addition of recent decisions issued by the Council. In this manner the *Official Summary* can become part of the permanent library of constituent and component societies and serve as a continuing resource.

This year the Council also issued an updated and revised *Model Bylaws for Component Societies.* This is the first extensive revision of this document in well over a decade. The *Model Bylaws* is replete with instructional notes to assist groups in revising or adopting bylaws in adapting this publication to their specific situation. The sections of the *Model Bylaws* relating to membership dues were drafted to blend with the ADA dues equity provisions adopted by the House in 1989 (*Trans.*1989:507) to be effective January 1, 1991. With respect to disciplinary hearings, the Council prepared the sections of the *Model Bylaws* to coincide with the Council's recommendations that such hearings be conducted at the constituent society level.

Ethics Workshops: The Council conducted an ethics workshop for the Texas Dental Association on May 4, 1990. The workshop was an adjunct of the TDA meeting in San Antonio, Texas. The primary invitees were members of ethics committees of the TDA component societies. The Council will present a workshop to a similar audience for The Dental Society of the State of New York in Albany, New York on October 5, 1990. An ethics workshop will be available to the entire membership when the Council presents its program as part of the ADA Scientific Session in Boston on October 16.

This is the second year of the Council's ethics workshop programs and, according to the evaluation sheets turned in by the participants, the workshops have been well-received. The workshops present an overall view of dental ethics. An ethicist presents the philosophical basis for self-regulation of a profession pursuant to a code of ethics. The legal restraints on the extent to which a profession is permitted to regulate itself are also discussed. Finally, hypothetical fact situations or advertisements are examined to provide an example of how to determine whether an ethical problem is presented and, if so, how to proceed to resolve it. Programs designed for presentation to members of a society's ethics committee place significant emphasis on the appropriate manner of conducting a disciplinary proceeding and other enforcement techniques. However, it is recognized that disciplinary proceedings are by their nature an inefficient and expensive way to enforce a code of ethics. The principal purpose of the workshop is to instill a level of knowledge in the participants that will enable them to conduct similar proceedings and discussions in their own societies. It is hoped that the example that is set and the discussions that are generated will instill an awareness among the entire membership of the individual professional's obligation to conduct himself or herself in an ethical and professional manner.

Societies interested in a presentation of such a workshop by the Council should contact the Council on the ADA WATS line. The publications discussed in this section were furnished to all constituent and component societies and are available from the Council on request.

Update and Clarification of ADA "Constitution and Bylaws": This Council has responsibility, under the ADA *Bylaws,* Chapter IX, Sections I.e. and f., for maintaining the ADA'S *Constitution and Bylaws* in an appropriate form and with the proper grammatical structure. The Council, either on its own, or as the Standing Committee on Constitution and Bylaws is often called upon to draft amendments to the *Constitution and Bylaws* for consideration by the House of Delegates (Chapter V, Section 140). In proceeding to draft such proposals the Council must develop language which not only achieves the desired effect of the amendment but also avoids any conflict with other existing provisions of these documents. The passing years have seen many amendments to these documents. Ambiguities and inconsistencies have, in the vast majority of cases, been avoided. However, the numerous amendments tend to produce a grammatical structure that is unduly complex and cumbersome. An example of how the language of the *Bylaws* can be clarified was presented by last year's amendment of Chapter II, Constituent Societies, Section 40, Membership. The old provision had provided:

> Section 40. Membership:
> A. The active, life, and retired membership of each constituent society, except as otherwise provided in these *Bylaws,* shall be limited to dentists practicing within the territorial jurisdiction of such constituent society or to dentists in a federal dental service, provided that such dentists are in good standing in a component society thereof, if such exists, and provided that they are active or life members in good standing of this Association, or to a member of a federal dental service who has never practiced within the territorial limits of a component society and is a member in good standing of the constituent society and this Association.
> *Explanatory Note: A dentist who has retired from active practice or who is engaged in activities furthering the object of this Association shall be considered to be practicing dentistry within the meaning of this section.*

This provision was clarified by the adoption of amendatory language (*Trans.*1989:537). It now provides:

Section 40. Membership:
A. The active, life, and retired membership of each constituent society, except as otherwise provided in these *Bylaws*, shall consist solely of dentists practicing within the territorial jurisdiction of the constituent society; dentists retired from active practice; dentists engaged in activities furthering the object of this Association; and dentists in the federal dental service (providing that the federal dentist is either licensed in or serving within the confines of the constituent society's jurisdiction), provided that such dentists are active, life or retired members in good standing of a component of the constituent (except for the federal dentists), if such exists, and this Association.
Explanatory Note: A dentist who has retired from active practice or who is engaged in activities furthering the object of this Association shall be considered to be practicing dentistry within the meaning of this section.

Another example of the simplification and clarification of language that is possible is the amendatory language submitted as a resolution to this report. The resolution addresses the changes that must be made to the *Bylaws* concerning the filling of vacancies on the Board of Trustees because of changes in governing Illinois law.

At its meetings this year the Council discussed the advisability of undertaking an overall revision of the ADA's governing documents. It concluded that this would be a service to the Association. However, there were two factors that weighed heavily against undertaking such a task. The first was the magnitude of the project. The time and energy required to complete an appropriate revision of these documents in a reasonable period of time, as part of a single project, would have severely hampered the primary function of the Council in the area of professionalism and ethics. Second, *Sturgis, Standard Code of Parliamentary Procedure*, Third Edition, page 199, "Revision of Bylaws," states:

> The report of a special revisions committee proposing a substantial number of changes in bylaws for either clarifying or reorganization purposes is approved or rejected by a majority vote in the same manner as adoption of original bylaws.

It was the consensus of the Council that opening up the governing documents of the Association to amendment by majority vote was not in the best interest of the Association. While the purpose of the Council would be to clarify and simplify the grammatical structure, there can never be absolute assurance that the recommendations would not be amended in a manner that would produce a substantive change. To avoid the problems of undertaking a project which would place an undue strain upon the Council's resources, and might result in opening up the governing documents of the Association to amendment by majority vote on substantive matters, the Council determined that it would not seek to act, or have another body named, as a bylaw revision committee under the parliamentary procedures outlined by *Sturgis*. However, the Council believes that going forward with specific recommendations to clarify certain portions of the *Bylaws* is in the best interest of the Association. Therefore, it will proceed in future years to recommend editorial corrections to various sections of the *Bylaws* for purposes of simplication and clarification. Any suggested changes will therefore come before the House in normal resolution form which will require a two-thirds majority for adoption.

Advisory Opinion

Advisory Opinion 1 to "Code of Professional Conduct," Section 1-C, Community Service: The question of the duty of health care professionals in this country to address the problem of the standard of care delivered by those within their ranks who are impaired or who suffer from a disease has been widely discussed in recent years. The Council has monitored the discussion of these issues very closely. It has been the position of the Council that the public is protected under the Association's *Code of Ethics* under the *Principle*, Section 1, which recognizes the obligation of the dentist to provide care in a competent and timely manner. Inherent in this obligation is the requirement that the health care practitioner take all reasonable steps to avoid harm to the patient. In this regard it must be recognized that the ability of a health care practitioner to provide quality care may be compromised by certain types of impairment. Addiction, mental illness, debilitating diseases, and if appropriate precautions are not taken, communicable diseases are examples. A decision on whether a dentist or dental auxiliary should continue to treat patients is one which must be made on the facts and circumstances of each case. A dentist who is impaired or has an impaired staff member has an ethical obligation to consult recognized medical and dental authorities with respect to the treatment of patients by the impaired individual and to abide by the recommendations received (assuming a clear consensus as to the appropriate standard of care is available). Where appropriate, the professionals consulted should review the practice and infection control procedures utilized therein. The Council believes that the profession has the obligation to regulate itself to protect the public from its members who are unable, because of impairment or disease, to provide the requisite standard of care. This obligation falls under Section 1-C, Community Service, which places service to the community above the interests of the individual professional. The following advisory opinion was issued on May 7, 1990:

> **Advisory Opinion 1 to "Code" 1-C, Community Service:**
> 1. A dentist who becomes ill from any disease or impaired in any way shall, with consultation and advice from a qualified physician or other authority, limit the activities of practice to those areas that do not endanger the patients or members of the dental staff.

Amendment of the ADA "Bylaws"

Vacancy on the Board of Trustees: In the course of reviewing the *Bylaws* for the purpose of evaluating the

merits of a Council project for a general revision of the *Bylaws*, a conflict between the Illinois Not-for-Profit Corporation Act and the ADA *Bylaws* was discovered. The conflict relates to the ADA bylaw provision for vacancy and absence of a member of the Board of Trustees, *Bylaws*, Chapter VI, Section 70, page 28.

In brief, the current *Bylaws* provision provides that upon a trustee position becoming vacant, the President appoints a successor, either with the advice and consent of, or pursuant to the rules of the trustee district, to fill the post *until* a successor is elected by the next House of Delegates. With regard to a temporary absence, the substitute is appointed in the same manner but only for the time of the absence.

This provision does not comply with Illinois law. There are three applicable provisions in the Illinois Not-for-Profit Corporation Act. Chapter 32 of the Illinois Revised Statutes, Sec. 108.30 provides:

> Sec. 108.30, Vacancies. Any vacancy occurring in the Board of Directors and any directorship to be filled by reason of an increase in the number of directors may be filled by the Board of Directors unless the *Articles of Incorporation* or the *Bylaws* provide that a vacancy or directorship so created shall be filled in some other manner, in which case such provision shall control. *The director elected or appointed, as the case may be, to fill a vacancy shall be elected or appointed for the unexpired term of his or her predecessor in office.* (Emphasis added.)

A second applicable Illinois provision is Sec. 108.10(c). Sec. 108.10(c) provides, in part:

> The term of a director elected to fill a vacancy expires at the next annual meeting of the members entitled to vote *at which his or her predecessor's term would have expired....* (Emphasis added).

The Illinois Not-for-Profit Act also prohibits members of a board of directors from acting on any matter by proxy. Sec. 108.50(d).

The result of the Illinois statutory provisions is that substitute directors appointed to fill a vacancy must be appointed for the unexpired term of the predecessor in office. These statutory provisions overrule the ADA *Bylaws* provisions which permit temporary appointments or appointments until a successor is elected to serve out the unexpired term. Therefore, the *Bylaws* provisions must be amended to reflect Illinois law.

To bring the *Bylaws* into compliance with Illinois law, the *ad interim* appointment of the substitute trustee, from the time of the vacancy until the next House of Delegates, must be eliminated.

The recommended amendatory *Bylaws* language drafted by the Council attempts to follow the present *Bylaws* provisions as closely as possible. It provides that a vacancy shall be filled when the President and the trustee district concur on the replacement. If there is no concurrence, the vacancy remains until the following House of Delegates, where the vacancy is filled by nomination and election in the same manner as followed for a new trustee, but for the remainder of the previous trustee's term.

In drafting this language the Council is aware that it provides checks and balances between the authority of the President to fill the vacancy and the authority of the trustee district in which the vacancy occurs to nominate a replacement for the president to appoint. This process reflects the dual role a trustee fills. The trustee is a representative of the trustee district and also a representative who must act in a fiduciary capacity for the benefit of all ADA members. It is for this reason that the ADA *Bylaws* provide that the trustee is elected by the entire House of Delegates, not just the trustee district. Therefore, the Council recommends the adoption of the following resolution.

Summary of Resolutions

Amendment/Rescission of Current Policy:

25. Resolved, that Chapter VI, Board of Trustees, Section 70, Vacancy and Absence, of the *Bylaws* be amended by deleting said Section in its entirety, and substituting therefor the following revision:

> Section 70. VACANCY.
> In the event of a vacancy in the office of trustee, an active, life or retired member may be appointed by the President to fill the unexpired term of the vacancy. The appointment shall be made by the President with the advice and consent of the former trustee's district. A trustee district may file rules with the Association's Executive Director setting forth how its nominee shall be chosen. In the event an appointment to fill the vacancy has not been made by the time of the next meeting of the House of Delegates following the occurrence of the vacancy, then a successor trustee shall be elected for the remainder of the unexpired term by the House of Delegates pursuant to the provisions of Chapter VI, Sections 40 and 50 of these *Bylaws*. If the term of the vacated trustee position has less than fifty percent (50%) of a full four-year term remaining at the time the successor trustee is appointed or elected, the successor trustee shall be eligible for election to a new, consecutive four-year term. If fifty percent (50%) or more of the vacated term remains to be served at the time of the appointment or election, the successor trustee shall not be eligible for another term.

Council on Governmental Affairs and Federal Dental Services

Katz, Harmon R., New Jersey, 1990, chairman
Bartheld, Robert L., Oklahoma, 1990, vice-chairman
Cross, Chauncey, Illinois, 1992
Downes, Edward J., New York, 1991
Gwynn, J. Cliff, Florida, 1992
Kincheloe, Earl B., Wyoming, 1993
Lainson, Phillip A., Iowa, 1993
Mehlman, Edwin S., Rhode Island, 1992
Miller, H. Franklin, Tennessee, 1990
Rummel, David G., Ohio, 1993
Sampe, David, Wisconsin, 1992
Simms, Richard A., California, 1991
Sugg, Robert W., North Carolina, 1991
TenPas, William S., Oregon, 1990
Thompson, Kay, Pennsylvania, 1993
Wood, Gene, Texas, 1991
O'Donnell, John F., secretary

Meetings: The Council met on March 24-25 in Washington, D.C. A second meeting is scheduled for June 23-24 in Washington, D.C.

The Council also met with national dental organizations on March 26 and participated in the Public Affairs Conference on March 27-28.

At the March meeting, the Dental Chiefs of the Army, Navy, Air Force, Public Health Service and Department of Veterans Affairs and the Special Assistant for Dental Affairs, Department of Defense, briefed the Council on issues of concern to the profession, including recruitment and retention of dental corps officers, bankruptcies being suffered by junior dental officers, the formation of a forum for young Air Force dentists, support for reinstitution of the Health Professions Scholarship Program, the appointment of the new Surgeon General, Antonia Novello, MD, and fellowships in the Department of Veterans Affairs.

Vice-Chairman: At the March meeting, Dr. Robert L. Bartheld was unanimously elected vice-chairman of the Council.

Supplemental Report: This report reflects the status of legislation and regulatory matters as of May 18, 1990. A supplemental report on subsequent developments to September will be submitted to the House of Delegates.

Federal Legislation

Following is a summary of Congressional actions of interest to the profession since September 1989, when the Council last reported to the House of Delegates, along with projections on activities during the remaining months of the 101st Congress.

Enacted Legislation

Physician Payment Reforms in Medicare: The system of paying for physician services under Medicare was overhauled through an agreement between the House and Senate supported by the Administration.

It established (for introduction January 1, 1992) a resource-based relative value system of physician payment, replacing the present "customary, prevailing and reasonable charge" system. Under the new system, surgical services are expected to be reimbursed at lower rates, cognitive services at higher rates, than is currently the case. Beginning in 1991, charges to Medicare patients will be limited to 125% of the allowable charge, and in 1992, to 120%. This limit will be reduced to 115% in 1993.

The method of controlling the number of procedures performed annually under Medicare was a matter of great contention. The compromise system, termed "volume performance standards," is intended to encourage restraint among physicians by authorizing Congress to lower fees for physicians' services if the standards are exceeded in a preceeding year. These physician payment reforms apply to dentists, when performing services within the Medicare program.

Catastrophic Repeal: The expanded benefits under Part A (Hospital Insurance Benefits) and Part B (Supplementary Medical Insurance Benefits), enacted in the Medicare Catastrophic Coverage Act of 1988, were repealed in response to concerns of senior citizen groups over higher premiums. The 1988 law's Medicaid provisions regarding payment of Medicare premiums for the indigent elderly, coverage for impoverished pregnant women and infants, and protection of income of spouses of nursing facility residents were retained.

Medicaid: Specifically affecting dental care delivery are several Medicaid reforms enacted as part of the Omnibus Budget Reconciliation Act of 1989. These reforms are directed to eligibility standards, reimbursement and the Early and Periodic Screening, Diagnosis, and Treatment Program. They are described in detail in the annual report of the Council on Dental Care Programs (see page 49).

Self-Employed Persons Health Insurance Costs: Deductibility by self-employed persons of 25% of the cost of health insurance, self and family, which had been due to expire December 31, 1989, was extended until September 30, 1990.

Section 89 Repeal: The controversial Section 89 of the Internal Revenue Code, which imposed on employers a series of complex tests to determine whether health and some other benefit programs discriminated between highly compensated and other employees, was repealed.

Protection for Professional Review Activities: Amendments were made to the Health Care Quality Improvement Act of 1986 to clarify that the Act's protections of persons engaged in professional review activities do not preempt or override any state law which provides incentives, immunities or protection for persons so engaged that is in addition to or greater than the federal protections.

Legislative Projections

As of May 18, the Congress is scheduled to be in session 33 days before the target adjournment date of October 5. This abbreviated election year work schedule serves to limit the issues for consideration and possible Congressional action. Of particular interest to the profession are:

Americans With Disabilities Act: HR 2273 seeks to establish a clear and comprehensive prohibition of discrimination on the basis of physical or mental disability. The legislation has already passed the Senate, and with the House Judiciary Committee favorably reporting the bill on May 2, it has now completed the committee process in the House and is expected to reach the floor by mid-June.

Perhaps the most contentious issue surrounding the legislation is the potential for an expansion of remedies available should the Civil Rights Act of 1990 be enacted.

HR 2273 sets forth remedies available under Title VII of the Civil Rights Act. Originally, the sponsors of the legislation wanted to expand these remedies to include punitive and compensatory damages, but withdrew these provisions in the face of severe opposition from the Administration. The White House would support the Americans With Disabilities Act only if it did not contain punitive and compensatory damages.

The Civil Rights Act of 1990 would amend Title VII to provide punitive and compensatory damages, and would therefore alter the scope of remedies available under HR 2273, and threaten the delicate arrangement worked out between the Congress and the Administration.

In addition, floor battles are expected over amendments allowing a small-business phase-in and a tax credit for the costs incurred by public accommodations for making necessary architectural changes. These provisions are supported by the Association.

The Civil Rights Act of 1990: S 2104, approved by the Senate Labor and Human Resources Committee on April 4, seeks to counter six 1989 Supreme Court rulings that narrowed the reach and remedies of laws to combat job discrimination. Dentists as employers would be covered by applicable provisions of this bill.

S 2104 would make it easier for women and minorities to challenge employment discrimination and allow greater awards for victims of job bias. The bill would permit jury trials and monetary damages for intentional job discrimination based on race, religion, national origin or gender. It would also permit damage awards for racial discrimination in all aspects of an employment relationship.

There are 40 sponsors of the bill in the Senate and 168 in the House (HR 4000). Early in May, the Administration threatened a veto of the bill. Later in the month, Administration objections were described as minimal.

The bill is awaiting Senate floor action and the House Education and Labor Committee has begun hearings on it.

Campaign Finance Reform: Both Senate Democrats and Republicans appear to have begun serious deliberations on campaign finance reform with each faction staking out tactical negotiating positions from which, it is hoped, they will reach a consensus.

The Republicans seek to eliminate political action committees and to eliminate all soft money contributions, while the Democrats support elimination of PAC contributions to candidates but not to political parties. In addition, the Democratic alternative resurrects voluntary spending limits (tied to reduced rates on media costs) and public financing.

Deliberations began the week of May 7. With both the majority and minority leaders actively working on this issue, it is expected that a compromise package of reforms will be constructed.

VA Dental Special Pay: HR 4557, legislation providing special pay increases for VA physicians and dentists, passed the House of Representatives on May 1. The bill provides favorable increases for dental specialists, board certification, administrative pay and geographic location. However, the bill is deficient in its recommendations for full-time and tenure pay. In effect, no increase was provided for full-time pay, and a nominal increase was proposed for tenure pay.

Discussions with the Senate Veterans Affairs Committee are in progress in hopes of correcting these shortfalls. Senate hearings are scheduled to begin June 14.

Unrelated Business Income Tax: Republican members of the House Ways and Means Subcommittee on Oversight developed, in conjunction with the Treasury Department, a comprehensive package of reforms that is intended as a response to the Democratic proposal offered by Subcommittee Chairman J.J. Pickle (D-TX) in 1988.

The Ways and Means Committee's Ranking Minority Member Bill Archer (R-TX) refused to support the draft recommendations, likening them to the Section 89 debacle experienced last year. Therefore, any action on this issue this year appears unlikely.

Twenty-five Percent Deduction for Self-Employed Health Insurance: This deduction is due to expire on September 30. The prospects for a permanent extension appear to be bright due to the support of the Administration and many key Congressional Democrats. A serious attempt at increasing the deduction to 100% is also a distinct possibility.

Student Loan Interest Deduction: Hearings were held earlier this year before the House Ways and Means Subcommittee on Revenue Measures. Support for this deduction is widespread, but budgetary concerns have diminished prospects of passage this year.

USPS Nonprofit Mailing Rates: In the FY 1990 appropriations bill, Congress asked the United States Postal Service to make a report on the abuse of nonprofit mailing rates. Senator Dennis DeConcini, (D-AZ), chairman, Subcommittee on Treasury, Postal Services and General Government, Committee on Appropriations, sought this report as a basis for addressing abuses found. In February, the USPS returned its report recommending that legislation be drafted that would eliminate completely nonprofit rate eligibility for mailings which solicit the purchase of products or services offered by for-profit companies.

In March, the Administration sent Congress draft legislation that would "terminate abuses" of reduced postage rates. One of the key provisions would deny these rates for any association mail that advertises an article or product unless more than half the labor of producing such article or product was performed by members of the mailing association.

As of May 4, no member of Congress has introduced the Administration's proposal. Congressional staffers do not expect any movement on it this year.

However, it is expected that the Senate Appropriations Committee will address the issue in its FY 1991 appropriations bill. There does not appear to be suppport for the USPS proposal in the Committee, including Senator DeConcini. The issue, however, will remain on the Committee's agenda into the next Congress.

Appropriations: Because of the lack of agreement on a budget proposal, House Appropriations Subcommittees have not made significant progress. While the House approved a budget which added $750 million above the President's request for the National Institutes of Health, subsequent events indicate this increase may not occur. When the House voted on the budget bill, the Republicans did not offer the President's budget as an alternative. The economic assumptions in the President's budget are outdated. Various assumptions have indicated that if a sequestration were to go in effect because of the Gramm-Rudman law, it could result in across-the-board cuts as high as 5%, much more severe than last year's cut of 1.2%.

The Administration has also announced that it will hold a summit with House and Senate leaders to work out a final budget agreement. Because the summit is with party leaders instead of the budget committee chairmen, there is speculation that drastic measures will be enacted.

Medical Malpractice Legislation: Senator Orrin Hatch (R-UT) is expected to introduce a medical liability/tort reform bill by the end of June. The bill will differ from previous bills in that it will include issues on quality control. Senator Hatch's office does not expect the Senate to act on the bill this year. Their goal is to persuade Senator Edward Kennedy (D-MA), chairman of the Senate Labor and Human Resources Committee, to hold a hearing on the bill this year.

Other Measures: Legislation to require employers to provide health benefits to their employees is not expected to advance in this Congress. Improvements in the Medicaid program appear unlikely to be enacted, unless included in a budget reconciliation bill as in 1989. With budget meetings between the Administration and Congress just underway, the need for a reconciliation bill cannot be determined at this time.

A uniformed services pay bill is expected to be addressed by the House Subcommittee on Military Personnel and Compensation, Committee on Armed Services, prior to the October adjournment.

Federal Agency Issues

Infection Control—Occupational Safety and Health Administration (OSHA): In September 1989, OSHA began a series of five public rulemaking hearings on its proposed rule on Occupational Exposure to Bloodborne Pathogens. These hearings terminated in San Francisco, January 1990. The Association testified at the Washington, D.C. and Chicago hearings. OSHA expects to publish its final rule on this matter early in 1991. The Association submitted additional comments in April and a post-hearing brief in May. In the meantime, the Subcommittee on Health and Safety, Committee on Education and Labor, U.S. House of Representatives, conducted five hearings on the proposed rule from November 1989 to January 1990. The American Dental Association presented its testimony to the Subcommittee on November 15, 1989. The Subcommittee has now scheduled OSHA to testify before it on May 23, 1990.

In October 1989, President Arthur Dugoni and senior Association staff met with Mr. Gerard Scannell, newly appointed Assistant Secretary of Labor for Occupational Safety and Health, primarily to discuss the Association's position on the proposed infection control rule. Mr. Scannell also spoke at the Association's Public Affairs Conference on March 27, 1990. At that presentation, he announced that OSHA, so far, has agreed to make two changes requested by the Association: (1) dental workers will not be required to wear surgical hats or shoe covers for routine dental procedures, and (2) dental workers will not be required to wear fluid-resistant gowns for routine dental procedures. He explained that OSHA is actively considering the other issues raised by the Association.

From reviewing inspection data supplied by OSHA, it appears that approximately 20-25 dental offices have been inspected by OSHA from July 1987 (when inspections first began) through January 1990. Inspections are scheduled on a random basis for offices having 11 or more employees, or upon receipt of a complaint by OSHA. Most dental offices are inspected as a result of complaints being filed by employees.

At the March Council meeting, the Chairman appointed an ad hoc committee, with Dr. Chauncy Cross as chairman, to develop and report to the Council at its June meeting with a proposed strategic plan regarding how to further address the OSHA proposed infection control rule.

Hazard Communication: OSHA is also studying proposed changes to the format and content of Material Safety Data Sheets (MSDSs) and hazard communication labels.

For additional information on the Hazard Communication program, see the response to Resolution 95H on page 158).

Medical Waste: The five jurisdictions covered by the Medical Waste Tracking Act of 1988 and by the regulations thereto, issued by the Environmental Protection Agency, began implementation of the Act in summer 1989. Since then, 20 dental facilities have been inspected in New Jersey, New York and Puerto Rico. Nine had no violations; ten received warning letters; one clinic received two warnings; and no action was taken on another facility. Warning letters asked dentists to respond in 30-60 days, indicating steps taken to correct the problem. In Connecticut and Rhode Island, only 16 inspections have been conducted, none in dental facilities. Most of the fines levied by EPA have been against medical waste transporters and hospitals. This two-year demonstration program is scheduled for completion in July 1991.

The Council was provided with a full report on the medical waste survey of its members and members of the Council on Dental Practice conducted by the Division of Scientific Affairs in October 1989. The survey determined that the participating dentists generated, on average, less than one pound each of sharps and tissues, nearly 75 lbs of operatory waste and over 15 lbs of laboratory waste per month.

National Practitioner Data Bank (NPDB): The final NPDB regulations were issued in October 1989. The Department of Health and Human Services (HHS) held briefings on the Data Bank on November 17 and March 12 in Washington, D.C., and on December 14 and March 27 in Chicago. HHS has announced that it expects to begin operation of the Data Bank in summer 1990. It will contain no retroactive information; data will be reported to the Bank only if the event occurs on or after the first day of operation.

The HHS staff and its contractor, Unisys, have prepared three important documents to inform affected parties about the Data Bank: a basic guidebook with forms and instructions to be mailed to all pre-enrolled reporting entities prior to the opening of the Bank; a Question and Answer document, answering the most frequently asked questions about the Bank; and fact sheets prepared specifically for dentists. The Association submitted comments on the first two items in April. Two weeks before the Bank's opening, Unisys will institute a long distance "Hot Line," staffed by full time operators trained to answer "how to" questions about the Bank.

Washington Office staff made a presentation to the Peer Review Conference in Chicago in September 1989 about the impact of the Data Bank on dental peer review activities. A copy of the tape made of that presentation is available from the Council on Dental Care Programs.

In March, HHS representatives advised the Association that they considered any exchange of money, made by a dentist to a patient or by an insurance carrier to a patient on behalf of a dentist, for the purpose of resolving a written complaint by the patient, to be a "medical malpractice payment," reportable to the Data Bank by the person or entity making such payment.

This interpretation contradicts the earlier HHS position on such payments. Inasmuch as the current interpretation would make some of the results of dental peer reviews reportable to the Data Bank, Washington Office staff have arranged a May meeting with representatives of the Health Resources and Services Administration, HHS seeking a reversal of this position as being not in accordance with the intent of Health Care Quality Improvement Act and detrimental to the effective operation of an informal process to resolve disputes over the quality and appropriateness of dental care efficiently and inexpensively.

Regulatory Compliance Manual: The Association published its Manual in January 1990; it is available for purchase from the Salable Materials Office, Association Headquarters. It covers OSHA regulations on infection control and hazard communications, EPA regulations on medical waste for the five jurisdictions covered by the federal law, and suggestions on how to obtain information on state and local regulations on these issues.

Federal Trade Commission (FTC): The American Optometric Association filed a lawsuit challenging the FTC rule against state prohibitions of lay ownership of optometric practices on Constitutional and other grounds. The U.S. Court of Appeals for the District of Columbia ordered an indefinite stay of that rule on August 15, 1989, until it has time to consider the merits of the case. Since then, the American Dental Association has filed an *amicus curiae* brief jointly with the American Podiatric Medical Association, supporting the position of the American Optometric Association.

Toxic Waste: The Consent Decrees, settling the lawsuit brought by the EPA against 58 New England dentists and five dental supply companies, made no findings of dental amalgam being a toxic waste or hazardous substance under federal environmental laws.

Compensation of Dental Specialists in the Federal Dental Services: At its March meeting, the Council discussed the current system of compensation of dental specialists in the federal dental services, noting that, at present, specialty pay in the Department of Veterans Affairs is provided to some

specialties and not to other specialties, depending on the scarcity of certain specialists in the Department. The Council concluded that, with respect to specialty pay, all dental specialties should be treated in the same manner. Accordingly, the Council recommends adoption of the following resolution:

26. Resolved, that the American Dental Association recommends that where special remuneration considerations are offered to dental specialties in the Federal Dental Services, all eight ADA-recognized dental specialties be treated equally.

State Legislation

Dental Hygiene: Dental hygiene has continued to be an area of significant legislative activity in many states. The constituent societies faced challenges from organized hygiene on several fronts and, while dentistry succeeded in most cases, organized dental hygiene continues to press for relaxed supervision, expanded functions, self-accreditation and regulation and, ultimately, unsupervised practice.

Proposed legislation to further the goals of organized dental hygiene has been introduced in a number of states. Bills relating to board composition, expanded functions, general supervision and unsupervised practice and continuing education/CPR are pending before state legislatures. Several proposals would eliminate any reference to the Commission on Dental Accreditation as the accrediting body for dental hygiene programs.

A bill recently introduced in New York would increase the number of hygienists on the dental board from two to not less than seven and change the name to the State Board of Dentistry and Dental Hygiene. The current law calls for not less than 13 dentists on the Board. A bill has been introduced that would add one dentist and one dental hygienist to the Arizona board. A New Jersey proposal would increase board membership by one hygienist, while a bill is pending in Ohio to increase from one to three the number of hygienists on the board. In South Carolina, a bill is pending that would increase the number of hygienists on the board from one to four and decrease the number of dentists from seven to six. A bill has been introduced in Tennessee that would change the composition of the dental board from six dentists and one hygienist to four dentists, two dental hygienists and one consumer. A recent statutory amendment added an additional dentist and an additional hygienist to the Idaho board.

A bill is pending in Tennessee that would expand the dental hygienist's permitted duties. Hygienists would be authorized to extract deciduous teeth with Class III mobility and to administer nitrous oxide and inject local anesthesia. Pending legislation in Washington would permit dental hygienists who have practiced under the supervision of a dentist for two of the preceding five years to work without supervision of a dentist, to make assessments and formulate treatment plans for dental hygiene services and to inject local anesthesia.

Last year, dental hygienists in Wisconsin succeeded in an effort for legislation which relaxes supervision. General supervision measures, however, were defeated in Illinois, Kentucky, Missouri, Oklahoma, South Dakota, South Carolina, Tennessee and Texas and unsupervised practice bills failed in Illinois, New York, Oregon and Washington.

Freedom of Choice: Montana was the only state to adopt freedom-of-choice legislation in 1989. The law affords only partial rights to free choice in that it applies only to PPOs and HMOs and allows for substantially lower payments to noncontracting dentists, thereby creating a disincentive for patients to exercise their freedom of choice. This brings to 16 the number of states that have enacted patient freedom-of-choice provisions.

Bills to establish freedom of choice failed in Arizona, Arkansas, Idaho, Massachusetts and Texas in 1989. In March, 1990, a freedom-of-choice bill was narrowly defeated in Maryland. Opposition came from a coalition of business, labor and insurance groups, including a joint lobbying effort by the Chamber of Commerce and AFL-CIO. Bills to establish or expand freedom of choice are currently pending in Connecticut, Missouri, Nebraska, New Jersey and South Carolina.

Several constituent societies have taken steps to educate the public regarding rights under freedom-of-choice laws. Presentations to employers and unions and the placement of newspaper advertisements have been successful.

Denturism: Denturism proposals were defeated in Connecticut, Indiana and Mississippi in 1989. Bills carried over in 1990 in Washington and Illinois and a second proposal to legalize the practice of denturitry has been filed in Illinois. Denturism bills have been reintroduced in Mississippi and New Jersey. A bill that would repeal the denturism law is pending in Arizona.

Dental Laboratories: A bill to license dental laboratories, which passed in the House in Rhode Island in 1989, was not enacted. Instead, a joint resolution creating a study commission to investigate the issue was adopted. Proposals to regulate dental laboratories failed in Mississippi and Nebraska and carried over in South Carolina. A bill recently introduced in Illinois would permit laboratories to take shades for prostheses pursuant to a dentist's prescription. A proposal to license dental laboratories in Mississippi has been reintroduced. The National Association of Dental Laboratories has a model bill for licensure of dental labs and is encouraging its state affiliates to seek legislation.

To date, no state licenses dental laboratories. Florida, Kentucky, Oklahoma and Texas register dental laboratories and Kentucky and South Carolina register dental technicians.

Denture Identification: No states have enacted mandatory denture identification laws yet this year, but bills are pending in Georgia, Iowa, Massachusetts and New York. Twelve states currently mandate identification of all new dentures; two require identification only at the patient's request, and; several states require nursing homes to mark residents' dentures on admission.

Licensure by Credentials: A proposal to establish licensure by credentials in Alaska was recently defeated. At present, 31 states grant dental boards the authority to waive theoretical and clinical examination requirements and grant licenses to dentists licensed in other states. However, at least nine states with that authority have so far not exercised it.

Prompt Payment: A measure requiring prompt payment of insurance claims became law in Massachusetts. Prompt payment bills are currently pending in California, Illinois, Michigan and Rhode Island. At least 16 states require insurers to pay uncontested claims within a specific period of time. Some laws authorize penalty and/or interest payments for failure to pay promptly.

Professional Liability: Tort reform activity has slackened considerably. Laws enacted in 1989 include limitation on liability when providing free dental care in Illinois and immunity from liability for volunteer services performed in Maine. Joint and several liability was limited in Mississippi and a Utah law limits punitive damages. Both Oregon and Washington enacted laws which immunize health care providers from civil liability for failure to obtain one parent's consent to treatment of a minor if the consent of the minor's other parent has been obtained.

Universal Health Insurance: The Massachusetts universal health insurance law is being implemented. Proposals are pending in at least ten states which, if enacted, would expand health insurance coverage. Among the approaches embodied in the bills is the creation of pools to offer insurance to individuals and, in some cases, employers, who are unable to obtain coverage on the open market. A Delaware bill would provide catastrophic coverage and a New York proposal would authorize creation of IRA-type accounts to pay for long-term care. Three states have created bodies to study the issue of access to health care and insurance benefits. One approach under consideration is to permit residents to buy into the Medicaid program. Bills have been introduced in several states that would not only create a state universal health insurance program but would prohibit the sale of health coverage by private insurance companies, HMOs and similar entities.

While some universal health proposals include coverage for dental services, many cover only certain oral surgical procedures.

AIDS: Legislative activity on the subject of AIDS/HIV infection was varied in 1989. Arkansas joined Missouri when it passed a law requiring people who are HIV positive to inform dentists and physicians of this circumstance. Maryland made refusal to treat a person who is HIV positive grounds for discipline of dentists and dental hygienists. Montana, New Jersey, North Dakota and Wyoming enacted statutes permitting health care practitioners to inform employees of patients' HIV status, when the employees are at risk of exposure. An opinion of the state attorney general authorizes disclosure to employees in Iowa. Four states adopted measures which prohibit HIV testing without the informed consent of the patient, but an Oregon law permits a health care worker who has been exposed to an individual's body fluids to petition a court to test that individual for HIV without his or her consent.

Bills currently pending in Florida, Georgia, Hawaii, Mississippi and Missouri would permit testing of a patient for HIV without the patient's consent if a health care worker has been exposed to the patient's blood or body fluids. Proposals which require patients to inform health care providers of positive HIV status are pending in Hawaii, Iowa, Massachusetts and Pennsylvania. In Arizona, a bill has been introduced that would permit disclosure of a patient's HIV status to health care workers who have been significantly exposed to the patient's body fluids, permit disclosure to health care providers on a need-to-know basis and permit HIV testing without informed consent when emergency medical care is rendered. Eighteen states now permit disclosure to dentists of a patient's HIV status without specific authorization from the patient.

Medical Waste: State regulatory activity regarding medical waste continues. Over half the states now have adopted or are considering provisions defining medical waste and setting forth requirements for handling and disposal of such matter. The economic impact of certain regulatory provisions has been the subject of consideration in a number of states. Some states have enacted legislation regulating waste in general terms and have delegated authority to a state agency, usually the health department or environmental protection agency, to make rules specifying what categories of waste are regulated and setting forth permitted methods of treatment and disposal.

Fluoridation: A bill requiring fluoridation of the public water supply is still pending in Pennsylvania. Proposals have been introduced in Illinois, Massachusetts and Washington to prohibit adding chemicals to the public water supply other than to improve taste, clarity or safety. Several bills which would prohibit or restrict fluoridation of water or use of fluoridated water in food products have been introduced in New York. Two bills which would have required voter approval prior to fluoridating a water system recently failed in Oregon.

Anesthesia: California enacted legislation in 1989 to regulate the use of conscious sedation. As of January 1, 1992, dentists in California must have permits to administer or order the administration of conscious sedation on an outpatient basis. Nevada and Wyoming also passed bills which regulate parenteral sedation. A new Maryland law authorizes the dental board to regulate administration of general anesthesia and parenteral sedation by permit. The number of states that regulate anesthesia/sedation are: general anesthesia, 44; intravenous/parenteral sedation, 42; and, nitrous oxide, 23.

TM Disorder: The Tennessee insurance commissioner has taken the position that health and accident insurance policies must cover treatment of disorders of the temporomandibular joint. Both surgical and nonsurgical treatments are covered and services rendered by a dentist must be covered to the same extent those services would be covered if rendered by a physician. Orthodontics and

treatment of the teeth and gums may be excluded from coverage.

A TM bill in Utah failed. Bills that would require insurance plans to cover diagnosis and treatment of TM disorders to the same extent services for other skeletal joints are covered are pending in Connecticut, Kentucky, Michigan, Mississippi, Oklahoma and Rhode Island. The Mississippi proposal contains coverage limits and the Oklahoma bill covers only diagnostic and surgical procedures.

In addition to Tennessee, the following states require insurance coverage for TM disorders: Maryland, Minnesota, Nevada, New Mexico, North Dakota, Texas, Washington and West Virginia.

Amalgam: Antiamalgam resolutions were introduced in Alaska, Illinois and North Carolina in 1989. The Illinois and North Carolina proposals directed certain agencies to study the issue and report to the legislature. The Alaskan resolution asked the dental board to recommend procedures for informing patients about alternatives to fillings containing mercury. The North Carolina proposal died. No action was taken in Alaska and Illinois, but the resolutions in those states carry over to 1990.

Amalgam foes are active in at least five other states. It is expected that legislation will be introduced in one or more legislatures.

Responses to Assignments from the 1989 House of Delegates

Support for Prevention Block Grants Which Can Be Used for Local Fluoridation Projects: Resolution 21H (*Trans.*1989:558) calls upon the Association to encourage increased federal funding for Prevention Block Grants, which can be used for local fluoridation projects, to seek support for fluoridation in Congress, and in public and private sectors to bring fluoridation to all citizens.

The Administration's Budget requests that Congress fund the preventive health and health services block grant program for FY 1991 at $84,115,000. The Association testified in both the Senate and House of Representatives in support of funding of $89,716,000, the level previously approved by the House of Representatives. With budget negotiations between the Administration and the Congress continuing, final appropriations for this program are unsettled.

In response to the National Toxicology Program's release of preliminary data from its fluoridation study, the Association's position in support of fluoridation was furnished to all members of the Senate and House Health Appropriations Subcommittees.

Revised Policy on Medicare: Resolution 30H (*Trans.*1989:559) directs that, if legislation is proposed in the Congress to include dental benefits under any part of Medicare, the appropriate Association agencies are to stress to Congress the advantages to subscribers of a dental benefit plan that allows the patient freedom of choice of dentist and provides the dentist with voluntary enrollment and fee-for-service compensation. Resolution 30H further states that, with these provisions, the American Dental Association supports the inclusion of dental benefits in Medicare.

Although two bills are currently in the Congress (HR 139, to amend Title XVIII of the Social Security Act to provide payment for dental services under Part B of Medicare, and HR 207, the Medicare Part C Program Act, providing coverage for certain vision, hearing and dental services and for prescription drugs,) neither bill is expected to advance.

Both bills were referred to the Committee on Ways and Means and the Committee on Energy and Commerce. No hearings have been held or scheduled on either bill in either committee, nor are any anticipated this year.

HR 139 would pay dentists for covered services in the same manner as physicians are paid. It is probable that HR 207 would establish the same payment provisions. Both bills were introduced prior to enactment of the Medicare Physician Payment Reforms late last year.

In accordance with the tenor of Resolution 30H, the Washington Office has made no attempt to encourage Congressional interest in these bills.

A revised Association position paper on "Dental Care for the Elderly" incorporates the advantages to subscribers of a dental benefit plan that allows the patient freedom-of-choice of dentist and that provides the dentist with voluntary enrollment and fee-for-service compensation. This position paper has been furnished to the President's Domestic Policy Council and to all Members of Congress.

Discrimination Based on Degree of Provider: Resolution 55H (*Trans.*1989:562) directs appropriate agencies of the Association to prepare model legislation, and upon request, assist constituent dental societies in the pursuit of legislative and administrative initiatives that may be needed to ensure that all states prohibit discrimination of benefit payments based on the type of license and/or professional degree of the dentist and/or physician.

The Department of State Government Affairs has available a summary, sample laws, a fact sheet and model legislation to assist the constituents to pursue legislative remedies to degree of provider discrimination. The Department has provided materials in response to requests from constituent societies for assistance.

ERISA Amendment on Health Benefit Plans: Resolution 64H (*Trans.*1989:561), through an amendment to Resolution 72H-1982 (*Trans.*1982:550), directs the Association to initiate and actively support an Employee Retirement Income Security Act amendment to assure that beneficiaries of employee health benefit plans have the right to receive health care from the providers of their choice, to prevent plans from discriminating against legally qualified health care providers and to assure the solvency of such plans. The Association has sought amendments to the Employee Retirement Income Security Act to accomplish the purposes delineated in Resolution 64H, for several years. These efforts have been unsuccessful largely due to steadfast opposition from both the business community and organized labor.

In May, in concert with two other national health organizations, the Association entered into an agreement

with a leading political consulting firm to develop a grass-roots campaign involving local business, civic and labor leaders, and directed to a ranking member of the Subcommittee on Labor-Management Relations, House Committee on Education and Labor, in an attempt to demonstrate support for these ERISA amendments in this member's district.

OSHA Hazard Communication Regulation—Requests for Changes to the Regulation and Action on Material Safety Data Sheets (MSDSs): Resolution 95H (*Trans.*1989:569) directs the appropriate agencies of the Association to seek to clarify the existing hazard communication rule or to exempt all dental materials regulated by the Food and Drug Administration (FDA); directs the Association to demand that all manufacturers appropriately label and supply Material Safety Data Sheets for hazardous materials; and directs the Association in the meantime, to compile a library of MSDSs of OSHA-specified hazardous materials to be available to members at cost.

Exemption from the OSHA Hazard Communication rule of all dental materials regulated by the Food and Drug Administration depended on the outcome of a Supreme Court case that was decided on February 21, 1990 (*Dole, Secretary of Labor, et. al. v. United Steelworkers of America, et. al.*) This lawsuit was prompted by the Office of Management and Budget (OMB) having disapproved that portion of the rule exempting certain FDA-regulated materials from its provisions. The Supreme Court held that OMB has no authority under the Paperwork Reduction Act of 1980 to review or countermand OSHA regulations mandating disclosure by regulated entities directly to third parties. As a result, that part of the rule which now exempts from the labeling requirements certain materials regulated by the FDA was upheld. This exemption applies to foods, food additives, color additives, drugs, cosmetics, and medical devices, including materials intended for use as ingredients in such products.

The exemption also applies to the labeling requirements of any drug that is approved by the FDA when it is in solid, final form for direct administration to the patient (i.e., tablets or pills).

With regard to the third directive of Resolution 95H, the Division of Scientific Affairs is in the process of compiling a library of MSDSs of OSHA-specified hazardous dental materials. Over 2,000 MSDSs have already been included in the library, and more are being added continually. These MSDSs will be made available for puchase by members for those MSDSs they are unable to obtain from their manufacturer or supplier.

Support of Child Health and Welfare Legislation: Resolution 89H (*Trans.*1989:562) calls upon the Association to assume, whenever possible, a "pro-active" position on issues of child health and welfare (e.g., hunger, homelessness, drug abuse) and to encourage constituent and component dental societies to actively support this position.

In addition to continuing its support for health measures in the Congress directed to children, or which largely benefit children (e.g., Medicaid eligibility expansion, Early and Periodic Screening, Diagnosis and Treatment improvements, Head Start funding and funding for preventive block grants), the Washington Office, in its liaison with the Children's Defense Fund, a national advocacy organization for child health and welfare, is being kept apprised of legislative activity on the broader issues noted in this resolution.

At its March meeting, the Council noted that Association support for the broader welfare measures addressed in Resolution 89H should be offered to coalitions and advocacy groups after determining that specific legislative measures, which are directed to the welfare of children, or which largely benefit children, are compatible with Association policy. This process of determining Association support parallels the process employed for health legislation.

As of May, the Association has expressed its support for three welfare measures before the Congress: HR 3489, an amendment to the Controlled Substances Act, which would increase the penalties for employment of children in illegal drug transactions; HR 3789, an amendment to the Homeless Assistance Act to extend programs providing urgently needed assistance to the homeless, and S 1965, the Victims of Child Abuse Act of 1989. This latter legislation would require any person who knows or has reasonable cause to believe that a child is an abused or neglected child to report to appropriate authorities, and would provide immunity from liability for having made such report.

Medicaid: Resolution 106H (*Trans.*1989:559) urges constituent dental societies, in cooperation with the Association, to seek as a priority matter uniform benefits, adequacy of payments and voluntary practitioner participation in Medicaid, and then seek expansion of Medicaid benefits for all segments of the indigent population. In addition, this resolution directs the appropriate agencies of the Association to investigate the feasibility of a buy-in system being incorporated into the Medicaid program to fund dental care for the working poor and low-income elderly. Results of this investigation, according to the resolution, are to be reported to the 1990 House of Delegates by the Board of Trustees.

The Department of State Government Affairs has advised the constituent dental societies of this resolution, offering assistance in its implementation and stressing the importance to the oral health of the nation's poor of improving the Medicaid program.

A number of states have made strides recently toward Medicaid equity. For example, Illinois, Nebraska, Ohio and South Dakota won payment increases ranging from 4% to 10%. Maine made some dental services available to adults. Similar efforts are underway in other states. Legislation pending in California would pay long-term care facilities for dental services provided to their Medicaid-eligible residents.

At the federal level, Association representatives requested a meeting with Gail Wilensky, Ph.D., administrator, Health Care Financing Administration, to enlist the support of HCFA in enforcing existing federal Medicaid requirements in the states and seeking uniformity in benefits, improved compensation and greater voluntary practitioner participation in the program nationwide.

Further, with respect to Medicaid policy, the Council, at its March meeting, reviewed Association policy on Medicaid

dental care for the elderly poor, adopted as Resolution 56H-1983 (*Trans.*1983:548), and concluded that, while the Association continues to support the principle of this policy, it should be amended to reflect promotion of dental benefits, rather than their being mandated, in order to be consistent with Resolution 106H. Accordingly, the Council recommends that the following resolution, which amends Resolution 56H-1983 by changing the verb "mandate" to "promote," be adopted:

27. Resolved, that Resolution 56H-1983 (*Trans.*1983:548), Medicaid Dental Care for the Elderly Poor, be amended to read as follows:

> **Resolved,** that the ADA work in concert with support groups for the elderly to lobby for an amendment to the Medicaid program to promote dental benefits for low-income elderly individuals.

In response to the second and third resolving clauses of Resolution 106H, opinions on the feasibility of a buy-in arrangement in Medicaid are being collected from organizations and agencies with a history of interest in the program, and prominently, from the Health Care Financing Administration. This information will be reviewed by the Council at its June meeting, preparatory to advising the Board of Trustees on this subject for the Board's report to the 1990 House of Delegates.

Review of Legislative Policies

At its March meeting, the Council reviewed Association policies on federal and state legislative issues for currency and appropriateness. Policies which the Council deems to be in need of amendment, as well as those it believes should be rescinded, are discussed below.

Insurance Industry Antitrust Exemption: This policy, adopted as Resolution 71H-1985 (*Trans.*1985:605), refers in its text to a bill in the 99th Congress, S 379, the Health Care Cost Containment Act of 1985. This bill would have provided a limited antitrust exemption to allow insurance carriers jointly to acquire and analyze health care information, including cost and fee information, and then to negotiate agreements with providers of care. It was not enacted. The Council recommends that reference to this outdated legislation be deleted from the text of the resolution, but that the statement of opposition to legislation of this kind be retained. Accordingly, the Council recommends adoption of the following resolution:

28. Resolved, that Resolution 71H-1985 (*Trans.*1989:605), Insurance Industry Antitrust Exemption, be amended to read as follows:

> **Resolved,** that the Association strongly opposes legislation that would extend an antitrust exemption to the insurance industry for certain activities including negotiation of agreements between insurers and providers and other information gathering endeavors such as collecting and distributing information on cost and utilization of health care services.

Preferred Provider Legislation: This policy, adopted as Resolution 72H-1983 (*Trans.*1983:583), refers in its text to HR 2956, the Preferred Provider Health Care Act of 1983. This bill would have overridden state laws, restricting the operation of preferred provider organizations (contract dentist organizations). It was not enacted. In the Council's view, reference to this outdated legislation should be deleted from the text of this policy, but the statement of opposition to federal overrides of state insurance laws and other state laws regulating benefit plans should be retained. Therefore, the Council recommends that the following resolution be adopted:

29. Resolved, that Resolution 72H-1983 (*Trans.*1983:583), Preferred Provider Legislation, be amended to read as follows:

> **Resolved,** that all appropriate agencies of the ADA be directed to oppose legislation which would override state insurance or other laws or regulations which prohibit discrimination among beneficiaries of health benefit plans.

Alternative to HMO Programs: This policy, adopted as Resolution 21H-1980, sought to require employers, who offer a health maintenance organization plan only, to offer a conventional health benefit plan as well. This was intended to create a balance in the Health Maintenance Organization Act of 1973, which required employers offering conventional health benefits to offer an HMO option to employees, when certain conditions were met. Interest in the Congress in amending the 1973 law in this way was never generated, for the reason that the law was intended to assist the fledgling HMO in competing with the established conventional programs.

The HMO Amendments of 1988 repealed the requirement upon employers to offer an HMO option, effective October 24, 1995. In light of this amendment, and because of broader Association policies on HMOs (*Trans.*1978:530; 1985:606) adopted more recently, the Council recommends that this policy be rescinded:

30. Resolved, that Resolution 21H-1980 (*Trans.*1980:582), Alternative to HMO Programs, be rescinded.*

Unfair Legislation: For the reasons stated in regard to Resolution 21H-1980, above, the Council supports rescission of Resolution 54-1974-H (*Trans.*1974:686) as proposed by the Council on Dental Care Programs in its annual report (see page 58).

Modification of Keogh Law: This policy, adopted as Resolution 58H-1979 (*Trans.*1979:638), sought authority for self-employed persons to act as trustees for their own approved Keogh Plans, and an increase in the limit on the deferrals for contributions to retirement programs for self-employed individuals and their employees. Both these objectives were attained, although the increases in income deferrals, enacted in the early 1980's, were largely negated by the Tax Reform Act of 1986, which set the limit at $7,000 annually, subject to indexing in subsequent years. Accordingly, the Council recommends that this policy be rescinded:

31. Resolved, that Resolution 58H-1979 (*Trans.*1979:638), Modification of Keogh Law, be rescinded.*

Legislative Delegations: This policy, adopted as Resolution 135H-1977 (*Trans.*1977:950), was superceded by a 1982 policy (*Trans.*1982:550). In addition, a reference to the Public Education Program in the text of this policy is now obsolete. As a consequence, the Council recommends that this policy be rescinded:

32. Resolved, that Resolution 135H-1977 (*Trans.*1977:950), Legislative Delegations, be rescinded.*

Legislation to Improve Dentist Distribution: Because the 1976 House adopted comprehensive policy on the conduct of the National Health Service Corps (*Trans.*1976:849), the Council recommends that a 1974 policy be rescinded as no longer necessary.

33. Resolved, that Resolution 64-1974-H (*Trans.*1974:695), Legislation to Improve Dentist Distribution, be rescinded.*

Advertising of Health Services: This policy, adopted as Resolution 55-1974-H directed the appropriate agencies of the Association to investigate the manner and type of advertising by certain HMOs and to take action to restrict such advertising if it was found to be in violation of federal law. It also called for a strong legal and legislative campaign to stop advertising under the Health Maintenance Organization Act of 1973.

As was reported by legal staff at the 1974 House of Delegates, the U.S. Supreme Court in *United Transportation Union v. State Bar of Michigan* supported the advertising provision of the HMO Act of 1973.

While the agencies of the Association remain alert to advertising by any health entity that is illegal (i.e., false and misleading), the Council concludes that a campaign to prohibit advertising under the HMO Act is not a productive undertaking for the Association. Accordingly, the Council recommends that this policy be rescinded:

34. Resolved, Resolution 55-1974-H (*Trans.*1974:687), Advertising of Health Services, be rescinded.*

Assistance to Victims of Natural Disasters: This policy, adopted as Resolution 29-1970-H (*Trans.*1970:467) supported the Disaster Assistance Act of 1970. Subsequent enactment of the Disaster Relief Act of 1974 largely satisfied the provisions of this policy. The Council recommends that, in light of current federal disaster relief law, this policy be rescinded:

35. Resolved, that Resolution 29-1970-H (*Trans.*1970:467), Assistance to Victims of Natural Disasters, be rescinded.*

Dental Care Under Medicaid: The Council, in reviewing this policy, adopted as Resolution 74H-1983 (*Trans.*1983:584), along with the Inclusion of Dentists in Health Legislation and Programs, adopted as Resolution 44-1971-H (*Trans.*1971:524), concluded that the two policies should be updated and combined into one policy, and therefore recommends adoption of the following resolution:

36. Resolved, that the substance of Resolution 74H-1983 (*Trans.*1983:584), Dental Care Under Medicaid, and Resolution 44-1971-H (*Trans.*1971:524), Inclusion of Dentists in Health Legislation and Programs, be revised to read:

> **Resolved,** that the American Dental Association, through its appropriate agencies, seek to insure that all health legislation and all public and private health care programs that include care of a nature that a dentist is licensed to perform and traditionally renders, include dentists as providers, and be it further
> **Resolved,** that there be no discrimination in the payment schedule or payment provision of covered services or procedures when performed by a licensed dentist, and be it further
> **Resolved,** that Resolution 74H-1983 (*Trans.*1983:584) and Resolution 44-1971-H (*Trans.*1971:524) be rescinded.*

Summary of Resolutions

New Policy/Directive:

26. Resolved, that the American Dental Association recommends that where special remuneration considerations are offered to dental specialties in the Federal Dental Services, all eight ADA-recognized dental specialties be treated equally.

Amendment/Rescission of Current Policies/Directives:

27. Resolved, that Resolution 56H-1983 (*Trans.*1983:548), Medicaid Dental Care for the Elderly Poor, be amended to read as follows:

> **Resolved,** that the ADA work in concert with support groups for the elderly to lobby for an amendment to the Medicaid program to promote dental benefits for low-income elderly individuals.

28. Resolved, that Resolution 71H-1985 (*Trans.*1985:605), Insurance Industry Antitrust Exemption, be amended to read as follows:

> **Resolved,** that the Association strongly opposes legislation that would extend an antitrust exemption to the insurance industry for certain activities including negotiation of agreements between insurers and providers and other information gathering endeavors such as collecting and distributing information on cost and utilization of health care services.

29. Resolved, that Resolution 72H-1983 (*Trans.*1983:583), Preferred Provider Legislation, be amended to read as follows:

> **Resolved,** that all appropriate agencies of the ADA be directed to oppose legislation which would override state insurance or other laws or regulations which prohibit discrimination among beneficiaries of health benefit plans.

***Note:** As the volume of policy being proposed for rescission is significant, this report will only provide the appropriate citations. Copies of the policies to be rescinded will be provided to the House of Delegates prior to its meetings and to all other individuals upon request.

30. Resolved, that Resolution 21H-1980 (*Trans.*1980:582), Alternative to HMO Programs, be rescinded.

31. Resolved, that Resolution 58H-1979 (*Trans.*1979:638), Modification of Keogh Law, be rescinded.

32. Resolved, that Resolution 135H-1977 (*Trans.*1977:950), Legislative Delegations, be rescinded.

33. Resolved, that Resolution 64-1974-H (*Trans.*1974:695), Legislation to Improve Dentist Distribution, be rescinded.

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> **Resolved,** that the American Dental Association, through its appropriate agencies, seek to insure that all health legislation and all public and private health care programs that include care of a nature that a dentist is licensed to perform and traditionally renders, include dentists as providers, and be it further
>
> **Resolved,** that there be no discrimination in the payment schedule or payment provision of covered services or procedures when performed by a licensed dentist, and be it further
>
> **Resolved,** that Resolution 74H-1983 (*Trans.*1983:584) and Resolution 44-1971-H (*Trans.*1971:524) be rescinded.

Notes

Division of Scientific Affairs

Council on Dental Materials, Instruments and Equipment

Council on Dental Research

Council on Dental Therapeutics

American Dental Association Health Foundation

Research Institute

Paffenbarger Research Center at the National Institute of Standards and Technology

Notes

Council on Dental Materials, Instruments and Equipment

Johnson, Glen H., Washington, 1991, chairman
Heymann, Harald O., North Carolina, 1991, vice-chairman
Anusavice, Kenneth, Florida, 1992
Brooks, Sharon L., Michigan, 1993
Donovan, Terence E., California, 1993
Lancione, Raymond R., Pennsylvania, 1991
Moffa, Joseph P., Nevada, 1990
Mohl, Norman D., New York, 1992
Overberger, James E., West Virginia, 1992
Sneed, W. Dan, South Carolina, 1990
Thompson, Van P., Maryland, 1990
Stanford, John W., secretary
Fan, P. L., associate secretary
Schoenfeld, Charles M., assistant secretary
Wozniak, Wayne T., manager, Council laboratories

Meetings: The Council met on November 27-28, and on May 9-11, 1990. Dr. John V. Hinterman, Trustee, Ninth District, attended portions of the November 1989 and May 1990 Council meetings. An Open Session of the Council was held on May 9, 1990 with representatives of dental industry and other interested parties present. Liaison representatives of the Center for Devices and Radiological Health, Food and Drug Administration (FDA), the National Institute of Dental Research (NIDR), the National Institute of Standards and Technology (NIST), and the Centers for Disease Control (CDC) were present for one or both meetings. Dr. Glen H. Johnson was appointed chairman and Dr. Harald O. Heymann was elected vice chairman of the Council for 1990.

Liaison Activities: Consultants and staff of the Council participated in meetings with the following: American Association of Orthodontists, Association for the Advancement of Medical Instrumentation, American Pharmaceutical Association, American Academy of Dental Radiology, National Council for Radiation Protection and Measurements—Scientific Committee No. 16, American Society for Testing and Materials, International Association for Dental Research—Dental Materials Group (IADR), American National Standards Institute (ANSI), European Committee for Standardization, International Organization for Standardization (ISO), Féderation Dentaire Internationale (FDI), Food and Drug Administration, Occupational Safety and Health Administration (OSHA), National Institute for Occupational Safety and Health (NIOSH), Environmental Protection Agency (EPA), National Institute of Dental Research (NIDR) and the World Health Organization (WHO).

Personnel: Dr. J. W. Stanford was nominated to the List of Honor of the FDI and as Chairman of ISO/TC106, Dentistry. Dr. P. L. Fan was elected a member of the FDI's Commission on Dental Products.

Conferences: Council members and/or staff participated in the following conferences or workshops:

—American National Standards Institute. Public conference on standardization in the 90s: success in a global market. Washington, D.C.
—Council sponsored. Criteria for in vitro evaluation of posterior composites. Chicago.
—Northwest Center for Occupational Health and Safety, University of Washington, Occupational hazards to health care workers. Seattle.
—National Institute of Occupational Safety and Health, Workshop on AIDS and personal protective equipment. Seattle.
—Engineering Foundation. Dental biomaterials: assessment of performance based on engineering and statistical methods. Santa Barbara.
—American Association of Orthodontists. Ceramic bracket workshop. St. Louis.
—American Dental Trade Association's 107th Annual Meeting. Maui.

The Council Secretary served on a program committee for the First World Congress on Health Technology Standards, sponsored by the International Organization for Standardization and the International Electrotechnical Commission, held on August 27-29, 1990 in Dublin, Ireland. A Workshop entitled "Development in Dental Products" was held during the World Congress.

Grants: At the request of the NIDR, a proposal was submitted for a symposium on "Esthetic Restorative Materials," to be held on May 8-10, 1991. A shared instrumentation grant of $169,668 was funded by the NIH to purchase a new Instron servohydraulic test system for testing products as well as for research purposes. In addition, a small instrument grant of $10,166 was received from NIH.

Responses to Assignments from the 1989 House of Delegates:

Proposal to Reconvene ADA Task Force on the Biocompatibility of Dental Materials. A review of literature published and conferences held since the Association-sponsored 1984 Workshop on Biocompatibility of Metals in Dentistry was expanded to cover all dental products as directed by Resolution 76H (*Trans.* 1989:571). At this time there appears to be insufficient new information to warrant

recommending a workshop in the near future. The current status was best summarized by Bergman in an article entitled, "Side-effects of amalgam and its alternatives: local, systemic and environmental," (Int Dent J 1990; 40:4.):

> It is clearly established that dental restorative materials, like all other foreign materials introduced into the human body, may cause pathological changes both local and general in type. However, in a proper evaluation of the side-effects occurring, their type, severity and frequency have to be considered. Local side-effects of dental restorative materials on oral mucosa are of either irritative or allergic nature while systemic effects are mainly due to allergic and other kinds of hypersensitivity reactions. Most side-effects of dental restorative materials seem to be insignificant and of short duration, although systemic hypersensitivity reactions may be most harmful to those affected. Although the frequency of side-effects seems to be low in comparison with the vast number of restorations that are placed, it is reasonable to assume that the more complex and diverse application of an increasing number of dental materials will increase the frequency.

Furthermore, a consensus conference on dental amalgam is being considered by the NIH for 1991. This may be expanded to cover other materials. Therefore, it does not appear that any new information would be brought forward by an Association-sponsored workshop.

The Council is continuing its national as well as international activities in establishing and revising "Recommended Standard Practices for Biological Evaluation of Dental Materials." Three documents with the foregoing title are currently being used by industry in submitting products to the Council for evaluation. They are ANSI/ADA Document No. 41, FDI Technical Report No. 9 and ISO/TR 7405. Therefore, all submitted products are being screened at the present time for any possible biocompatibility problem.

Resolution 95H, Material Safety Data Sheets. Requests were sent to 578 dental manufacturers to obtain Material Safety Data Sheets (MSDSs) in order to comply with Resolution 95H (*Trans.*1989:569) calling for a compilation or library of MSDSs. At this time, over 70% of the manufacturers have responded with more than 3,000 MSDSs. It is anticipated that the library, when complete, will total approximately 4,000. The *ADA News* will carry instructions on how to obtain MSDSs from the library and what the costs will be. It is anticipated that requests will begin to be filled by September 1990.

Waste Disposal. Council staff met with representatives of the American Dental Trade Association and Dental Manufacturers of America to urge their members to utilize biodegradable or recyclable packaging and packing materials whenever possible in accordance with Resolution 98H-1989 (*Trans.*1989:571). A letter was sent to each participant in Council programs alerting them to the resolution and the desire of the profession to reduce the problems of solid waste disposal. Respondents have indicated a desire to cooperate, and changes have already been made by several companies. In addition, the Council requested Accredited Standards Committee MD156 to establish an ad hoc group to review Association specifications and standards for all packaging and marking requirements to ensure that they do not prohibit the use of biodegradable or recyclable packaging.

Mercury and Dental Amalgam: The Council continues to respond to inquiries on the use of mercury in dentistry and to assist in the preparation of printed information on the safety and use of dental amalgam. The Council provided technical assistance to constituent societies to deal with amalgam issues including mercury in waste water.

Waste Disposal: The Council continues to work with manufacturers of radiographic chemicals to evaluate the amounts of silver in waste water, as well as to provide information on disposal of wastes from dental offices.

Infection Control: The Council cooperated with other Association agencies in preparing comments on government regulations and responding to inquiries and in the production of *The American Dental Association Regulatory Compliance Manual.*

Standardization Activities: The Council acts as Administrative Sponsor and Secretariat of the national and international voluntary standardization programs in dentistry. The Council monitors federal programs affecting standardization activities.

Accredited Standards Committee MD156. Activities of this Council-sponsored committee were conducted by 49 subcommittees working on the development or revision of 85 specifications. This committee is the only group in the United States accredited by ANSI to develop standards for dentistry. Standards are submitted to ANSI for approval as American National Standards when completed and are approved by the Council as American Dental Association specifications. During this reporting period, development of two new standards, revision of one existing standard and reaffirmation of 12 standards were completed. Work programs were initiated for magnets and keepers for intraoral and extraoral retainers for prosthetic use, combined reversible/irreversible hydrocolloid impression materials, indicator pastes, panoramic X-ray equipment, prophy angles, interligamentary and perio-syringes, impression trays and dental brazing alloys. ASC MD156 met on March 7, 1990 in Cincinnati with over 90 persons in attendance. In addition, meetings of 18 subcommittees of ASC MD156 were held during the IADR meeting week.

Coordination between the activities of the ISO and the ASC MD156 continues. Subcommittees review all corresponding ISO standards for possible adoption as American National Standards. The United States also submits American National Standards to the ISO for adoption as international standards. The European Economic Community has agreed to consider adopting ISO standards in the dental field, which lends added importance to the development of standards in the United States. A strong participation in ISO activities by the United States will assure high quality of products sold worldwide.

The Council wishes to express its appreciation to the nearly 600 volunteers participating in the activities of ASC MD156. These include participants from over 200 dental

companies, 36 schools, government agencies, and members of the profession. Volunteers participate in activities at their own expense. The Council also gratefully acknowledges the continued support of NIDR in the development of test methodology to properly evaluate dental products.

International Standards Organization/Technical Committee 106: The Association, through CDMIE, sponsors participation of the United States in ISO/TC106, Dentistry. The Council also acts as Secretariat of ISO/TC106 Subcommittee 2, Prosthodontic Materials. Members of the U.S. committee voted for seven Draft International Standards, 12 Draft Proposals, and reaffirmation of eight International Standards. The ISO published five dental standards, which were approved by the ISO Council during this reporting period. Over 30 delegates of the United States attended the meeting of ISO/TC106 in Rotterdam, Netherlands from September 11-16, 1989.

Evaluation Programs: The Council has three evaluation programs—Certification, Acceptance and Recognition.

Certification Program. Since May 1989, 41 new products have been added to the list of certified materials, instruments and equipment, which now includes over 900 products. Because of the revision of four specifications, 118 products are in the process of recertification. A total of 57 products are being reevaluated to verify continued compliance with the appropriate specification.

Acceptance Program. The Council currently has developed submission guidelines to cover 40 product areas. In 1990 and 1991, the Council will be considering six additional generic areas for inclusion in this evaluation program. Twenty three products were evaluated and 16 were classified as Acceptable or Provisionally Acceptable since May 1989. Renewals of classification were completed for 43 products. Over 300 products are now included in the Acceptance Program.

Recognition Program. The Council is phasing out the Recognition program which covers products currently not covered by a specification for the Certification program or specific guidelines for the Acceptance Program. Programs for three product areas have been or will be transferred by the end of 1990 to either the Certification or Acceptance Programs. Thirty seven new products were evaluated and 31 were recognized since May 1989. Renewals of recognition were completed for six products. Over 100 products are now included in the Recognition Program.

Applied and Basic Research Programs: Research was conducted on susceptibility of porcelains to staining when exposed to acidulated phosphate fluoride gels, visible light curing units, dentin bonding agents, investment materials/or titanium castings and fiber reinforced polymeric materials. Projects on developing national and international standards an collaborative research with the World Health Organization were also continued in the Council laboratory.

Council Position Statement on Instruments as Aids in Diagnosis and Treatment of Temporomandibular Disorders: The Council in May 1989 adopted a position statement on instruments as aids in the diagnosis and treatment of temporomandibular disorders (TMD), which recommends that further objective scientific studies be conducted to define clearly the role of such instrumentation.

Status Reports: Updates on safety of amalgam and the status of posterior composite resins were published. Reports approved and awaiting publication include the Council's position statement on instruments promoted as aids in diagnosis and treatment of TMD, vinyl polysiloxane impression materials, glass ionomers and porcelain repair materials.

Complaint Reporting Program: Forty-two complaints were processed under this program. Most regarded nondelivery and refunds. Technically related complaints were resolved with the cooperation of manufacturers.

Other Activities: Service to the members of the Association continued with responses to inquiries for information and recommendations concerning safe and effective products and techniques in dentistry. Meetings were held with over 40 different companies regarding submission of products and review of advertising. Approximately 600 pieces of advertising copy were reviewed. All industrial exhibits were reviewed for eligibility of products prior to the opening of the 1989 annual session in Honolulu.

Published and Other Reports: There were ten publications by Council and staff during the reporting period. In addition, eight Bulletins were prepared, and five research reports were presented at the 1990 meeting of the IADR. The list of standards, status reports, information and/or original research reports follows:

1. Obstacles to the development of a standard for posterior composite resins. JADA 1989; 118:649.
2. Safety of dental amalgam—an update. JADA 1989; 119:204.
3. ANSI/ADA Specification No. 66 for dental glass ionomer cements. JADA 1989; 119:205.
4. Fan PL, McGill SL. How much waste do dentists generate? CDAJ 1989; 17:39.
5. Mueller HJ. Electrochemical change and protein adsorption. Biomed Mat Dev 1989; 110:605.
6. Mueller HJ. Corrosion and calorimetry of MS copper-aluminum dental restorative alloy. Corrosion 1989; 45:735.
7. Mueller HJ. Microscopy analysis of dental titanium casting investment materials. Scan Microsc 1989 33:837.
8. Mueller HJ. Fracture toughness of metal particulate and carbon fiber reinforced glass ionomers and carboxylate. Trans Acad Dent Mater 1990; 3:26.
9. Mueller HJ. Short rod fracture toughness of dental ceramics, lining, build-up, and filling materials. Trans Soc Biomater 1990; 256.
10. Stanford JW. The European Economic Community 1992 with harmonized standards and regulations. What is the U.S. dental community's role? ADTA Update 1990; 4-7.

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

Council on Dental Research

Genco, Robert J., New York, 1990, chairman
Anderson, Allen W., Illinois, 1992
Barkmeier, Wayne W., Nebraska, 1990
Crout, Richard J., West Virginia, 1991
Dahl, Eva C., Wisconsin, 1993
Greenspan, John S., California, 1990
Mandel, Irwin D., New York, 1990
Morgan, Warren A., Massachusetts, 1992
Nabers, Claude, Texas, 1990
Page, Roy C., Washington, 1993
Picozzi, Anthony, New Jersey, 1991
Verrusio, A. Carl, secretary

Meetings: The Council met at the Headquarters Building on September 28-29, 1989 and February 5-6, 1990. In addition to Council members and Association staff, the following were present at the meetings: Dr. Preston A. Littleton, Jr., deputy director, National Institute of Dental Research (NIDR), Dr. Lois K. Cohen, currently director, Extramural Program, NIDR; Dr. John A. Gray, executive director, American Association for Dental Research (AADR); Dr. Alex McDonald, research consultant for the American Student Dental Association (ASDA); Dr. Robert Klaus, executive director, American Fund for Dental Health; and Dr. William R. Maas, oral health services research director, Agency for Health Care Policy and Research.

Preparation of Congressional Testimony in Support of the 1991 National Institute of Dental Research Budget: The Council reviewed NIDR's 1990 and 1991 budgets with Dr. Littleton, Dr. Cohen and Dr. Gray. The Council was informed that the NIDR budget for 1990 will be $135.5 million. This represents a 3.6% increase over the 1989 appropriation ($130.8 million) and will make necessary downward negotiations of 12% for existing research grants, 15% for new grants and 12% for research centers. The number of new grants funded in 1989 decreased from 109 to 90. The expectation that less than 20% of approved grants will be funded this year may have a negative impact on present and future young investigators.

The National Institutes of Health (NIH) tried again to eliminate the Biomedical Research Support Grant program; however, Congress restored funding for these grants. It is unlikely that Congress will continue to rescue this program if NIH does not support it.

The Council considered the budget being proposed for NIDR in 1991 by the National Affairs Committee of AADR and decided to support the same level of funding, approximately $200 million. In its Congressional testimony, the Association will highlight the plight of the young researcher and request $7.5 million to support newly graduated dental researchers. It will continue to support long-term emphasis on the "Research and Action Program for Improving the Oral Health of Adults and Older Americans" until tooth loss is eliminated in the United States.

Dental Students Conference on Research: The 26th Annual Dental Students Conference on Research was held on April 1-3, 1990 in San Francisco, California, at the School of Dentistry of the University of California at San Francisco (UCSF). Approximately 75 students, representing about 55 dental schools in the United States, Canada and Puerto Rico, attended the conference.

Students met scientists, clinicians, dental educators and administrators from the university, industry and the federal government in an informal atmosphere and learned not only about the wide variety of careers available in dental research but about the many areas of research under investigation by the faculty at UCSF. Research topics discussed included health effects of smokeless tobacco, biological characteristics of calcified tissue, prostaglandins and tooth movement, induced osteogenesis in maxillofacial reconstruction, bone density analysis by computed tomography, temporomandibular joint issues and AIDS. Dr. John Greenspan, head, Department of Stomatology, UCSF, spoke on AIDS and dental research and moderated a panel discussion on dentistry, health care and AIDS. The conference ended with a tour of the dental school and an opportunity for students to visit many of the investigators in their research laboratories.

The Council wishes to express its sincere appreciation to Drs. Robert Boyd and John Knapp for organizing the program, the entire faculty of the School of Dentistry for their enthusiastic participation, the dean, Dr. John C. Greene, for his gracious hospitality and Dr. Greenspan for his stimulating keynote address, "AIDS and Dental Research: The Springboard of Adversity." The Council also wishes to thank the late Dr. Norton M. Ross and the Warner-Lambert Company for their continued support of this important student program.

Fluoridation Issues: At its September 1989 meeting, the Council discussed extensively the issue of resurgence of antifluoridationist activities in the United States. It was felt that, based upon several published articles which were at best misleading and which unfairly questioned water fluoridation, a potentially serious situation exists where the continuation of water fluoridation is challenged. Therefore, the Council agreed on the following actions, which are to be carried out in collaboration with other agencies of the Association responsible for fluoride issues, i.e., the Council on Community Health, Hospital, Institutional and Medical Affairs (CCHHIMA) and the Division of Communications.

—An interagency meeting on fluoride concerns with a two-stage agenda was held. The first stage considered the responses to the commonly asked questions on fluoride safety and efficacy. The second

stage was to develop appropriate strategies for communicating the revised information to the public and the profession expeditiously.

—A "state of the science" review should be prepared for publication in *JADA*. The Council suggested that Dr. Carl Verrusio write the review and use as a basic source the recently completed paper by the New York State Department of Health entitled "Fluoride: Benefits and Risks of Exposure."

—A strategic session for communicating fluoride information should be held soon after the interagency meeting and should include a consultant in risk assessment communications as well as staff from the Division of Communications and public information staff from NIDR and the Centers for Disease Control (CDC). The Council urges the committee to act quickly and to take the lead in the dissemination of information to counter the active antifluoridation campaign catalyzed by the article in *Chemical and Engineering News*.

—The research agenda of the *NIDR Long-Range Research Plan for the Nineties* should serve as the basic guideline for fluoride research. The Council urges, however, that high priority be given to: (1) a national epidemiologic study of fluorosis, as well as future monitoring and (2) a national fluoride intake study of dietary and nondietary fluorides to supplement the recent New York State study. Funding for these studies should be provided by an NIDR/industry collaboration.

At the February 5-6, 1990 meeting of the Council, representatives from the NIDR, the AADR, and staff from the Division of Scientific Affairs and CCHHIMA continued their discussion of the fluoride issues and made the following recommendation to the Board.

> The Council reaffirms its continued support of the public health benefits of water fluoridation and the validity of the broad scientific base for both safety and efficacy developed over the last 40 years. However, the Council also favors ongoing research and monitoring in this area. Association support and public advocacy of fluoridation should be contingent not only on the long-term human historical data in naturally occurring and fluoridated areas, but on scientific research as well. The Council applauds the effort of the Association to more effectively coordinate its fluoride activities within the organization and to increase the dissemination of information to the profession and to the public.

A resolution was passed by the Council to sponsor with AADR and AADS a special symposium on the National Toxicology Program (NTP) study at the AADR Meeting in March 1990. Dr. Mandel assisted Dr. Gray in organizing the session. The program included presentations on the NTP study, the public health and epidemiologic perspectives, public perception and professional communication.

Scientists from The Procter & Gamble Company (P & G) have shared the data from a rodent study at the Hazelton Laboratories of America commissioned by P & G. This study, on rats and mice consuming diets containing large doses of fluoride, closely parallels the NTP study in design but not in results and will be submitted to the NTP.

Also in March, CCHHIMA and CDR responded to requests from the Environmental Protection Agency, NTP, and the Public Health Service for scientific literature on the safety and effectiveness of water fluoridation.

Health Screening Program: Since 1964, dentists attending the Association's annual sessions have been offered a free health screening. The Health Screening Program (HSP) has two objectives: (1) to make individual dentists aware of their own health status and encourage complete physical examinations on a regular basis and (2) to collect data on the health and disease patterns of the profession.

In 1989, the following tests or examinations were available to participants: audiology examination, blood pressure, weight, clinical blood chemistry, cholesterol testing, including high and low density lipoproteins, hepatitis B virus surface antigen and antibody markers, HIV antibody screening, organic mercury concentration, podiatric examination, resting electrocardiogram, urinary mercury concentration and head, neck and soft tissue examination.

The 25th annual HSP held in Honolulu last November was the largest in the program's history. Over 1,650 U.S. and foreign dentists participated. Some noteworthy findings follow.

—The HSP demonstrated an encouraging trend in the acceptance of the hepatitis B vaccine among dental professionals, Nearly 71% of the dentists had been inoculated against hepatitis B. This is a 14% increase over the number vaccinated in 1988.

—Urinary mercury concentrations were determined on site for 1,253 dentists. The results appear in the report of the Department of Chemistry, ADAHF Research Institute.

—For the second year, audiology screening was provided; the data are currently under analysis.

—Electrocardiograms were recorded from over 1,100 members; cardiologists were available to interpret the results. Each dentist received a laminated card showing his/her electrocardiogram.

—Head, neck and oral examinations were carried out on 828 dentists by dentists from the Department of Veterans Affairs. A total of 94 abnormalities were noted, and approximately 59 of these were deemed to be significant. These dentists will be contacted to learn if they sought treatment.

—For the third successive year, anonymous testing for the antibody to the human immunodeficiency virus was performed on 1,481 samples. The results of the 1989 screening are reported in the report of the Department of Toxicology, ADAHF Research Institute.

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

Council on Dental Therapeutics

Joy, Edwin D., Jr., Georgia, 1990, chairman
Olson, Robert A. J., Iowa, 1990, vice-chairman
Barrington, Erwin P., Illinois, 1991
Cassingham, R. Jack, Louisiana, 1993
Fiegal, Robert J., Minnesota, 1993
Ferrillo, Patrick J., Jr., Illinois, 1992
Gage, Tommy W., Texas, 1990
Gherardi, Robert J., New Mexico, 1991
Terezhalmy, Geza T., Ohio, 1992
Trummel, Clarence L., Connecticut, 1991
Van Hassel, Henry J., Oregon, 1992
Burrell, Kenneth H., secretary
Langan, Dan C., assistant secretary
Whall, Clifford W., assistant secretary

Meetings: The Council met in the Headquarters Building on October 3-4, 1989 and April 17-18, 1990, with all members in attendance. Dr. Jack S. Opinsky, First District trustee, attended the October 1989 meeting and Dr. Richard W. D'Eustachio, Fourth District trustee, attended the April meeting.

At its October meeting, the Council concluded that manufacturers of teeth whiteners need to conduct long-term safety studies in order to assess possible soft tissue damage, pulpal damage and carcinogenic effect of these agents before they can be considered for evaluation by the Council.

A report on antibiotic prophylaxis for dental patients with prosthetic joints was approved at the April meeting. This report is the result of a workshop sponsored by the Council in November 1987 at which infectious disease experts and orthopedic surgeons examined all relevant data and concluded that there were no acceptable studies linking dental treatment and the development of prosthetic joint infections. Based on this conclusion, the Council recommended in its report that dentists should consult with the patient's orthopedic surgeon on the advisability of antibiotic premedication prior to dental treatment.

A special meeting was held in June to consider the issue of whether sodium fluoride dentifrice is superior to sodium monofluorophosphate dentifrice in the prevention of caries. After reviewing the data, the Council concluded that there was insufficient data to demonstrate the superiority of sodium fluoride in reducing caries and denied the use of a superiority claim for dentifrices with sodium fluoride.

The Council classifies its 598 currently accepted products in 44 categories, which cover a broad spectrum of dental applications. During the past year, the Council accomplished the following:

—accepted 54 therapeutic agents for the first time;
—reaccepted 79 therapeutic agents;
—denied acceptance for 13 products;
—removed seven agents from the program because they are no longer manufactured;
—took action on 17 revisions of labeling and/or package inserts; and
—took action on four reformulations of currently accepted preparations

Council staff members processed approximately 300 formal inquiries from manufacturers concerning evaluation of new products and answered several hundred questions from the profession, the media and the public about the evaluation process and accepted products.

Liaison Activities: The Council continued its involvement in the Federation Dentaire Internationale (FDI). Council staff served as consultants to two working groups of the FDI's Commission on Dental Products and reviewed the FDI draft document, *Drugs in Sports,* and an FDI/ISO joint working group report on toothpastes.

The Council continued liaison activities with the Drug Enforcement Administration (DEA), especially regarding the prescribing of controlled substances by dentists.

The Council collaborated with the Department of Veterans Affairs, Centers for Disease Control (CDC), National Institute of Dental Research (NIDR), and the Food and Drug Administration (FDA) to produce three instructional videotapes and an accompanying manual on infection control, *Infection Control in the Dental Environment,* which became available in September 1989. This videotape program can be used by dentists to fulfill Occupational Safety and Health Administration's (OSHA) requirement that all dental office staff receive training on infection control.

Council staff made a presentation on the role of organized dentistry in promoting ethics and equity of care for persons with HIV infection or acquired immune deficiency syndrome (AIDS) at the October meeting of the American Public Health Association. In addition, Council staff members served on the Midwest AIDS Training and Education Center's Coordinating Council and the Professional Liaison Committee of the East Central AIDS Education and Training Center, providing guidance and information to the centers on the AIDS education needs of dental professionals.

Interagency Activities: The Council assisted in the preparation of the Association's comments on the OSHA's proposed regulation on occupational exposure to bloodborne pathogens. Extensive scientific and cost analyses of the regulation were performed. Council staff also testified before the Education and Labor Committee, Health and Safety Subcommittee, on the proposed regulation.

The Council played an integral role in the preparation of a step-by-step manual to assist dentists in complying with OSHA and EPA regulations. *The American Dental Association Regulatory Compliance Manual* is divided into four major sections: general information for dentist-employers; OSHA infection control regulations; the OSHA Hazard Communication Standard; and regulations concerning the handling and disposal of medical wastes. Purchasers of the manual will be provided information about changes in the regulations and laws on a semiannual basis until December 31, 1992.

A monograph on *Safety and Infection Control in the Dental Office* was published by the Council. The monograph provides detailed information on safety in the dental office, infection control recommendations, sterilization and disinfection and topical antiseptics.

The Council staff has been instrumental in responding to requests from the membership for information on OSHA and EPA regulations and to numerous inquiries on infection control, AIDS, hepatitis B vaccines and chemical agents for disinfection.

Regulations on medical waste were reviewed and an article was written for the *ADA News*. Staff also met with several waste management companies to obtain information for the membership on medical waste disposal services.

A joint report on the safety of dental amalgam was developed with the Council on Dental Materials, Instruments and Equipment and published in *The Journal*. Council staff also participated in the preparation of an article to assist dentists in answering questions from patients on mercury and amalgam published in the April issue of *The Journal*.

Response to Assignment from the 1989 House of Delegates:

Provisions for Acceptance. The Council has amended the provisions of the ADA Seal Program as outlined in Resolution 29H (*Trans*:1989:569).

Publications: The following reports or news stories were published since the last annual report.

1. Council on Dental Therapeutics and Council on Dental Materials, Instruments and Equipment. Safety of dental amalgam—an update. JADA 1989;119:204-5.
2. American Dental Association regulatory compliance manual. February 1990.
3. Department of Veterans Affairs, American Dental Association and Department of Health and Human Services. Infection control in the dental environment. Video and training manual. September 1989.
4. Infectious waste disposal in the dental office. Q & A. ADA News 1989;20(15) (insert).
5. Whitening agents trigger calls. ADA News 1989;20(12): 23.
6. Host of new whiteners floods market. ADA News 1989;20(18): 1.
7. Council on Dental Therapeutics, Council on Dental Materials, Instruments and Equipment. Monograph series on dental materials and therapeutics. Safety and infection control in the dental office. I., 1990.
8. Divisions of Communications and Scientific Affairs, and Department of State Government Affairs. When your patients ask about mercury in amalgam. JADA 1990;120:395-8.

Amendments to "Provisions for Acceptance": This year the Council reviewed the "Provisions for Acceptance of Products by the Council on Dental Therapeutics," and in light of current activities, the Council wishes to recommend adoption of the following amendments.

In order to clarify the Council's purpose, the Council recommends a general revision of the "Purpose" section to highlight its review of the safety and efficacy of products and claims made about them. In regard to classifications of acceptance, the Council believes that a product should either be accepted or not accepted. Therefore, the Council recommends that the provisional acceptance classification be eliminated and the "Provisions for Acceptance of Products" section be amended by deleting all references to that classification.

Reference to withdrawal of acceptance should be consolidated in one section, so the Council recommends that VI.E. Reference to Council Acceptance be deleted from the section on "General Provisions for Acceptance." In regard to withdrawal of acceptance, the Council wishes to include as grounds for withdrawal violations of contracts the Council may have with the product's manufacturer or distributor concerning the terms of acceptance. Also, the Council recommends replacement of the provision on Reference to Council Acceptance (II) under this section on "Withdrawal of Acceptance." The new provision would give the Council needed flexibility to shorten the period (usually six months) for withdrawing existing product labeling in special circumstances.

The Council recommends adoption of the following resolution to implement these changes in the "Provisions for Acceptance of Products by the Council on Dental Therapeutics."

Summary of Resolutions

Amendment/Rescission of Current Policy:

37. Resolved, that "Provisions for Acceptance of Products by the Council on Dental Therapeutics" (*Trans.*1966:333; 1968:263; 1972:643; 1975:744; 1983:554; 1984:533; 1986:534; 1987:482; 1989:569) be amended so the section entitled "Purpose of the Council" reads as follows:

> Under the *Bylaws* of the American Dental Association, the Council on Dental Therapeutics studies, evaluates and disseminates information with regard to: the safety, efficacy, promotional claims, and proper use of dental therapeutic agents, their adjuncts and dental cosmetic agents used by the public or profession; and aspects of the dental practice environment related to the health of dentists, dental auxiliaries and the public.

> Additionally, the Council maintains liaison with related regulatory, research and professional organizations, and encourages, establishes and supports research in the field of dental therapeutics.

and be it further
Resolved, that provisional acceptance no longer be awarded by the Council on Dental Therapeutics and accordingly all reference to provisional acceptance be deleted from "Provisions for Acceptance of Products by the Council on Dental Therapeutics" as follows:

- In the section entitled "Classification of Products Evaluated by the Council," the words "provisionally accepted" are deleted from the fourth paragraph, and the sixth and seventh paragraphs are deleted in their entirety.
- In the section entitled "General Provisions for Acceptance," the words "or provisionally accepted" are deleted from subpart B of I. Composition.
- In the section entitled "Provisions for Acceptance in Special Categories," the words "or provisionally accepted" are deleted from subpart C of I. Fixed Combination Drug.

and be it further
Resolved, that the said "Provisions" be amended by deleting from the section entitled "General Provisions for Acceptance" subpart E of VI. Reference to Council Acceptance, which reads as follows:

> E. In the event that a product is no longer acceptable to the Council, all use of the Seal of Acceptance and/or an authorized statement in connection with the product must be discontinued within six months of written notification of acceptance withdrawal.

and be it further
Resolved, that the said "Provisions" be amended by deleting from the section entitled "Withdrawal of Acceptance" the second paragraph of I. Conditions for Withdrawal, and substituting in its place a new second paragraph to read as follows:

> Any violation of these "Provisions for Acceptance," the "Advertising Standards of the American Dental Association," the Council "Rules for Use of the Seal of Acceptance," and/or individual contracts between the American Dental Association and product distributors/ manufacturers will also be considered grounds for Council withdrawal of product acceptance. Further, any such violation during the period between notification of Council recognition of product safety and efficacy and approval of labeling, package inserts, advertising and other promotional material will be considered grounds for Council denial of product acceptance.

and be it further
Resolved, that the said "Provisions" be amended by deleting from the section entitled "Withdrawal of Acceptance" the text of II. Reference to Council Acceptance, and substituting in its place a new paragraph to read as follows:

> In the event that Council acceptance of a product is withdrawn, the Council may, at its election, immediately terminate or suspend without prejudice to any other rights which the Council may have the company's right to display the Seal of Acceptance and any Council-approved statement, and/or to refer to any manner whatsoever to Council acceptance in any labeling, package inserts, advertising or other promotional material, or other display of the product. Ordinarily, the company will have six months from the date of such withdrawal to use existing labeling, package inserts or similar supplies, but the Council reserves the right to require a shorter time-frame for removal of the Seal and any Council-approved statement from such existing supplies if necessary from the standpoint of safety and efficacy of the product or if the reason for termination is company's misuse of the Seal of Acceptance or a Council-approved statement.

American Dental Association Health Foundation

Overbey, R. Malcolm, president
Truono, Eugene J., president-elect and treasurer
Grothaus, Bernard J., first vice-president
Nolen, John G., second vice-president
Rainwater, Gary, speaker, House of Delegates
Ginley, Thomas J., secretary
Neidle, Enid A., director
Schaid, Rodney J., director of administration

Meetings: The Board of Directors of the American Dental Association Health Foundation (ADAHF) met in August 1989. The meeting of the Board of Directors was held in conjunction with the session of the Board of Trustees of the American Dental Association.

The Health Screening Program is supported in part by the American Fund for Dental Health and by corporate sponsors from the dental industry. Recently, contributions in excess of $80,000 have been received annually by the ADAHF for support of this annual session program. Approximately 30,000 dentists have participated in the program over the last 25 years. The Division of Scientific Affairs offers this program at no charge to the dentists attending the annual session. Similar screening programs offered to the public cost between $50 to $100.

The Biomedical Research Support Grant Program of the Division of Research Resources, National Institutes of Health (NIH) was started in 1962. Since 1968, when policy changes allowed research organizations such as the ADAHF to participate in the program, awards to the Foundation have totaled $1,026,240. These monies are used to make internal awards to the research staff. A total of 156 awards in five major categories of dental research have been made during the last 20 years. The most recent federal grant was for $33,718.

Administrative and Financial Activities: The two research branches of the ADAHF are the Research Institute in the Chicago Headquarters Building and the Paffenbarger Research Center (PRC) at the National Institute of Standards and Technology (NIST) in Gaithersburg, Maryland. The Extramural Programs comprise additional research activities not designated for either of these branches. The program permits corporate monies and other awards and gifts to the ADAHF to be held separately from other research program funds. Thus, the ADAHF establishes, monitors and otherwise manages the fiscal aspects of many programs of the Association as well as the Foundation.

Sponsored Programs and Activities: During the reporting period the Foundation received a total of $2,258,539, slightly more than the $2,246,329 reported last year. The various projects under Extramural Programs are shown in Table 1. Grants from federal sources totaled $408,342 whereas corporate sources provided $382,548. A total of $1,411,076 from federal agencies is provided to PRC which also derives financial benefits from the space and facilities provided by the NIST. The remainder of its support comes from Association funds. The specific projects, and the level of their support, are shown in Table 2. Corporate-funded activities in the Research Institute totaling $50,905 are shown in Table 3.

An analysis of the Foundation's research activities shows that although the overall receipts increased only 0.5% in one year, the emphasis has shifted away from corporate grants (at $438,453 down 49.8% from the $872,934 received last year) to federally funded programs (at $1,819,418 for an increase of 32.5% over last year). It is important to note that the research programs initiated during the last 12 months at the PRC will continue for a minimum of 5 years, thus assuring the trend to more federal support. The awarded indirect costs (overhead) increased during the reporting period to $557,670, for an increase of 20.2% over last year.

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

Table 1: Extramural Programs

AWARD DATE	PRINCIPAL INVESTIGATOR	TITLE	GRANT/CONTRACT NO.	CENTER NO.	SPONSOR	TOTAL DIRECT COSTS	TOTAL INDIRECT COSTS	TOTAL ALLOWABLE COSTS
08/18/89	STANFORD	SMALL INSTRUMENTATION PROGRAM	1 S15 DE 09282-01	5-15-15-06	NIDR	10,166	0	10,166
05/01/90	STANFORD	INSTRON SERVOHYDRAULIC TEST SYSTEM	1 S10 RR 05865-01	5-15-15-07	DRR/NIH	169,000	0	169,000
06/30/89	NADLER	CAPACITY BUILDING IN DENTISTRY FOR MONITORING DISCIPLINARY ACTIONS	240-89-0018	5-15-20-02	HRSA/DHHS	137,935	57,523	195,458
03/29/90	VERRUSIO	BIOMEDICAL RESEARCH SUPPORT GRANT	2 SO7 RR 05689-22	5-25-22-XX	DRR/NIH	33,718	0	33,718
VARIOUS	STANFORD	FDI OPEN SESSION	---	7-15-15-01	INDUSTRY	6,008	0	6,008
VARIOUS	WOZNIAK	FABRICATION OF OPACITY STANDARDS	---	7-15-15-03	INDUSTRY	246	0	246
VARIOUS	SCHAID	SPECIAL PROJECTS IN DRUGS & THERAPEUTICS	---	7-15-30-01	INDUSTRY	65,200	0	65,200
VARIOUS	BURRELL	MONOGRAPH SERIES	---	7-15-30-06	INDUSTRY	20,000	0	20,000
11/14/89 & 02/05/90	NEIDLE	GOLD MEDAL AWARD	---	7-15-35-01	CHESEBROUGH-POND'S 1989 ADA MATCHING FUNDS 1990	5,000 5,000	0 0	5,000 5,000
06/07/89	GREENBERG	SPEAKERS BUREAU	---	7-15-35-05	PROCTER & GAMBLE	75,000	0	75,000
05/23/89 & 07/19/89	NEIDLE	ETHICAL & LEGAL ISSUES	---	7-15-35-06	PROCTER & GAMBLE WARNER LAMBERT	5,000 5,000	0 0	5,000 5,000
01/26/90 & VARIOUS	GREENBERG	HEALTH SCREENING PROGRAM 1989	---	7-15-55-02	AFDH INDUSTRY	12,000 12,500	0 0	12,000 12,500
VARIOUS	GREENBERG	HEALTH SCREENING PROGRAM 1990	---	7-15-55-02	INDUSTRY	46,500	0	46,500
08/24/89	SHUCK	NATIONAL CONFERENCE ON THE YOUNG DENTIST	---	7-15-75-01	CHESEBROUGH-POND'S	55,000	0	55,000
VARIOUS	WISE	STUDENT APPOINTMENT BOOK	---	7-15-75-02	WARNER-LAMBERT	40,094	0	40,094
08/01/89	KISER	FIRST NATIONAL DENTAL SYMPOSIUM ON SMOKING CESSATION	---	7-15-80-02	MERRELL DOW	30,000	0	30,000
					TOTALS	$ 733,367	$ 57,523	$ 790,890

Table 2: Paffenbarger Research Center at the National Institute of Standards and Technology

AWARD DATE	PRINCIPAL INVESTIGATOR	TITLE	GRANT/CONTRACT NO.	CENTER NO.	SPONSOR	TOTAL DIRECT COSTS	TOTAL INDIRECT COSTS	TOTAL ALLOWABLE COSTS
06/29/89	TUNG	THREE APPROACHES TO RAPID REMINERALIZATION OF THE TOOTH	1 RO1 DE 08916-01	5-20-20-14	NIDR	37,094	19,810	56,904
07/18/89	BROWN	CALCIFICATION IN THE CARDIOVASCULAR SYSTEM	5 RO1 HL 30035-06	5-20-20-15	NHL&BI	89,290	50,057	139,347
07/28/89	BOWEN	IMPROVEMENT OF PREVENTIVE & RESTORATIVE MATERIALS	2 R37 DE 05129-12	5-20-25-07	NIDR	106,228	58,895	165,123
08/31/89	CHOW	PREVENTION OF DENTAL CARIES	2 RO1 DE 05354-12	5-20-20-16	NIDR	155,128	83,806	238,934
09/28/89	BOWEN	CENTER OF EXCELLENCE FOR MATERIALS SCIENCE RESEARCH	1 P50 DE 09322-01	5-30-00-01	NIDR	307,238	173,894	481,132
11/30/89	MATHEW	CRYSTAL CHEMISTRY OF CALCIUM PHOSPHATES	2 RO1 DE 05030-12	5-20-10-05	NIDR	104,678	54,773	159,451
12/20/89	VOGEL	MICRO EQUIPMENT FABRICATION	---	7-20-20-07	UNIVERSITY OF IOWA	5,000	0	5,000
02/27/90	BOWEN	MINORITY HIGH SCHOOL STUDENTS RESEARCH APPRENTICE PROGRAM	2 S03 RR 03041-10	5-20-00-07	DRR/NIH	4,500	0	4,500
03/13/90	VOGEL	MECHANISM OF DENTAL CARIES	5 RO1 DE 04385-14	5-20-20-17	NIDR	106,773	58,912	165,685
					TOTALS	$ 915,929	$ 500,147	$ 1,416,076

Table 3: Research Institute

AWARD DATE	PRINCIPAL INVESTIGATOR	TITLE	GRANT/CONTRACT NO.	CENTER NO.	SPONSOR	TOTAL DIRECT COSTS	TOTAL INDIRECT COSTS	TOTAL ALLOWABLE COSTS
VARIOUS	VARDIMON	MAGNETIC FORCES RESEARCH	---	7-10-00-04	KENILWORTH RESEARCH FOUNDATION	20,935	0	20,935
06/16/89 & 01/10/90	NALEWAY	AMBIENT VS. ENAMEL-BOUND FLUORIDE	---	7-10-00-16	SUNSTAR COLGATE-PALMOLIVE	14,970 15,000	0 0	14,970 15,000
					TOTALS	$ 50,905	$ 0	$ 50,905
					GRAND TOTALS	$ 1,700,201	$ 557,670	$ 2,257,871

Research Institute

Neidle, Enid A., director
Naleway, Conrad A., director, chemistry department
Siew, Chakwan, director, toxicology department

In recent years, the Research Institute has sharply focused its goals, which can be characterized as follows:

—to provide scientific support for the two councils, Council on Dental Therapeutics (CDT) and Council on Dental Materials, Instruments and Equipment (CDMIE), with seal programs. For instance, Institute scientists review the chemical composition and consistency of dentifrices, conduct fluoride availability studies on dental products, study the toxicologic properties of products submitted to the acceptance programs, solicit scientific information from consultants and contribute to the development of new guidelines for product categories;

—to respond to research initiatives identified by the Council on Dental Research, e.g., the design of an epidemiologic study on the safety of dental amalgam and the effects on mice of chronic exposure to mercury vapor;

—to identify subjects for workshops and conferences, organize them and contribute to them, as, for instance, the Workshop on Technological Advances in Intraoral Model Systems Used to Assess Cariogenicity in July 1990;

—to conduct original research, relevant to dentistry, both independently and in collaboration with scientists from the Paffenbarger Research Center (PRC), universities and industries;

—to participate in relevant activities of the Federation Dentaire Internationale and the World Health Organization through membership on committees, working groups, and commissions;

—to develop the largest data base in the world on the health of the dentist, the prevalence of serum markers for hepatitis B and hepatitis C in the dental population, the prevalence of antibody to human immunodeficiency virus (HIV) and therefore the rate of occupational transmission of HIV infection among dentists;

—to make available to visiting scientists the facilities and support services of the Institute; and

—to educate the membership and the staff on matters of scientific importance and on current developments in dental science.

These diverse activities have had a widespread effect. The remarkable increase in the number of dentists and their staff members who have been vaccinated against hepatitis B is widely held to be attributable, in major part, to the efforts of the Research Institute of Dr. Siew and his staff to track this phenomenon and at the same time to educate the membership on the importance of immunization against HBV. The continuing monitoring of mercury in the blood and urine of dentists has heightened awareness of the need for scrupulous handling and careful disposal of amalgam. The institute has played an important role in the Association's efforts to deal with hazardous waste issues that have been thrust into prominence by local, state and federal regulatory agencies.

The design and characteristics of dentifrice and other consumer dental products is importantly influenced by research originating in the Institute and by guidelines developed with the help of Institute scientists and ultimately adopted by the CDT.

The Research Institute has sponsored a series of seminars, which have attracted staff from various agencies of the Association as well as people outside the ADA and has played an important educational role. The roster of speakers in early 1990 included the following: Dr. Stephen J. Moss, Department of Pediatric Dentistry, New York University, who spoke on the benefits of fluoride; J. Boscia, M.D. from SmithKline Beecham, who spoke on hepatitis B and the efficacy of a newly licensed synthetic vaccine in creating immunity; Dr. W.R. Maas, director of Oral Health Services Research for the Public Health Service, who spoke on the research interests of his agency; Dr. R.V. Katz of the University of Connecticut, who discussed the different types of epidemiological studies and their potential to support statements of causation; Dr. D.G. Pendrys of the University of Connecticut, who spoke on the use of epidemiological findings in the study of occupational disease in dentistry.

Infectious Disease and Infection Control Among Dentists: A significant decrease in the prevalence of infectious diseases among dentists continues as adherence to infection control procedures increases. Since 1983, the Department of Toxicology has monitored hepatitis B virus (HBV) serum markers among dentists attending the Association's Health Screening Program (HSP) at the annual session. In 1989, 1,437 dentists participating in the HSP were screened for serum markers to HBV infection; 71% had been vaccinated against HBV, representing a 400% and 14% increase over the rates recorded in 1983 and 1988, respectively. Furthermore, fewer than one-third of dentists remain at risk for HBV infection and less than 9% show serum evidence of HBV infection. In 1983, the natural exposure rate was over 15%. The rate of HBV infection among dentists has been reduced more than 40%, since vaccines against hepatitis B became available. This decrease is most likely attributable to the widespread practice of infection control procedures and increased acceptance of HBV vaccine.

Dentists were anonymously screened for antibody against the human immunodeficiency virus (HIV) at the HSP. None of the 1,480 samples tested were seropositive for HIV. Over the last three years a total of 3,840 dentists have been tested, and only one dentist has tested positive for HIV antibody. This represents a risk of 0.026% or one-tenth the risk for the general population (0.25%). These data, plus those from a small sample collected in 1986, support the hypothesis that

HIV infection is not a significant occupational risk for the dental profession.

Hepatitis C virus (HCV) is the major cause of transfusion-related hepatitis and is thought to be transmitted parenterally. In 1989, 1,437 dentists participating in the HSP were screened for HCV using a newly developed assay for antibody against HCV. The prevalence of HCV infection in the general population is about 0.5%. The measured rate of 0.069% in this dental population is well below the incidence for the general population. Thus, it appears that dentists are not at increased risk for HCV infection.

Hepatitis B, HCV and HIV antibody testing will be continued at the 1990 annual session, adding to the cumulative data bank, the largest in the world, the Association is amassing on infectious diseases among dentists.

Additionally, 105 dental technicians were screened for serum HBV markers at the 1989 Annual Meeting of the National Association of Dental Laboratories. Dental technicians have been assumed to be at increased risk for HBV infection because they handle blood- and saliva-contaminated impressions, models and appliances. The results indicated that 23% had received vaccination against HBV, and less than 3% showed exposure to the HBV. The natural HBV exposure rate in the general population is 4.5%. Dental technicians do not seem to be at increased risk for HBV infection. The high rate (85%) of routine disinfection of patient specimens and a lack of direct patient contact probably account for the low HBV exposure rate among dental technicians.

Disinfectant Evaluation Laboratory: There is considerable controversy surrounding the current protocols for evaluation of disinfectants of the American Organization for the Analytical Chemist (AOAC) and the Environmental Protection Agency (EPA), in part because of the inconsistent results achieved by different laboratories. The Department of Toxicology has established a laboratory to provide the Association with the independent capability to evaluate antimicrobial solutions for use in the dental operatory. Consultants from the Florida Department of Agriculture and private industry visited the laboratory and offered to cooperate with the Association in developing and/or improving methods for evaluation and data analysis of disinfectants.

Elimination Kinetics of Fluoride in Dentrifices: In another study reported last year, it was established that in rats and mice stannous fluoride (SnF_2) is the most toxic, with sodium fluoride (NaF) and monofluorophosphate (MFP) about equivalent in toxicity. MFP has been alleged to be less toxic than NaF to support increasing its concentration in new dentifrices. In this study peak fluoride levels were highest for SnF_2 with primary and secondary half lives of 20 and 160 minutes. NaF peak fluoride levels were about one third less than SnF_2, with primary secondary half-lives of 21 and 175 minutes. MFP, however, had the lowest peak fluoride levels that were also biphasic. MFP had the longest primary and secondary half-lives of 65 and 434 minutes. Fluoride toxicity apparently is highly dependent on both the initial peak fluoride level attained (acute toxicity is displayed very soon after dosage) and the length of time fluoride remains in the blood. Although NaF and MFP are considered to have equivalent toxicity over a 24-hour period, NaF would appear more toxic than MFP if toxicity is measured over only a 4-hour period. The slower absorption of MFP would allow more time to counteract toxic effects following overdose and therefore might be considered "safer" than NaF.

Amalgam Scraps as an Environmental Hazard: This project was initiated in collaboration with the Council on Dental Materials, Instruments and Equipment to determine whether amalgam scraps when discarded as solid waste would pose an environmental hazard. Traditionally, in dental offices amalgam scraps were often saved and sold to refiners for recycling of the precious metals.

Proper handling of amalgam scraps during the recycling process would allow valuable metals to be processed and reused and thereby conserve resources. Mishandling by a refiner, however, can result in mercury being released into the soil, as occurred in a recent incident in Connecticut. A laboratory procedure developed by the Environmental Protection Agency (EPA) to simulate the leaching process a waste material in a sanitary landfill might undergo was followed. A representative sample of scrap dental amalgam was extracted with an aqueous solution of acetic acid at pH 5. The extract was analyzed for mercury, copper, tin and silver. Preliminary data indicate that the resulting concentrations in the extract were below the maximum concentrations set by the EPA for toxicity. It was concluded that amalgam scraps are not hazardous solid wastes if properly handled.

Concentration of Urinary Mercury in Practicing Dentists: To provide the dentists participating in the 1989 HSP with immediate diagnostic data, urinary mercury (Hg) assays (N = 1,253) were performed on site, and in most cases the dentist was notified of the results before completion of the screening program. Dentists with high Hg concentrations were offered the opportunity to consult with staff members concerning their mercury hygiene practices. The mean concentration for participating dentists was 5.7 μg Hg per liter of urine. Fifty-eight (4.6%) of the participating dentists were found to have Hg concentrations above 20 μg/L; 14 dentists had levels above 50 μg/L. This can be compared to a mean of approximately 3 μg/L in the nondental population.

Role of Fluoride in the Mechanism of Caries Formation: The chemistry program is engaged in a collaborative project designed to assess the roles of ambient versus enamel-bound fluoride in the decalcification of enamel by comparing the caries-protective role of ambient fluoride with that of fluorapatite-rich enamel. A microbiological model to simulate the conditions found in the mouth was used. This study focuses on the shift in bacterial metabolite production as influenced by fluoride and pH under aerobic and anaerobic conditions and the rates of decalcification of enamel associated with these specific conditions. Results indicate that both ambient and incorporated fluoride play active roles in the reduction of demineralization. However,

incorporated fluoride is more resistant to decalcification within a microbiological model.

Chemical Dynamics of Plaque: A kinetic model that permits the analysis of multiple organic acids associated with the decalcification of enamel has been used to interpret the chemistry of plaque. These studies emphasize the importance of identifying the specific concentrations of all organic acids in plaque, since they do not play the same role in the decalcification of enamel.

Examination of Subgingival Plaque Acids: Little is known about the clinical relationship between toxic plaque acids and the severity of periodontal disease. Studies were conducted on the possible association between the presence of short-chain fatty acids (SCFA) in subgingival plaque and the severity of periodontitis. Subgingival plaque samples were collected from five different periodontal sites from each of 15 patients, and plaque samples were analyzed for concentrations of SCFA using a dual-phase ion chromatography technique capable of measuring quantities as a low as 10 nanograms of butyric acid. These studies suggest that the concentrations of butyric and propionic acids in subgingival plaque increase with disease severity and that these acids are potential markers of periodontal health and may be etiologic factors in gingival inflammation.

Functional Orthopedic Magnetic Appliances II and III: Studies on primates have demonstrated the ability of functional orthopedic magnetic appliances (FOMAs) to increase performance compared to conventional appliances. Total mandibular length increased by 25% to 28% in FOMA II-treated primates with a skeletal class II malocclusion as compared to animals undergoing the usual functional treatment. This increased growth was the result of augmented condylar growth in a posterosuperior direction and selective bony remodeling of the condylar neck.

A preliminary study on the mechanism of functional growth using FOMA IIs and the long-term interaction between sutural and secondary cartilage growth sites during FOMA III treatment was initiated. A total of 28 *Macaca fascicularis* monkeys were treated with FOMA IIs and 20 *Cebus apella* monkeys were treated with FOMA IIIs to determine the long-range effects of treatment.

Activities in Support of the Council Programs: The chemistry program and the toxicology program continue to play active roles in the assessment and supplementation of tests submitted to the Council on Dental Therapeutics for fluoride products, with special involvement in the review of fluoride dentifrices. Both programs have assisted in the periodic review and updating of the guidelines for fluoride dentifrices and in the development of international specifications for toothpastes.

Presentations: Scientists at the Research Institute made eight presentations at local, regional, national and international scientific conferences during the past year.

Publications:

1. Vardimon AD, Graber TM, Voss LR, Muller TP. Functional orthopedic magnetic appliance (FOMA) III-Modus operandi. Am J Orthod Dentofacial Orthop 1990; 97:135-48.

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

The Paffenbarger Research Center at the National Institute of Standards and Technology

Bowen, Rafael L., director
Brown, Walter E., director emeritus
Eichmiller, Frederick C., associate director and chief research scientist, Clinical Research
Rupp, Nelson W., associate director emeritus
Chow, Laurence C., assistant director and chief research scientist, Dental Chemistry
Johnston, Allen D., chief research scientist, Polymer Chemistry
Mathew, Mathai, chief research scientist, Dental Crystallography
Waterstrat, Richard M., chief research scientist, Dental Metallurgy
Marjenhoff, William A., administrative manager

The partnership in dental research between the Association and the federal government, which extends back to 1928, was further strengthened during the past year with the establishment of the Center of Excellence for Materials Science Research. This new research entity was funded by a National Institute of Dental Research (NIDR) grant to the American Dental Association Health Foundation (ADAHF). The Center of Excellence is directed by Dr. Rafael L. Bowen and is codirected by Dr. John A. Tesk, leader of the National Institute of Standards and Technology (NIST) Dental and Medical Materials Group. Scientists from both the Paffenbarger Research Center (PRC) and NIST are working on five projects: research on glass ceramic inserts and inlays for composite restorations; the development of radiation shielding materials; the synthesis of novel monomers and polymers for protective tooth coatings; the development of monomers and polymers that exhibit minimal shrinkage during polymerization; the development of a synthetic dentin.

The status of PRC and Center of Excellence projects are described below.

Dental Chemistry

The objectives of this program are to develop effective therapeutic and preventive treatments for dental hard-tissue diseases and to develop calcium phosphate biomaterials for dental and medical applications.

Synthetic Dentin: This project seeks to develop a new biomaterial called "synthetic dentin" (SD). The organic phase of SD will comprise a three-dimensional hydrated network of inherently crosslinked polymers analogous to collagen, which has calcium-binding groups on the backbone of the carbon chains. The inorganic phase of SD will be a rigid network of mineral components consisting of interlocking hydroxyapatite crystals.

In Vitro Remineralization of Enamel Lesions by a Two-Component Fluoride Mouth Rinse: An experimental two-component fluoride (F) was evaluated for its ability to remineralize caries-like lesions formed in the enamel of extracted human molars. The results showed that (1) no significant de- or remineralization was detected in the controls, (2) a 12% increase in mineral content in the outer 50 μm of the lesion was produced by NaF rinses, and (3) a 32% mineral gain in the lesion and a 19 μm-thick surface coating were produced by the two-component F rinse treatment.

Effect of Firmly Bound Fluoride on In Vitro Caries Formation in Root: Tooth-bound F content of enamel or root dentin can be increased significantly by pretreatment with a viscous acidic (pH 2) gel—containing monocalcium phosphate monohydrate (MCPM), followed by exposure to a saliva-like solution containing 1 ppm of F. With increased F content, the average rate of demineralization for the controls was about twice that of the MCPM-treated samples, and there exists a correlation between tooth-bound F content and resistance to lesion formation.

Enamel Fluoride Uptake Produced by an Acidic Gel Containing Fluorosilicate and Monocalcium Phosphate: Enamel specimens were treated in vitro with an experimental gel that contained MCPM, carboxymethyl cellulose, Na_2SiF_6 and water. The total F content was 1.2%, the same as that in acidulated phosphate F (APF) gel. For a given treatment time, the experimental gel produced significantly more loosely bound F than did APF and the amounts of firmly bound F increased with length of treatment time.

Biocompatibility and Osteoconductivity of Calcium Phosphate Cement: A collaborative study with A. Sugawara, Nihon University, Tokyo, evaluated the in vivo biocompatibility and osteoconductivity of calcium phosphate cement (CPC) as compared to that of a commercial hydroxyapatite and several endodontic materials: Grossman's cement, calcium hydroxide-iodine paste and guttapercha plate. Biocompatibility was evaluated by subcutaneous implantation of the materials in Donryu rats and osteoconductivity by implanting the materials in surgically formed pockets in the lower jaws of dogs. Results of the rat study showed very slight inflammatory reactions from CPC and hydroxyapatite and severe inflammatory reactions from Grossman's Cement. Results from the dog study showed no inflammatory reactions in tissue areas adjacent to CPC or hydroxyapatite. CPC showed better biocompatibility and osteoconductivity than a number of currently used materials.

In Vivo Evaluation of Calcium Phosphate Cement: In a study with P. D. Constantino, K. Jones, H. J. Pelzer and

G. A. Sisson, Northwestern University, and C. D. Friedman, Yale University, discs fabricated from CPC were implanted subcutaneously, intramuscularly above the periosteum of the skull and directly on the calvarium below the periosteum in nine cats. Because the CPC can be contoured to fill skeletal defects, and since it is replaced by bone over time, it may be useful in the reconstruction of skeletal tissue that do not bear significant stresses.

Nine cats had the anterior table of the frontal sinus unilaterally removed, and the sinus cavities stripped of mucosa. CPC was used to obliterate the cavities and reconstruct the overlying anterior table defects. Up to 18 months postoperatively, histological examination revealed progressive replacement of the implant with woven bone without a loss of volume. This is postulated to occur through a combination of implant resorption with osteoconduction.

In another study, CPC was used to reconstruct bilateral, 2 cm diameter, full-thickness parietal skull defects in ten cats. One side was reconstructed with 100% CPC and the other with a 50/50 (by weight) mixture of CPC and ground autogenous bone. Bone deposition was more rapid in defects reconstructed with the CPC/bone mixture as compared to the pure cement. CPC is efficacious in the reconstruction of small calvarial defects in cats and may be applicable in humans.

Effect of pH on Bacteria in the Decalcification of Hydroxyapatite and Fluorapatite: The effect of pH and acid type on the dissolution processes of fluorapatite (FAp) and hydroxyapatite (OHAp) was studied in collaboration with scientists from the ADAHF Research Institute. The rate of lactic acid production (43.9 ppm/hr) at pH 4.7 was 54% of that found at pH 6.5 and was only slightly influenced by the F in the solution. The relatively high basicity of OHAp results in a higher pH during bacterial metabolism and a greater amount of acid production. Thus the quick drop in pH for the FAp slurry can be interpreted as a protective process since it directly reduced the rate of acid production.

Decalcification in Hydroxyapatite-Fluorapatite Slurries Containing Bacteria: Dissolution behavior of fluorapatite (FAp) and hydroxyapatite (OHAp) as influenced by thermodynamic, kinetic and bacterial factors was studied in collaboration with ADAHF Research Institute scientists. When both OHAp and FAp were present, the dissolution of OHAp dominated. OHAp slurries containing substantial amounts of F resulted in extensive coverage of the crystal surfaces and dissolution in a manner intermediate to OHAp and FAp.

Dissolution of Bovine Enamel in Artificial Plaque: This project, done in collaboration with researchers from the ADAHF Research Institute and W. Yotis, Loyola University Medical Center, is described under the title "Role of Fluoride in the Mechanism of Caries Formation" in the report of the Research Institute.

Effects of Fluoride and Differential Diffusion on Lesion Composition: A micro-well model (*J Dent Res* 67:1172-88) was used to study the fluid within a developing lesion with test solutions based on plaque fluid near a typical cariogenic pH. These solutions included F and high concentrations of neutral salt. A dramatic effect on lesion compositions was produced by as little as 0.2 ppm F in the solution phase. Differential diffusion effects are not overwhelmed by the high ionic strengths found in vivo.

Microelectrode Analyses of Plaque Fluids: Ion-selective micro-electrodes were used to analyze quantitatively pH, Ca, K and other components in separated plaque fluid and whole plaque fluid obtained from single-site overnight-starved plaque. Results indicated a centrifugeable source for Ca and pH buffering in plaque, and they emphasized the role of plaque solids in controlling the composition of plaque fluid.

Effects of Oxalate and Calcium Phosphate Solutions on the Closing of Dentinal Tubules: This study evaluated the effects of experimental calcium phosphate solutions (two-step) and a commercially available acidic potassium oxalate solution on obstruction of dentinal tubules. Both treatments reduced the permeability of dentin in vitro between 26% and 98%. After acidic potassium oxalate treatments, the tubules were still visible in micrographs, suggesting the dissolution of dentin followed by reprecipitation inside the tubules. After the two-step treatments, the tubules were covered with calcium phosphate precipitates, which probably hydrolyze to apatite in situ. This work was done in collaboration with K. Kaminske, Naval Dental School, Bethesda.

Effect of Pyrophosphate on Growth of Octacalcium Phosphate (OCP) and Hydroxyapatite (OHAp) Crystals: Under physiological conditions OCP is a precursor that hydrolyzes to a more apatitic phase. OHAp does not form under these conditions, apparently because of natural inhibitors in blood. Since pyrophosphate ($P_2O_7^{4-}$) is an important inhibitor of OHAp growth in blood, its effects on the relative growth rates of OCP and OHAp were studied in collaboration with J. L. Meyer, National Institute of Allergy and Infectious Diseases, NIH. Results suggest that OCP precipitated on both OCP and OHAp seeds followed by its hydrolysis to a more apatitic phase.

Mineralization of Bovine Pericardium Under In Vivo and In Vitro Conditions: This collaborative study with scientists from the ADAHF Research Institute is discussed in the ADAHF Research Institute report.

Clinical Research

The clinical program at PRC develops and evaluates materials and techniques for the future transfer of technology to private industry.

Dentin and Enamel Bonding Systems: Phase two of the clinical trial evaluating permanent restorations on class III, IV and V restorations has continued through the 18th month, and a majority of the 24-month recall evaluations have been completed. Approximately 250 restorations have

been placed using the original experimental protocol comparing Scotchbond Dual Cure to the ferric oxalate system. In addition, over 100 restorations have been placed utilizing a simplified two-step system consisting of a dentin-enamel conditioning solution and an adhesive monomer solution. This clinical trial has been instrumental in the development of proper application techniques, packaging and delivery of this adhesive system. Additional clinical trials evaluating this bonding system with other dental materials is continuing.

Attempts to further improve and refine the two-step system have led to the development of chemical analogues of N-phenylglycine (NPG) and PMDM (the reaction product of pyromellitic dianhydride and 2-hydroxyethyl methacrylate) that have demonstrated improved adhesive properties to dentin. These materials are currently being evaluated for storage stability and packaging conditions.

Radiation Shielding Materials: Significant progress has been made in the development of materials used for shielding of soft tissues from radiation damage during head and neck tumor therapy. This project has formulated elastomeric material, similar to impression putty, which are capable of blocking over 40% of ^{60}Co gamma-rays and 10 MeV X-rays and almost 100% of 7 MeV electron beams with thicknesses of 2 cm and less.

Chemical Methods of Preparing Unusual Forms of Prosthetic Metal Alloys: A pilot project exploring methods of preparing superstrong alloys for dental prostheses, such as resin-retained bridges, precision attachments and implant superstructures, was initiated. Several die materials have been evaluated for dimensional accuracy and applicability to dental laboratory procedures. Work will focus on refining die materials and evaluating candidate alloy systems with high corrosion resistance and superior physical properties.

Polymer Chemistry

This program investigates the mechanism of adhesive bonding and the storage longevity of adhesive bonding components.

Adhesive Bonding to Hard Tooth Tissues: The problem of clinically satisfactory adhesive bonding of composites and resins to both dentin and enamel has motivated research in this area.

Structurally related molecules in adhesive bond tests were compared within a range of concentrations and in a three-step bonding procedure. The more efficient bond-promoting molecules delivered a higher average bond strength to dentin at given concentrations, indicating the molar efficiency of the compounds. Comparison of the molecular structural features provides illumination of the detailed structure/function relationships of dentin bonding.

Development of Protective Tooth Coatings: Synthesis and evaluation of new candidate monomers designed for use in protective/preventive coating materials was initiated. Typically, these monomers will each contain two carboxylic acid groups for interaction with enamel and dentin surfaces and two methacrylate groups for polymerization with high crosslink density to withstand the oral environment. Liquid formulations of these will be applied to the tooth surfaces and polymerized.

ADAHF Multinuclear NMR Facility: NIST staff have utilized the carbon-13 and phosphorus-31 solid state NMR capabilities, and scientists from the University of Oregon have utilized the silicon-20 solid-state nucleus capability for work with glasses. The number of users has tripled from last year. Due to the volume of traffic seeking to acquire solution proton spectra, a second probe for protons has been acquired, and the memory of the computer has been upgraded.

Dental Crystallography

This program continues to provide information on the formation, properties and crystal chemistry of calcium phosphates, biominerals, microcrystalline glass ceramic insert/inlay materials and other compounds associated with hard tissues and dental materials.

Biomineralization: Investigations of octacalcium phosphate (OCP) and its role in biomineralization continue. Double salts of OCP and dicarboxylates were studied and crystal structure of a calcium adipate salt was completed. This structure is not compatible with the proposed model for OCP-succinate double salt, indicating that there could be different models for these double salts. Attempts to grow single crystals of these double salts for structural studies are continuing.

Glass Ceramic Inserts: This project is designed to develop microcrystalline glass ceramics containing beta-quartz solid solutions as the major phase. Test compositions are given heat treatments, and X-ray powder diffraction techniques are used to identify the crystalline phases developed as well as the crystallinity of these ceramic materials.

Dental Metallurgy

This program investigates metal alloys that have potential value in dentistry and develops new investment materials and novel casting techniques.

Development of Ternary Metal Alloys: A patent application has been submitted for ternary alloys of the class $Zr(A_{1-x}B_x)$, where A is a noble metal such as Ru, Os or Co and B is another noble metal such as Pd. These alloys are strengthened and hardened by martensitic transformations that occur at room temperature under stress and are expected to have excellent biocompatibility. Studies continue to elucidate the nature of various factors that enhance the ductility and other characteristics of these alloys for use in dental and medical applications.

Other PRC Activities

Honors and Awards: R.M. Waterstrat, D.Sc., presented the 16th Annual Eugene Skinner Memorial Lecture at the Northwestern University Dental School.

Appointments: Dr. R.L. Bowen is secretary of the American National Standards (ANSI) Committee/MD156, Dental Materials, Instruments and Equipment Subcommittee on Biological Evaluation of Dental Materials and is a member of its Subcommittee on Direct Filling Resins. Dr. F.C. Eichmiller is a member of ANSI Committee/MD156 Task Group 39, Pit and Fissure Sealants, is the International Standards Organization representative for the Pit and Fissure Sealants specification, and is secretary/treasurer of the AADR Washington Section. C.M. Carey is master of ceremonies of Alpha Chi Sigma, a chemistry honor society at American University, Washington, D.C. Dr. N.W. Rupp is a lecturer at the Navy Dental Center and Georgetown University Dental School. L.C. Chow, Ph.D., served on the AADR Student Fellowship Committee and cochaired the 1989 Gordon Conference on Calcium Phosphates.

Papers: Twenty papers, listed below, were published by staff members.

1. Blosser, RL, Rupp, NW, Stanley HR, Bowen RL. Pulpal and micro-organism responses to two experimental dental bonding systems. Dent Mater 1989; 5:140-4.

2. Bowen, RL, Eichmiller, FC, Marjenhoff WA, Rupp, NW. Adhesive bonding of composites. J Am Coll Dent 1989; 56:10-3.

3. Bowen RL, Rupp NW, Eichmiller FC, Stanley HR. Clinical biocompatibility of an experimental dentine-enamel adhesive for composites. Int Dent J 1989; 39:247-52.

4. Chow LC. Tooth-bound fluoride and dental caries. J Dent Res 1990; 69:595-600.

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Presentations: Twelve members of the PRC staff made presentations at the annual meeting of the IADR/AADR in Cincinnati, Ohio, March 7-11, 1990. In addition, 19 papers on original research were presented at meetings of other organizations and dental societies.

Cooperative and Educational Activities: PRC continues to engage in numerous national and international cooperative research programs with universities and laboratories in the United States, China, France, Japan, Switzerland and Taiwan.

Grants: Approximately 85% of the staff members of the PRC are wholly or partially supported by grants from the National Institutes of Health. The current grant awards (direct costs) are as follows: R.L. Bowen, principal investigator, Center of Excellence for Materials Science Research, first year of five, $441,115; R.L. Bowen, principal investigator, Improvement of Preventive and Restorative Materials (MERIT award), second year of five, $106,228; R.L. Bowen, principal investigator, Clinical Trial of an Adhesive Material, last year of a 5-year contract, $461,337; W.E. Brown, principal investigator, Calcification in the Cardiovascular System, third year of three, $89,290; L.C. Chow, principal investigator, Prevention of Dental Caries, first year of four, $155,128; M. Mathew, principal investigator, Crystal Chemistry of Calcium Phosphates, first

year of five, $104,678; M. Tung, principal investigator, Three Approaches to Rapid Remineralization of the Tooth, first year of four, $37,094; G.L. Vogel, principal investigator, Mechanism of Dental Caries, second year of five, $106,773; and a Minority High School Student Research Apprentice Program, one year, $4,500.

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

Resolutions

Notes

Resolutions

Delaware State Dental Society

Synopsis of Reference Committee Testimony

The following resolution was adopted by the Delaware State Dental Society's Delegation to the ADA House of Delegates and submitted on April 30, 1990 by Dr. Bruce B. Wright, delegate.

Background: It seems reasonable that when testimony is given in a reference committee, the report should consistently reflect the flavor of that testimony. Although a reference committee's conclusions may disagree with the consensus of the testimony it hears, it seems reasonable to expect that differing testimony should nevertheless appear in the committee's report in fairness to those who have taken the time and trouble to testify. This practice would subsequently better enable the delegates and alternates to be better informed, to more accurately assess the true feelings of the membership and to gain a clearer understanding of what actually transpired. Therefore, be it

38. Resolved, that "General Procedures for Reference Committees" in the *Manual of the House of Delegates* be amended in the second paragraph of the section entitled "Preparation of Report" by adding a new fourth sentence that reads:

> When the reference committee writes its report, a portion of the report shall be dedicated specifically to a synopsis of the testimony given at the hearing by the membership on each item considered.

so the amended paragraph reads as follows:

> All recommendations to the House of Delegates must be placed in the standard resolution form. Except in very unusual cases, the use of preliminary and explanatory "whereas" clauses is not permitted. The committee should place this prefatory material in its comment on the resolution in the general text of its report. When the reference committee writes its report, a portion of the report shall be dedicated specifically to a synopsis of the testimony given at the hearing by the membership on each item considered.

Delaware State Dental Society

Explanation of Board Minority Opinions

The following resolution was adopted by the Delaware State Dental Society's Delegation to the ADA House of Delegates and submitted on April 30, 1990 by Dr. Bruce B. Wright, delegate.

Background: Some issues addressed by the Board of Trustees are controversial and a significant number of dissenting votes result. Since the Board operates on a simple majority rule for most votes, it is possible to have eight (8) members voting in opposition to a proposal and still have that issue receive a favorable recommendation from the Board.

The members of the House have no way of knowing in most cases what this large minority is actually thinking. Even though sometimes a few sentences are given to discussing the minority view, often this is not adequate for delegates to give full consideration to that view. Therefore, be it

39. Resolved, that "Operation of the House of Delegates" in the *Manual of the House of Delegates* be amended in the fourth paragraph of the section entitled "Recommendations to House of Delegates" by adding a new third sentence that reads:

> When one-third or more of the Trustees vote on the minority side of an issue, report or recommendation that requires a simple majority for passage or adoption, a separate minority opinion shall be rendered as a part of the Board's comments fully explaining the views of the minority.

so the amended paragraph reads as follows:

> The reports of the Board of Trustees will be presented at the first meeting of the House on Sunday. All reports or comments on resolutions are presented on resolution worksheets. When one-third or more of the Trustees vote on the minority side of an issue, report or recommendation that requires a simple majority for passage or adoption, a separate minority opinion shall be rendered as a part of the Board's comments fully explaining the views of the minority.

Delegate Dwight W. Meierhenry, Nevada

Amendment of The "Manual of The House of Delegates" to Limit Discussion and Amendment of Resolutions

The following resolution was submitted on April 26, 1990 by Dr. Dwight W. Meierhenry, delegate, Nevada.

Background: During each session of the ADA House of Delegates it is obvious that all 418 delegates have been afforded complete files on the resolutions to be introduced in the House and have had ample opportunity to review and discuss the resolutions with their members in state caucuses, with other delegates in district caucuses and to lobby their positions with other representatives at the reference committee hearings.

Therefore, it is requested that the ADA House of Delegates approve the following:

40. Resolved, that the American Dental Association "Standing Rules of the House of Delegates" be amended to allow only three votes on all issues; aye, nay or postpone definitely (for clarifications, additional information or later

consideration). All discussion on and amendments of resolutions must be presented to the proper reference committee and acted upon by the committee prior to presenting their report to the House of Delegates. Each reference committee will select a spokesperson for each of their aye and nay positions being recommended to the House. If, by electronic vote, the House opts for clarification of an issue only the aye or nay spokespersons selected by the reference committee may provide the clarification requested.

ADA Audit, 1989

Notes

Association Finances: A Joint Letter from the Treasurer and the Executive Director

Introduction

The audited financial statements for the American Dental Association (ADA) and the American Dental Association Health Foundation (ADAHF) for the year ended December 31, 1989 and the audit of the American Dental Association Relief Fund and the American Dental Association Disaster Victims Emergency Loan Fund for the year ended June 30, 1989 are presented in *Annual Reports and Resolutions 1990* to provide the delegates and alternate delegates to the 1990 annual session with an independent opinion of the Association's financial position. In addition, supplemental unaudited financial information for the American Dental Association Operating Division and the American Dental Association Reserve Division for the year ended December 31, 1989 also is provided to assist the reader in assessing the audit report as well as in comparing the 1989 year-end results with the approved budget for 1989. To ensure that all interested parties have access to this financial information, notification has been placed in the June 1990 issue of *The Journal of the American Dental Association* which states that the audits are available upon written request to the Assistant Executive Director, Finance and Business Affairs.

Audit Report

The international accounting firm of KPMG Peat Marwick conducted the audit of the Association for the year ended December 31, 1989. The format of the audit is consistent with that of prior years, combining the presentation of results from operations for the Association's Operating Division and Reserve Division. The combined balance sheet, combined statements of revenues, expenses and equities, and the combined statements of cash flows enable comparison of the Association's financial position with the operating results of the prior year. In addition, the results of each division are shown separately in the divisional combining balance sheet, the divisional combining statements of revenues, expenses, transfers and equity, and the divisional combining statement of cash flows in Schedules 1-6.

KPMG Peat Marwick states in the audit report that the 1989 audited statements conform with generally accepted accounting principles. The auditing firm recommends that to best understand the audit reports the reader should start with notes to the financial statements, followed by the schedules at the end of the report, and finally the combined statements at the beginning of the report.

During 1989, the Board of Trustees adopted a resolution that changed the name of American Dental Office Systems, Inc. (ADOSI) to ADA Business Systems, Inc. (ADABSI) to more clearly reflect the activities of the corporation. In addition, the Association incorporated a subsidiary, American Dental Real Estate Corporation (ADREC), whose sole business is to hold the building purchased in Washington, D.C. ADREC is a non-profit real estate holding company, 501(c)(2). The financial results of these corporations, which are reflected in the Reserve Division, can be found in Schedules 4, 5 and 6 of the audit report.

Members of the audit firm met with the audit committee of the Board of Trustees and staff to review the annual results of operations. In the opinion of the auditors:

—The Association should continue to upgrade various internal control systems.

—Increase the liquid reserves of the Association to alleviate the need for outside borrowing.

—Continue the internal audit function in both the areas of finance and operations.

General Overview of Financial Statements

The following comments highlight significant changes in the financial status of the Association during 1989.

Association Balance Sheet—Assets:

—Cash and cash equivalents increased by $840,000, primarily due to constituent societies remitting 1990 membership dues to the Association during December of 1989.

—Inventories, primarily of educational materials sold through the Salable Materials Program were reduced. Increased internal controls which helped analyze prior sales and sales projections allowed for more prudent purchases. By using this extensive review, the reserve for obsolete merchandise was reduced by $125,000.

—Marketable securities decreased by $1.7 million. After reviewing interest rates on borrowed funds and expected earnings, it was determined that the best business decision at the time was to sell securities held in this account. The cash generated was transferred to the Operating Account which allowed the Association to meet its obligations without resorting to bank borrowing.

—Investments in securities at market increased by $920,000, reflecting earnings generated by the Reserve Division Investment Account net of the transfer of $500,000 to the Operating Account.

—Net property and equipment increased by almost $9,000,000. The major portion of this increase was the purchase of the Washington office building in February 1989 by American Dental Real Estate Corporation, a wholly-owned non-profit subsidiary of the Association. See Note 7 to financial statements for a more detailed explanation.

Association Liabilities and Equity:

—Notes payable in 1988 of $1.5 million were repaid in early 1989; no borrowings occurred in 1989 to meet the financial obligations of the Association.

—Notes payable in existence at the end of 1989 of $2,350,000 represent loans of American Dental Real Estate Corporation as follows:

- $1,750,000 was borrowed as a bridge loan to purchase the Washington office building. $1,450,000 of this loan was repaid in May 1990 from the permanent financing secured.
- $600,000 also was borrowed by ADREC to pay for lobby remodeling and to meet building cash expenditures for the mortgage and real estate taxes.

—Other liabilities which are now on the Association's Balance Sheet as part of the Reserve Division Capital Formation Account is the current mortgage loan payable of $809,600 and the mortgage payable beyond one year of $7,123,200. These liabilities came into existence with the purchase of the Washington office building.

—The equity of the Association increased by $785,000, primarily due to increases in the Reserve Division.

Association Revenues: Association revenues increased in 1989 by $2,075,000 or 4.6%. Major increases (decreases) over 1988 that occurred are as follows:

Membership Dues	$223,300
Publications	(687,900)
Building Income, Washington	1,057,800
Building Income, Chicago	207,900
Educational Services, Testing	112,400
Conference and Meeting Services	(865,200)
Investment Account Income	437,700
ADA Business Systems, Inc.	891,700
Special Projects, Communications Division	606,000
Sale of *Dental Abstracts*	300,000
Other Miscellaneous Items	(208,700)
	$2,075,000

Of major importance was the reduction of advertising expenditures in the health care field, which accounted for the drop in publications revenues. The reduced Conference and Meeting Services revenues reflect the difference in annual session sites. The 1989 Honolulu site provided considerably less exhibit revenue opportunity than the 1988 joint ADA-FDI World Dental Congress held in Washington, D.C.

Association Expenses: Association expenses for 1989 increased by $2,981,900 or 6.9% over 1988 expenses. Major increases (decreases) are noted below.

—Expenses of ADA Business Systems, Inc. (formerly ADOSI) decreased by ($229,600).

—American Dental Real Estate Corporation, organized in 1989, had 1989 total expenses of $1,642,700.

Operating Account expenses increased by $1,568,800 or 3.7% when the net of ADABSI and ADREC expenses are deducted.

This growth of operating expenses is below the 4.6% Consumer Price Index (CPI) increase during 1989.

Investment Account Analysis: Schedules 1-6 break out the Operating Division Investment Account and Reserve Division from the Association's Operating Account. Several important transactions occurring during 1989 are reported below:

—In February 1989 the Association, through its wholly owned subsidiary American Dental Real Estate Corporation, purchased the Washington office building.

—During April 1989, the Board of Trustees transferred $650,000 in operating funds to the Operating Division Investment Account.

—ADA Business Systems, Inc. (formerly ADOSI) generated additional revenues from the sale of Triad warrants as well as increased royalties. Net income for 1989 of $846,785 reduced prior year accumulated losses from $2,520,828 to $1,674,043.

—The Washington office building under ADREC ownership generated net operating revenues of $451,353. After deduction of depreciation and interest on the mortgage, the net loss for 1989 was $584,913.

—Earnings in the Reserve Division Restricted Investment Account amounted to $1,153,024.

—To eliminate short-term bank borrowing to meet operating expenses, a business decision based on interest rate differentials was made by the Board of Trustees to transfer some $3.0 million from the Operating Division Investment Account and Reserve Division Investment Account.

A recap of the transactions for the year appear in the table below.

Recap of Investment Accounts

	Investment Accounts		
		Reserve Division	
	Operating Division	Capital Formation	Reserve Restricted
Balance 12/31/88	$1,727,112	509,172	4,777,891
Interest Income	200,523		119,371
Dividend Income			134,223
Actual Capital Gains (Losses)	(4,742)		151,974
Unrealized Appreciation	—		769,079
Administrative Expenses	—		(21,623)
Transfers In	650,000		—
Transfers (Out)	(2,569,409)	(22,500)	(500,000)
ADA Business Systems, Inc., Net Income		846,785	
ADREC Net (Loss)		(584,913)	
Ground Rental Income		95,357	
Balance 12/31/89	$ 3,484	843,901	5,430,915

After all the transactions were recorded the amounts remaining in the Investment Accounts are as follows:

	December 31 1989	December 31 1988
Reserve Division Restricted Investment Account	$5,430,915	4,777,891
Capital Formation Account	843,901	509,172
Operating Division Investment Account	3,484	1,727,112
Total	$6,278,300	7,014,175

Liquid reserves, primarily the Operating Division Investment Account, have been depleted. The outside auditors confirm the Board's goal and need to increase these investments so that outside borrowing is not needed to meet short-term needs of the Association.

Major Variances—1989 Actual Compared to 1989 Budget

The supplemental unaudited financial information provides an overview of actual revenues and expenditures as compared to the budget.

In an effort to increase the Investment Accounts of the Association, the Board of Trustees recommended that the earnings of the Investment Accounts budgeted in the 1989 operating budget not be transferred to the Operating Account. The net amount of $634,500 therefore is reflected in the budget but no transfers are shown. Thus, the "Total from Operations" on the summary sheet indicates a deficit of $634,500.

The summary page indicates:

—Total revenues of $44,030,000 exceeded the amount budgeted by $2,467,300 or 5.94%.

—Expenses of $44,097,200 exceeded budget by $1,900,000 or 4.50%.

—The actual deficit for the year of $67,200 was under the budget deficit of $634,500 and under the deficit projected for the 1989 House of Delegates of $111,900.

Revenue Variances: Revenue increases over the amount budgeted occurred in five major areas. Other than those discussed below, no area varied from budget by more than $100,000.

—Membership dues revenue of $24,357,200 net of the annual dues rebate exceeded budget by $110,500. Membership dues revenue represented 55.3% of the Association's operating revenues.

—Miscellaneous revenues of $327,700 exceeded budget by $267,700. During 1989 the Association sold *Dental Abstracts* to Year Book Medical Publishers for a total of $400,000, of which $300,000 was received in 1989.

—The Division of Communications generated $606,000 in corporate support revenues that was not included in the 1989 budget since these projects were not secured at the time the budget was prepared. Funding for two brochures "Dental Outlook" and "Keeping Your Dental Health, An Adult Thing To Do" generated $547,500. Corporate film support generated an additional $59,100.

—The Division of Conference and Meeting Services generated total revenues of $3,102,300, which exceeded budget by $964,200. Major excess revenues were:

Exhibit Space Rental	$ 72,300
Registration Fees	41,000
Royalty Income, Financial Services	236,100
Ticket Sales	386,500
Corporate Grants	86,500
Aloha Shirt Sales	103,900
Other Income	37,900
	$964,200

—The Division of Education generated additional revenues of $190,400 of which $128,300 represented testing fees.

Expenditure Variances: Total expenses for the year 1989 exceeded budget by $1,900,000.

—The Division of Communications expenses exceeded budget by $540,000, which was for those projects which generated the $606,600 in additional revenues.

—The Division of Conference and Meeting Services expenses exceeded budget by $591,300, which were used to generate additional revenues discussed above.

—Other expense variances occurred as follows:

- Staff compensation costs were favorable to budget by $555,800. Pension fund expense and staff salaries were favorable by $433,500 and $494,300 respectively, while taxes and benefits were unfavorable by $372,000.
- Travel expenses for all agencies were unfavorable by $412,100, reflecting increased costs of hotel rooms and additional per diem days that exceeded budgeted amounts.
- Taxes on unrelated business income exceeded budget by $375,000.
- Capital expenditures exceeded budget by $128,000.

Income Reconciliation

The following information is intended to aid the reader in reconciling the net income per the audit report with the net income as shown on the unaudited internal financial statements. This reconciliation will not be necessary in future years since the Association's budget will include depreciation in lieu of capital expenditures.

(Deficiency) of Operating Revenues Over Expenses, Schedule 2	($724,672)
Add:	
Depreciation and Amortization	1,510,434
Rounding Factor	27
Deduct:	
Association and Foundation Capital	(795,960)
Research Fund Expenditures	(56,982)
Net Deficit Per Internal Financials	($67,153)

Summary

The Board of Trustees and management staff continue to make decisions intended to strengthen the Association financially. The Board believes that the purchase of the Washington office building, sale of *Dental Abstracts*, seeking additional corporate funding of projects and monitoring expenses help in attaining this goal. A restructure of the Publications Division to a for-profit subsidiary effective January 1, 1990 is now a reality. In addition, a holding company has been formed with a separate board of directors to oversee the for-profit subsidiaries of the Association.

As these new ventures mature a full report and audit will be provided to enable the membership to review the financial impact of these decisions.

A review of interest rates on borrowed funds was compared to earnings on government investments. It was determined that it was less costly for the Association to liquidate the investments held in the Operating Division Investment Account and use those funds to pay the obligations of the Association rather than borrow funds for the same purpose. For the first time in recent history the Association incurred no bank borrowings for operational needs. However, since the Operating Division Investment Account has now been depleted, a concerted effort must be made to add funds to the Operating Division Investment Account so that future cash needs can be met internally in lieu of bank borrowing. The Board and staff are working to develop a plan to increase this account in the near future.

Treasurer

Eugene J. Truono

Executive Director

Thomas J. Ferley

Report of Independent Auditor

Board of Trustees, American Dental Association

We have audited the accompanying combined and individual balance sheets of the American Dental Association (Association) and the American Dental Association Health Foundation (Foundation) as of December 31, 1989 and 1988, and the related combined and individual statements of revenues, expenses and equity, and cash flows for the years then ended. These financial statements are the responsibility of the Association and Foundation's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the combined financial statements referred to above present fairly, in all material respects, the combined and individual financial positions of the American Dental Association and the American Dental Association Health Foundation at December 31, 1989 and 1988, and the combined and individual results of their operations and their cash flows for the years then ended in conformity with generally accepted accounting principles.

Our audits were made for the purpose of forming an opinion on the combined financial statements taken as a whole. The supplementary information included in Schedules 1 through 6 is presented for purposes of additional analysis of the combined financial statements rather than to present the financial position, results of operations, and cash flows of the individual funds. Such information has been subjected to the auditing procedures applied in the audits of the combined financial statements and, in our opinion, is fairly presented in all material respects in relation to the combined financial statements taken as a whole.

KPMG Peat Marwick
Chicago, Illinois
March 2, 1990

American Dental Association and American Dental Association Health Foundation

December 31, 1989 and 1988

Combined Balance Sheets

AMERICAN DENTAL ASSOCIATION AND
AMERICAN DENTAL ASSOCIATION HEALTH FOUNDATION

COMBINED BALANCE SHEETS

December 31, 1989 and 1988

	1989			1988		
ASSETS	Association	Foundation	Combined	Association	Foundation	Combined
Current assets:						
Cash and cash equivalents	$ 1,645,626	33,566	1,679,192	801,963	38,866	840,829
Receivables, net of allowance for doubtful accounts of $227,100 ($214,400 in 1988)	2,522,177	87,162	2,609,339	2,224,814	199,596	2,424,410
Marketable securities, at market	75,771	1,568,528	1,644,299	1,796,283	1,143,395	2,939,678
Inventories, net of reserves of $425,000 ($550,000 in 1988)	1,187,586	-	1,187,586	1,275,907	-	1,275,907
Income tax receivable	240,500	-	240,500	-	-	-
Total current assets	5,671,660	1,689,256	7,360,916	6,098,967	1,381,857	7,480,824
Due from (to) affiliated organizations - net	69,229	1,918	71,147	134,688	(80,590)	54,098
Long-term receivables	155,739	-	155,739	203,988	-	203,988
Investments:						
Marketable securities, at market	5,417,446	-	5,417,446	4,494,404	-	4,494,404
Land	3,030,000	-	3,030,000	3,030,000	-	3,030,000
Property and equipment - net	21,603,408	52,704	21,656,112	12,732,522	69,219	12,801,741
Funds held for deferred compensation	2,850,054	-	2,850,054	2,390,860	-	2,390,860
Deferred charges and other assets	1,829,523	-	1,829,523	1,955,002	-	1,955,002
Prepaid pension expense (note 10)	211,094	-	211,094	-	-	-
	$40,838,153	1,743,878	42,582,031	31,040,431	1,370,486	32,410,917
LIABILITIES AND EQUITY						
Current liabilities:						
Accounts payable	2,904,594	124,620	3,029,214	3,033,836	73,852	3,107,688
Accrued liabilities	1,463,160	621	1,463,781	1,336,770	-	1,336,770
Notes payable (note 7)	2,350,000	-	2,350,000	1,500,000	-	1,500,000
Current portion of mortgage loan payable (note 7)	809,604	-	809,604	-	-	-
Capital lease obligations due within one year	78,448	-	78,448	66,738	-	66,738
Deferred revenues	4,265,942	1,460,019	5,725,961	4,087,701	1,154,308	5,242,009
Income taxes payable	-	-	-	114,049	-	114,049
Total current liabilities	11,871,748	1,585,260	13,457,008	10,139,094	1,228,160	11,367,254
Mortgage loan payable (note 7)	7,123,160	-	7,123,160	-	-	-
Liability for deferred compensation	2,850,054	-	2,850,054	2,390,860	-	2,390,860
Accrued pension expense	-	-	-	264,824	-	264,824
Other long-term liabilities	184,138	-	184,138	221,017	-	221,017
Equity	18,809,053	158,618	18,967,671	18,024,636	142,326	18,166,962
	$40,838,153	1,743,878	42,582,031	31,040,431	1,370,486	32,410,917

See accompanying notes to combined financial statements.

American Dental Association and American Dental Association Health Foundation

Years ended December 31, 1989 and 1988

Combined Statements of Revenues, Expenses and Equity

AMERICAN DENTAL ASSOCIATION AND
AMERICAN DENTAL ASSOCIATION HEALTH FOUNDATION

COMBINED STATEMENTS OF REVENUES, EXPENSES AND EQUITY

Years ended December 31, 1989 and 1988

	1989			1988		
	Association	Foundation	Combined	Association	Foundation	Combined
Operating revenues:						
Membership dues	$24,357,212	-	24,357,212	24,133,925	-	24,133,925
Publications	6,139,268	-	6,139,268	6,827,207	-	6,827,207
Sales of educational materials	2,977,213	-	2,977,213	3,035,931	-	3,035,931
Building income (principally rentals)	3,563,130	-	3,563,130	2,297,408	-	2,297,408
Education services	1,986,243	-	1,986,243	1,873,831	-	1,873,831
Conference & meeting services	3,083,944	-	3,083,944	3,949,108	-	3,949,108
Income on security and real estate investments	1,721,208	3,661	1,724,869	1,283,555	4,252	1,287,807
Other non-dues sources - net	3,800,114	3,121,271	6,921,385	2,152,436	3,536,573	5,689,009
Total operating revenues	47,628,332	3,124,932	50,753,264	45,553,401	3,540,825	49,094,226
Operating expenses:						
Executive Director, Board and House	2,968,141	-	2,968,141	2,619,059	-	2,619,059
Education services	3,582,944	-	3,582,944	3,803,417	-	3,803,417
Cost of educational materials	2,046,114	-	2,046,114	2,111,802	-	2,111,802
Building expenses	4,487,221	-	4,487,221	3,423,081	-	3,423,081
Dental practice	3,449,488	-	3,449,488	3,119,574	-	3,119,574
Publications	5,769,648	-	5,769,648	6,086,145	-	6,086,145
Scientific affairs	1,618,162	3,092,125	4,710,287	1,625,688	3,565,918	5,191,606
Communications	3,039,500	-	3,039,500	2,147,877	-	2,147,877
Legislative affairs	1,827,092	-	1,827,092	2,075,385	-	2,075,385
Legal affairs	1,230,303	-	1,230,303	1,211,179	-	1,211,179
Membership services	2,704,338	-	2,704,338	2,445,568	-	2,445,568
Finance affairs	2,307,544	-	2,307,544	1,756,214	-	1,756,214
Business affairs	2,833,094	-	2,833,094	2,728,118	-	2,728,118
Conference & meeting services	3,431,680	-	3,431,680	4,233,663	-	4,233,663
Grants to health related groups	1,693,424	-	1,693,424	1,736,051	-	1,736,051
Operating expenses of ADABSI	442,045	-	442,045	671,642	-	671,642
Depreciation and amortization	1,984,158	16,515	2,000,673	1,416,890	19,550	1,436,440
Interest	809,019	-	809,019	30,633	-	30,633
Total operating expenses	46,223,915	3,108,640	49,332,555	43,241,986	3,585,468	46,827,454
Excess (deficiency) of operating revenues over operating expenses	1,404,417	16,292	1,420,709	2,311,415	(44,643)	2,266,772
Income taxes (note 9)	(620,000)	-	(620,000)	(700,000)	-	(700,000)
Excess (deficiency) of revenues over expenses	784,417	16,292	800,709	1,611,415	(44,643)	1,566,772
Equity at beginning of year	18,024,636	142,326	18,166,962	16,413,221	186,969	16,600,190
Equity at end of year	$18,809,053	158,618	18,967,671	18,024,636	142,326	18,166,962

See accompanying notes to combined financial statements.

American Dental Association and American Dental Association Health Foundation

Years ended December 31, 1989 and 1988

Combined Statements of Cash Flows

AMERICAN DENTAL ASSOCIATION AND
AMERICAN DENTAL ASSOCIATION HEALTH FOUNDATION

COMBINED STATEMENTS OF CASH FLOWS

Years ended December 31, 1989 and 1988

	1989			1988		
	Association	Foundation	Combined	Association	Foundation	Combined
Cash flows from operating activities:						
Excess (deficiency) of revenues over expenses	$ 784,417	16,292	800,709	1,611,415	(44,643)	1,566,772
Adjustments to reconcile to net cash provided by operating activities:						
Depreciation and amortization	1,984,158	16,515	2,000,673	1,416,890	19,550	1,436,440
Unrealized (appreciation) depreciation on marketable securities/investments	(712,468)	378	(712,090)	(193,978)	(260)	(194,238)
Increase in allowance for doubtful accounts	12,647	-	12,647	38,000	-	38,000
Decrease in reserve for obsolete and excess inventory	(125,000)	-	(125,000)	(56,000)	-	(56,000)
Gain on sale of marketable securities/investments	(1,002,030)	-	(1,002,030)	(257,170)	-	(257,170)
Changes in assets - (increase) decrease:						
Receivables	(310,011)	112,434	(197,577)	(324,046)	(81,343)	(405,389)
Inventories	213,321	-	213,321	432,585	-	432,585
Income tax receivable	(240,500)	-	(240,500)	-	-	-
Due from (to) affiliated organizations - net	65,459	(82,508)	(17,049)	(1,793)	(38,930)	(40,723)
Long-term receivables	48,249	-	48,249	44,018	-	44,018
Deferred charges and other assets	125,479	-	125,479	(490,138)	264	(489,874)
Prepaid pension expense	(211,094)	-	(211,094)	-	-	-
Changes in liabilities - increase (decrease):						
Accounts payable and accrued liabilities	(2,854)	51,389	48,535	143,645	(16,460)	127,185
Capital lease obligations due within one year	11,710	-	11,710	(9,470)	-	(9,470)
Deferred revenues	178,241	305,711	483,952	59,783	392,746	452,529
Income taxes payable	(114,049)	-	(114,049)	(96,241)	-	(96,241)
Accrued pension expense	(264,824)	-	(264,824)	(626,478)	-	(626,478)
Other long-term liabilities	(36,879)	-	(36,879)	171,017	-	171,017
Net cash provided by operating activities	403,972	420,211	824,183	1,862,039	230,924	2,092,963
Cash flows from financing activities:						
Proceeds from notes payable	4,950,000	-	4,950,000	1,500,000	-	1,500,000
Proceeds from mortgage loan payable	8,018,448	-	8,018,448	-	-	-
Payments on notes payable	(4,100,000)	-	(4,100,000)	(2,200,000)	-	(2,200,000)
Payments on mortgage loan payable	(85,684)	-	(85,684)	-	-	-
Net cash provided by (used in) financing activities	8,782,764	-	8,782,764	(700,000)	-	(700,000)
Cash flows from investing activities:						
Purchase of marketable securities	(10,323,994)	(4,460,000)	(14,783,994)	(2,333,613)	(5,015,000)	(7,348,613)
Purchase of investments	(2,521,180)	-	(2,521,180)	(2,048,208)	-	(2,048,208)
Sale/maturity of marketable securities	12,039,764	4,034,489	16,074,253	2,180,524	4,749,280	6,929,804
Sale of investments	3,317,378	-	3,317,378	1,859,960	-	1,859,960
Aquisitions of property and equipment	(10,855,041)	-	(10,855,041)	(1,300,956)	-	(1,300,956)
Net cash used in investing activities	(8,343,073)	(425,511)	(8,768,584)	(1,642,293)	(265,720)	(1,908,013)
Cash and cash equivalents at beginning of year	801,963	38,866	840,829	1,282,217	73,662	1,355,879
Cash and cash equivalents at end of year	$ 1,645,626	33,566	1,679,192	801,963	38,866	840,829
Cash paid during the year for:						
Interest	$ 785,992	-	785,992	30,633	-	30,633
Income taxes	1,134,993	-	1,134,993	582,000	-	582,000

See accompanying notes to combined financial statements.

American Dental Association and American Dental Association Health Foundation

Notes to Combined Financial Statements

DECEMBER 31, 1989 and 1988

1. Significant Accounting Policies

Basis of presentation -

The American Dental Association (Association) is organized as an association of the members of the dental profession and is designed, as its corporate purpose states, "to encourage the improvement of the health of the public and to promote the art and science of dentistry." The American Dental Association Health Foundation (Foundation) is organized to operate exclusively for charitable, scientific and educational purposes. The Foundation conducts certain research projects financed by grants awarded by the Association and others.

The members of the Board of Trustees of the Association also serve as members of the Board of Directors of the Foundation. The Association and the Foundation are Illinois not-for-profit corporations. The accompanying combined financial statements include the assets, liabilities, equity and financial activities of the Association and the Foundation.

The Association has two wholly-owned subsidiaries, ADA Business Systems, Inc. (ADABSI), known as American Dental Office Systems, Inc. until October 29, 1989, and American Dental Real Estate Corporation (ADREC). ADABSI, a for-profit subsidiary, promotes, installs, trains and supports computer systems for the dental profession. ADREC, which commenced operations in February 1989, was organized as a not-for-profit corporation for the exclusive purpose of holding title to property, collecting rental income thereon, and remitting the net income to the Association.

All significant balances and transactions between the Association and the Foundation have been eliminated in the combined financial statements.

Cash and cash equivalents -

Cash and cash equivalents include repurchase agreements. At December 31, 1989, repurchase agreements which matured on January 2, 1990 amount to $1,596,864. At December 31, 1988, repurchase agreements which matured on January 3, 1989 amounted to $421,002.

Marketable securities -

Operating Division investments in marketable securities are carried at market value and are classified as current assets available for current use. Reserve Division investments in marketable securities are carried at market value and are classified as long-term assets and are not intended for current use. In the event of emergency situations, Reserve Division assets may be used upon approval of the Board of Trustees with subsequent explanations in reports to the Association House of Delegates.

Inventories -

Inventories of publications, operating materials and supplies are carried at the lower of average cost or market.

Investment in land -

The Association's investment in land is carried at cost.

Property and equipment -

Property and equipment are carried at cost. Depreciation is computed on the straight-line method over the estimated useful lives of the assets as follows:

Buildings	30 to 55 years
Building improvements	10 years
Leasehold improvements	Over the remaining term of the lease
Furniture, equipment and libraries	5 to 20 years

Revenue recognition -

Membership dues are recognized as income during the membership year which ends on December 31. Amounts received in advance are deferred to the subsequent year. Unearned membership dues, which have been included in deferred revenues in the accompanying combined financial statements, amounted to approximately $3,037,000 and $3,065,000 at December 31, 1989 and 1988, respectively.

Subscriptions to periodicals are recognized in income over the terms of the subscriptions. Advertising revenue and direct publication costs are recognized in the period the related periodical is issued. Other publication costs are expensed as incurred.

Testing fees are recognized as income when the related examinations are administered.

Grants received are recognized as income when costs of the related programs or projects are incurred. Amounts received but not yet expended are reported as deferred revenues in the accompanying combined balance sheets.

Grant expense -

Grants to other organizations are recorded as expense when authorized by the Board of Trustees.

Pension costs -

Pension costs are determined under the projected unit credit cost method. This method determines the present value of benefits accrued to date under the provisions of the pension plan and ignores any further benefit accruals.

2. Deferred Compensation

Pursuant to agreements between the Association and certain officers and employees, portions of their compensation have been set aside for investment as directed by those employees. Title to the segregated assets is retained by the Association until termination of employment, at which time that portion of the assets directly attributable to deferred compensation may be transferred to the participant. This transfer may take place in equal semiannual installments over a period of three to ten years or as a lump sum payment, as mutually determined.

Pursuant to agreements between the Association and certain officers and employees, the Association has adopted a supplemental retirement income plan, in addition to the benefits available under the pension plan for employees of the Association. Title to the segregated assets is retained by the Association until retirement, at which time that portion of the assets directly attributable to the participants will be transferred through supplemental retirement benefits as determined by the Association.

Funds held for deferred compensation and the supplemental retirement income plan are carried at market value and are classified as a non-current asset and liability as funds held (liability) for deferred compensation since they are not available for current use.

3. Affiliated Organizations

The members of the Association's Commission on Relief and Disaster Fund Activities serve as trustees of the American Dental Association Relief Fund (Relief Fund) and the American Dental Association Disaster Victims Emergency Loan Fund (Disaster Fund), both of which were established as Funds for charitable purposes. The Association may, by action of the Board of Trustees, amend or terminate the indentures of trust under which these Funds were established. Upon termination, trust property will revert back to the Association to be used exclusively for charitable purposes. Effective December 31, 1989, the indentures of the Disaster Fund's trust were terminated and the trust property was transferred to a new not-for-profit entity, ADA Endowment and Assistance Fund, Inc.

The Association provides administrative and financial support to these organizations, as well as to the Foundation. At December 31 the Association had receivables from (payables to) affiliated organizations as follows:

	1989	1988
Foundation	$ 9,841	82,095
Relief Fund	30,314	52,608
Disaster Fund	29,074	(15)
	$69,229	134,688

The Association also provides administrative and financial support to its two wholly-owned subsidiaries, ADABSI (note 6) and ADREC (note 7). Receivables from (payables to) these subsidiaries are recorded as due from (to) affiliated organizations and are eliminated in combination.

4. Marketable Securities

Investments at December 31 consist of the following:

	1989		1988	
	Market value	Cost	Market value	Cost
Current:				
Association:				
Money market funds	$ 4,191	4,191	114,319	114,319
Certificates of deposit	71,580	71,580	81,881	81,881
U. S. Government obligations	-	-	1,600,083	1,543,475
	75,771	75,771	1,796,283	1,739,675
Foundation:				
Certificates of deposit	1,556,572	1,556,572	1,131,062	1,131,062
U. S. Government obligations	11,956	12,964	12,333	12,963
	1,568,528	1,569,536	1,143,395	1,144,025
	$1,644,299	1,645,307	2,939,678	2,883,700
Long-term:				
Association:				
Money market funds	$ 487,236	487,236	912,554	912,554
Certificates of deposit	445,000	445,000	445,000	445,000
Common stocks	4,485,210	2,969,448	3,136,850	2,390,167
	$5,417,446	3,901,684	4,494,404	3,747,721

Investments totaling $445,000 are pledged as collateral to secure a loan made to an affiliated entity of the Association by a third party.

Investment income for the years ended December 31, 1989 and 1988 consist of the following:

	1989	1988
Association:		
Interest	$ 596,940	462,546
Dividends	134,223	119,346
Realized gains	203,843	257,170
Unrealized depreciation - current	(56,611)	(29,607)
Unrealized appreciation - long-term	769,079	223,585
Ground rental income	95,357	270,000
Investment fees and expenses	(21,623)	(19,485)
	1,721,208	1,283,555
Foundation:		
Interest	4,039	3,992
Unrealized appreciation (depreciation) - current	(378)	260
	3,661	4,252
Combined income on security and real estate investments	$1,724,869	1,287,807

The Foundation deferred investment income of approximately $118,900 in 1989 and $71,900 in 1988. These amounts will be recognized as income when costs of the related grant programs or projects are incurred.

5. Investment in Real Estate

In 1984, the Association purchased land in Washington, D.C. for approximately $3 million as an investment for the Reserve Division and entered into a ground lease, with an unaffiliated party, to rent this land for ninety-nine years at an annual rental of $270,000. Concurrently with this purchase, the Association entered into an operating lease to rent office space in the building located on the land. In February 1989, ADREC purchased the building located on the land (note 7) and both the ground lease and the operating lease were canceled.

Ground rental income of $95,357 and $270,000 was received in 1989 and 1988, respectively. Rent expense amounted to $156,595 and $394,946 in 1989 and 1988, respectively.

6. ADA Business Systems, Inc.

In August of 1986, ADABSI entered into an asset purchase and joint marketing agreement with Triad Systems Corporation (Triad) to promote, install, train and support computer systems for the dental profession. As part of the agreement, Triad may use the trade name ADABSI in connection with the marketing of Triad computer systems. In return, ADABSI received financial consideration for its assets, customer base and for the value of the ADABSI trade name as an endorsement of the Triad system. ADABSI also receives royalty payments. Royalty income amounted to approximately $493,000 in 1989 and $400,000 in 1988.

In 1989, ADABSI exercised certain rights attached to warrants obtained to purchase approximately 130,000 shares of stock. These shares were subsequently sold at a net gain of approximately $798,000.

7. American Dental Real Estate Corporation

ADREC is intended to be exempt from taxation under Section 501(c)(2) of the Internal Revenue Code (Code). Although an IRS letter of determination has yet to be received, management is unaware of any reason why ADREC would not be exempt from taxation under the Code.

In February 1989, ADREC purchased the building residing on the land owned by the Association at a cost of $9,500,000. In connection with the purchase, ADREC assumed the existing $8,018,000 mortgage on the building. The mortgage loan bears interest at a rate of 9 3/8% and matures on September 1, 1996. The mortgage loan requires monthly payments totaling $809,604 per year. In order to complete the purchase of the building, ADREC obtained a short-term bridge loan in the amount of $1,750,000 bearing interest at the prime lending rate. The loan matured on February 20, 1990 and a new bridge loan was negotiated which matures June 30, 1990. In December 1989, ADREC also obtained a $1,200,000 line of credit to meet short term operating and capital improvement needs, and immediately borrowed $600,000 against the line which was outstanding as of December 31, 1989. Borrowings against the line of credit vary with and bear interest at the prime lending rate. The building owned by ADREC and the land owned by the Association have been pledged as collateral, and the Association has also guaranteed the repayment of the loans.

In February 1990, ADREC entered into a commitment to refinance the existing mortgage in the principal amount of $9,550,000 at an interest rate of 9.125%. The new mortgage requires monthly payments totaling $933,036 per year and matures in five years from issuance of the proceeds. The remaining principal is due in one lump sum at the maturity of the loan. The new mortgage would be secured by the land and the building and would also be guaranteed by the Association. Principal proceeds remaining from the refinancing will be used to liquidate the bridge loan.

ADREC leases a portion of the building to unrelated parties under operating leases with varying terms. Minimum future rentals to be earned from leases currently in effect are approximately $860,587 in 1990, $841,335 in 1991, $779,621 in 1992, $771,438 in 1993 and $668,737 in 1994. These amounts may be adjusted upon renewal of the leases. Building expense includes the cost of facilities occupied by the Association, as well as those costs related to other tenants who occupy the majority of the building.

8. Property and Equipment

Property and equipment at December 31 consists of the following:

	1989	1988
Association:		
Land	$ 712,113	712,113
Buildings	21,998,831	12,381,169
Building improvements	4,254,957	4,138,077
Leasehold improvements	98,827	437,656
Furniture and equipment	4,984,352	4,265,935
Film and book libraries	440,190	440,190
	32,489,270	22,375,140
Less accumulated depreciation	10,885,862	9,642,618
	21,603,408	12,732,522
Foundation:		
Furniture and equipment	271,648	271,648
Less accumulated depreciation	218,944	202,429
	52,704	69,219
	$21,656,112	12,801,741

Depreciation and amortization expense for property and equipment utilized by the Association and Foundation was $1,601,088 and $1,093,875 in 1989 and 1988, respectively.

Furniture and equipment includes approximately $414,500 of costs at December 31, 1989 and 1988 related to data processing and copier equipment held under capital leases. Accumulated depreciation amounted to approximately $160,000 and $68,000 in 1989 and 1988, respectively.

Tenant leasehold improvements net of accumulated amortization amounting to $1,209,798 and $1,349,413 in 1989 and 1988, respectively, are shown on the balance sheet as deferred charges and other assets. Amortization is computed on the straight-line method over the remaining term of the lease. Amortization expense amounted to $399,585 and $342,565 in 1989 and 1988, respectively.

The Association leases portions of the headquarters building to unrelated parties under operating leases with varying terms. Minimum future rentals to be earned from leases currently in effect are approximately $1,871,000 in 1990, $1,514,000 in 1991, $819,000 in 1992, $737,000 in 1993, $598,000 in 1994, and $1,946,000 thereafter. These amounts may be adjusted upon renewal of the leases.

Headquarters building expense includes the cost of facilities occupied by the Association, as well as those costs related to other tenants, who occupy approximately 46% of the building.

9. Income Taxes

The Association and the Foundation are tax exempt organizations under Sections 501(c)(6) and 501(c)(3) of the Code, respectively.

As an exempt organization, the Association is subject to Federal and state income taxes on income determined to be unrelated business taxable income, principally advertising income from periodicals and debt financed rental income. The Association is also subject to income taxes on its for-profit subsidiary, ADABSI.

In 1989, income subject to tax amounted to $1,700,000. This amount has been reduced by a $210,000 rental loss from ADREC.

The provision for income taxes is composed of the following:

	1989	1988
Current provision:		
Federal	$509,000	560,000
State	111,000	140,000
	$620,000	700,000

This provision is the result of the following types of income (loss) and can be broken down as follows:

	Income Tax Expense (Benefit)		
	Federal	State	Total
Unrelated business taxable income, principally advertising	$576,000	124,000	700,000
Not-for-profit corporation rental loss	(67,000)	(13,000)	(80,000)
	$509,000	111,000	620,000

In 1988, the provision for income taxes was due to unrelated business taxable income, principally advertising.

The 1989 effective tax rate of 36% differs from the sum of the Federal and state statutory rates primarily as a result of the Federal surtax exemption and a deduction for state income taxes.

At December 31, 1989, ADABSI had a net operating loss carry-forward for income tax purposes of $1,602,000 which can be used to offset future taxable income of ADABSI and expires as follows: $918,000 in 2001, $410,000 in 2002 and $274,000 in 2003. The difference between the net operating loss for income tax and financial statement purposes relates principally to the treatment of start-up costs, and the use of the accelerated cost recovery system for tax depreciation.

10. Pension Plan

The Association has a defined benefit pension plan covering substantially all of its employees. The benefits are based on years of service and the employee's compensation during the last five years of employment. The Association's funding policy is to contribute annually the customary "20 year funding" contribution. Contributions are intended to provide not only for benefits attributed to service to date but also for those expected to be earned in the future.

The following table sets forth the plan's funded status and amounts recognized in the Association's statement of financial position at December 31:

	1989	1988
Actuarial present value of benefit obligations:		
Accumulated benefit obligation, including vested benefits of $9,660,918 and $8,014,419, respectively	$ 9,925,617	8,459,226
Projected benefit obligation for service rendered to date	14,172,708	11,216,949
Plan assets at fair value, primarily listed stocks and insurance guarantee contracts	13,566,296	11,220,390
Plan assets in excess of (less than) the projected benefit obligation	(606,412)	3,441
Unrecognized net (gain) loss from past experience different from that assumed and effects of changes in assumptions	127,224	(98,674)
Prior service cost not yet recognized in net periodic pension cost	915,227	74,100
Unrecognized net obligation at January 1 being recognized over 15 years	(224,945)	(243,691)
Prepaid (accrued) pension expense	$ 211,094	(264,824)
Net pension cost for 1989 and 1988 included the following components:		
Service cost-benefits earned during the period	944,418	721,742
Interest cost on projected benefit obligation	947,545	783,568
Actual return on plan assets	(1,734,593)	(1,094,459)
Net amortization and deferral	581,712	102,607
Net periodic pension cost	$ 739,082	513,458

The weighted-average discount rate and rate of increase in future compensation levels used in determining the actuarial present value of the projected benefit obligation were 8.25% and 6%, respectively. The expected long-term rate of return on assets was 10%. The discount rate used at the beginning of the year to determine the net pension cost was 8.25% (8.75% for 1988), with all other assumptions the same as described above.

11. Employee Savings and Retirement Plan

The Association has a savings and retirement plan for all eligible employees. The Association matches 25% of contributed amounts up to a maximum of $250 per participant each year. The Association paid approximately $60,000 in 1989 and $52,000 in 1988.

The Internal Revenue Service informed the Savings and Retirement Plan Trust on October 22, 1987 that it was qualified under Section 401(a) of the Code and, therefore, was exempt from Federal income taxes under provisions of Section 501(a) of the Code.

12. Commitments and Contingencies

The Association is involved in various asserted and unasserted claims incidental to the normal conduct of its business. In the opinion of management and the Association's legal counsel, the ultimate disposition of these matters will not have a material adverse effect on the combined results of operations or the combined financial position of the Association.

13. Reclassifications

Certain 1988 amounts have been reclassified to conform to the 1989 presentation.

14. Subsequent Events

Effective January 1, 1990, the Association's for-profit subsidiary, ADA Holding Company, Inc. (ADAHCI) began operations. ADAHCI was incorporated to hold the stock of ADABSI, ADA Publishers, Inc. (ADAPI) and any other for-profit corporations which may arise in the future. ADAPI, which also began operations on January 1, 1990, performs all publishing functions for the Association's major publications.

American Dental Association
Divisional Combining Balance Sheet

December 31, 1989

Schedule 1

AMERICAN DENTAL ASSOCIATION

DIVISIONAL COMBINING BALANCE SHEET

DECEMBER 31, 1989

	Operating Division					
ASSETS	Operating Account	Investment Account	Total	Reserve Division	Eliminations	Combined Association
Current assets:						
Cash and cash equivalents	$ 1,393,034	-	1,393,034	252,592	-	1,645,626
Receivables, net of allowance for doubtful accounts of $227,100	2,376,373	-	2,376,373	145,804	-	2,522,177
Marketable securities, at market	72,287	3,484	75,771	-	-	75,771
Inventories, net of reserves of $425,000	1,187,586	-	1,187,586	-	-	1,187,586
Income tax receivable	240,500	-	240,500	-	-	240,500
Total current assets	5,269,780	3,484	5,273,264	398,396	-	5,671,660
Due from (to) other funds - net	822,550	-	822,550	(822,550)	-	-
Due from affiliated organizations - net	69,229	-	69,229	-	-	69,229
Long-term receivables	155,739	-	155,739	-	-	155,739
Investments:						
Marketable securities, at market	-	-	-	5,417,446	-	5,417,446
Land	-	-	-	3,030,000	-	3,030,000
ADREC (1,000 shares, $1 par value)	1,000	-	1,000	-	(1,000)	-
ADABSI (100,000 shares, $10 par value)	1,000,000	-	1,000,000	-	(1,000,000)	-
Property and equipment - net	12,315,955	-	12,315,955	9,484,398	(196,945)	21,603,408
Funds held for deferred compensation	2,850,054	-	2,850,054	-	-	2,850,054
Deferred charges and other assets	1,656,420	-	1,656,420	173,103	-	1,829,523
Prepaid pension expense	211,094	-	211,094	-	-	211,094
	$24,351,821	3,484	24,355,305	17,680,793	(1,197,945)	40,838,153
LIABILITIES AND EQUITY						
Current liabilities:						
Accounts payable	2,834,296	-	2,834,296	70,298	-	2,904,594
Accrued liabilities	1,463,160	-	1,463,160	-	-	1,463,160
Notes payable	-	-	-	2,350,000	-	2,350,000
Current portion of mortgage loan payable	-	-	-	809,604	-	809,604
Capital lease obligations due within one year	78,448	-	78,448	-	-	78,448
Deferred revenues	4,265,942	-	4,265,942	-	-	4,265,942
Total current liabilities	8,641,846	-	8,641,846	3,229,902	-	11,871,748
Mortgage loan payable	-	-	-	7,123,160	-	7,123,160
Liability for deferred compensation	2,850,054	-	2,850,054	-	-	2,850,054
Other long-term liabilities	132,223	-	132,223	51,915	-	184,138
Capital	-	-	-	1,001,000	(1,001,000)	-
Equity	12,727,698	3,484	12,731,182	6,274,816	(196,945)	18,809,053
	$24,351,821	3,484	24,355,305	17,680,793	(1,197,945)	40,838,153

See accompanying independent auditors' report.

American Dental Association Divisional Combining Statement of Revenues, Expenses, Transfers and Equity

Year ended December 31, 1989

Schedule 2

AMERICAN DENTAL ASSOCIATION

DIVISIONAL COMBINING STATEMENT OF REVENUES, EXPENSES, TRANSFERS AND EQUITY

Year ended December 31, 1989

	Operating Division					
	Operating Account	Investment Account	Total	Reserve Division	Eliminations	Combined Association
Operating revenues:						
Membership dues	$24,357,212	-	24,357,212	-	-	24,357,212
Publications	6,139,268	-	6,139,268	-	-	6,139,268
Sales of educational materials	2,977,213	-	2,977,213	-	-	2,977,213
Building income (principally rentals)	2,505,316	-	2,505,316	1,057,814	-	3,563,130
Education services	1,986,243	-	1,986,243	-	-	1,986,243
Conference & meeting services	3,083,944	-	3,083,944	-	-	3,083,944
Income on security and real estate investments	276,429	195,781	472,210	1,248,998	-	1,721,208
Other non-dues sources - net	2,509,067	-	2,509,067	1,291,047	-	3,800,114
Total operating revenues	43,834,692	195,781	44,030,473	3,597,859	-	47,628,332
Operating expenses:						
Executive Director, Board and House	2,968,141	-	2,968,141	-	-	2,968,141
Education services	3,582,944	-	3,582,944	-	-	3,582,944
Cost of educational materials	2,046,114	-	2,046,114	-	-	2,046,114
Building expenses	3,880,760	-	3,880,760	606,461	-	4,487,221
Dental practice	3,449,488	-	3,449,488	-	-	3,449,488
Publications	5,769,648	-	5,769,648	-	-	5,769,648
Scientific affairs	1,618,162	-	1,618,162	-	-	1,618,162
Communications	3,039,500	-	3,039,500	-	-	3,039,500
Legislative affairs	1,827,092	-	1,827,092	-	-	1,827,092
Legal affairs	1,230,303	-	1,230,303	-	-	1,230,303
Membership services	2,704,338	-	2,704,338	-	-	2,704,338
Finance affairs	2,307,544	-	2,307,544	-	-	2,307,544
Business affairs	2,833,094	-	2,833,094	-	-	2,833,094
Conference & meeting services	3,431,680	-	3,431,680	-	-	3,431,680
Grants to health related groups	1,693,424	-	1,693,424	-	-	1,693,424
Operating expenses of ADABSI	-	-	-	442,045	-	442,045
Depreciation and amortization	1,510,434	-	1,510,434	276,779	196,945	1,984,158
Interest	46,698		46,698	762,321	-	809,019
Total operating expenses	43,939,364	-	43,939,364	2,087,606	196,945	46,223,915
Excess (deficiency) of operating revenues over operating expenses	(104,672)	195,781	91,109	1,510,253	(196,945)	1,404,417
Income taxes	(620,000)	-	(620,000)	-	-	(620,000)
Excess (deficiency) of revenues over expenses	(724,672)	195,781	(528,891)	1,510,253	(196,945)	784,417
Equity at beginning of year	11,010,461	1,727,112	12,737,573	5,287,063	-	18,024,636
Cash transfers in	3,091,909	650,000	3,741,909	-	-	3,741,909
Cash transfers out	(650,000)	(2,569,409)	(3,219,409)	(522,500)	-	(3,741,909)
Equity at end of year	$12,727,698	3,484	12,731,182	6,274,816	(196,945)	18,809,053

See accompanying independent auditors' report.

American Dental Association Divisional Combining Statement of Cash Flows

Year ended December 31, 1989

Schedule 3

AMERICAN DENTAL ASSOCIATION

DIVISIONAL COMBINING STATEMENT OF CASH FLOWS

Year ended December 31, 1989

	Operating Division					
	Operating Account	Investment Account	Total	Reserve Division	Eliminations	Combined Association
Cash flows from operating activities:						
Excess (deficiency) of revenues over expenses	$ (724,672)	195,781	(528,891)	1,510,253	(196,945)	784,417
Adjustments to reconcile to net cash provided by (used in) operating activities:						
Depreciation and amortization	1,510,434	-	1,510,434	276,779	196,945	1,984,158
Unrealized (appreciation) depreciation on marketable securities/investments	-	56,611	56,611	(769,079)	-	(712,468)
Increase in allowance for doubtful accounts	8,449	-	8,449	4,198	-	12,647
Decrease in reserve for obsolete and excess inventory	(125,000)	-	(125,000)	-	-	(125,000)
Gain on sale of marketable securities/investments	-	(51,869)	(51,869)	(950,161)	-	(1,002,030)
Changes in assets - (increase) decrease:						
Receivables	(280,400)	12,710	(267,690)	(42,321)	-	(310,011)
Inventories	209,873	-	209,873	3,448	-	213,321
Income tax receivable	(240,500)	-	(240,500)	-	-	(240,500)
Due from (to) other funds and affiliated organizations - net	789,708	-	789,708	(724,249)	-	65,459
Long-term receivables	48,249	-	48,249	-	-	48,249
Deferred charges and other assets	294,882	-	294,882	(169,403)	-	125,479
Prepaid pension expense	(211,094)	-	(211,094)	-	-	(211,094)
Changes in liabilities - increase (decrease):						
Accounts payable and accrued liabilities	9,164	-	9,164	(12,018)	-	(2,854)
Capital lease obligations due within one year	11,710	-	11,710	-	-	11,710
Deferred revenues	178,241	-	178,241	-	-	178,241
Income taxes payable	(114,049)	-	(114,049)	-	-	(114,049)
Accrued pension expense	(264,824)	-	(264,824)	-	-	(264,824)
Other long-term liabilities	(88,794)	-	(88,794)	51,915	-	(36,879)
Net cash provided by (used in) operating activities	1,011,377	213,233	1,224,610	(820,638)	-	403,972
Cash flows from financing activities:						
Proceeds from notes payable	2,600,000	-	2,600,000	2,350,000	-	4,950,000
Proceeds from mortgage loan payable	-	-	-	8,018,448	-	8,018,448
Payments on notes payable	(4,100,000)	-	(4,100,000)	-	-	(4,100,000)
Payments on mortgage loan payable	-	-	-	(85,684)	-	(85,684)
Proceeds from issuing equity	-	-	-	1,000	(1,000)	-
Net cash provided by (used in) financing activities	(1,500,000)	-	(1,500,000)	10,283,764	(1,000)	8,782,764
Cash flows from investing activities:						
Purchase of marketable securities	(6,400,572)	(3,923,422)	(10,323,994)	-	-	(10,323,994)
Purchase of investments	(1,000)	-	(1,000)	(2,521,180)	1,000	(2,521,180)
Sale of marketable securities	6,410,166	5,629,598	12,039,764	-	-	12,039,764
Sale of investments	-	-	-	3,317,378	-	3,317,378
Aquisitions of property and equipment	(1,099,218)	-	(1,099,218)	(9,755,823)	-	(10,855,041)
Net cash provided by (used in) investing activities	(1,090,624)	1,706,176	615,552	(8,959,625)	1,000	(8,343,073)
Cash transfers in	3,091,909	650,000	3,741,909	-	-	3,741,909
Cash transfers out	(650,000)	(2,569,409)	(3,219,409)	(522,500)	-	(3,741,909)
Cash and cash equivalents at beginning of year	530,372	-	530,372	271,591	-	801,963
Cash and cash equivalents at end of year	$ 1,393,034	-	1,393,034	252,592	-	1,645,626
Cash paid during the year for:						
Interest	$ 46,698	-	46,698	739,294	-	785,992
Income taxes	1,134,993	-	1,134,993	-	-	1,134,993

See accompanying independent auditors' report.

American Dental Association
Reserve Division
Divisional Combining Balance Sheet

December 31, 1989

Schedule 4

AMERICAN DENTAL ASSOCIATION - RESERVE DIVISION

DIVISIONAL COMBINING BALANCE SHEET

DECEMBER 31, 1989

	Capital Formation				
ASSETS	Land	ADREC	ADABSI	Reserved Investment	Combined Reserve Division
Current assets:					
Cash and cash equivalents	$ -	250,569	2,016	7	252,592
Receivables, net of allowance for doubtful accounts of $10,000	-	17,842	114,500	13,462	145,804
Total current assets	-	268,411	116,516	13,469	398,396
Due from (to) other funds - net	72,857	(102,328)	(793,079)	-	(822,550)
Investments:					
Marketable securities, at market	-	-	-	5,417,446	5,417,446
Land	3,030,000	-	-	-	3,030,000
Property and equipment - net	-	9,481,878	2,520	-	9,484,398
Deferred charges and other assets	-	173,103	-	-	173,103
	$ 3,102,857	9,821,064	(674,043)	5,430,915	17,680,793
LIABILITIES AND EQUITY					
Current liabilities:					
Accounts payable	-	70,298	-	-	70,298
Notes payable	-	2,350,000	-	-	2,350,000
Current portion of mortgage loan payable	-	809,604	-	-	809,604
Total current liabilities	-	3,229,902	-	-	3,229,902
Mortgage loan payable	-	7,123,160	-	-	7,123,160
Other long-term liabilities	-	51,915	-	-	51,915
Capital	-	1,000	1,000,000	-	1,001,000
Equity (deficit)	3,102,857	(584,913)	(1,674,043)	5,430,915	6,274,816
	$ 3,102,857	9,821,064	(674,043)	5,430,915	17,680,793

See accompanying independent auditors' report.

American Dental Association Reserve Division Divisional Combining Statement of Revenues, Expenses, Transfers and Equity (Deficit)

Year ended December 31, 1989

Schedule 5

AMERICAN DENTAL ASSOCIATION - RESERVE DIVISION

DIVISIONAL COMBINING STATEMENT OF REVENUES, EXPENSES, TRANSFERS AND EQUITY (DEFICIT)

Year ended December 31, 1989

	Capital Formation			Reserved	Combined Reserve
	Land	ADREC	ADABSI	Investment	Division
Operating revenues:					
Building income (principally rentals)	$ -	1,057,814	-	-	1,057,814
Income on security and real estate investments	95,357	-	617	1,153,024	1,248,998
Other non-dues sources (principally gain on sale of stock and royalty income)	-	-	1,291,047	-	1,291,047
Total operating revenues	95,357	1,057,814	1,291,664	1,153,024	3,597,859
Operating expenses:					
Building expenses	-	606,461	-	-	606,461
Operating expenses of ADABSI (principally payroll, professional fees, and advertising)	-	-	442,045	-	442,045
Depreciation and amortization	-	273,945	2,834	-	276,779
Interest	-	762,321	-	-	762,321
Total operating expenses	-	1,642,727	444,879	-	2,087,606
Excess (deficiency) of operating revenues over operating expenses	95,357	(584,913)	846,785	1,153,024	1,510,253
Income taxes	-	-	-	-	-
Excess (deficiency) of revenues over expenses	95,357	(584,913)	846,785	1,153,024	1,510,253
Equity (deficit) at beginning of year	3,030,000	-	(2,520,828)	4,777,891	5,287,063
Cash transfers out	(22,500)	-	-	(500,000)	(522,500)
Equity (deficit) at end of year	$ 3,102,857	(584,913)	(1,674,043)	5,430,915	6,274,816

See accompanying independent auditors' report.

American Dental Association Reserve Division Divisional Combining Statement of Cash Flows

Year ended December 31, 1989

Schedule 6

AMERICAN DENTAL ASSOCIATION - RESERVE DIVISION

DIVISIONAL COMBINING STATEMENT OF CASH FLOWS

Year ended December 31, 1989

	Capital Formation				Combined
	Land	ADREC	ADABSI	Reserved Investment	Reserve Division
Cash flows from operating activities:					
Excess (deficiency) of revenues over expenses	$95,357	(584,913)	846,785	1,153,024	1,510,253
Adjustments to reconcile to net cash provided by (used in) operating activities:					
Depreciation and amortization	-	273,945	2,834	-	276,779
Unrealized appreciation on investments	-	-	-	(769,079)	(769,079)
Increase in allowance for doubtful accounts	-	-	4,198	-	4,198
Gain on sale of investments	-	-	(798,187)	(151,974)	(950,161)
Changes in assets - (increase) decrease:					
Receivables	-	(17,842)	(24,500)	21	(42,321)
Inventories	-	-	3,448	-	3,448
Due from (to) other funds - net	(72,857)	102,328	(753,720)	-	(724,249)
Deferred charges and other assets	-	(173,103)	3,700	-	(169,403)
Changes in liabilities - increase (decrease):					
Accounts payable	-	70,298	(82,316)	-	(12,018)
Other long-term liabilities	-	51,915	-	-	51,915
Net cash provided by (used in) operating activities	22,500	(277,372)	(797,758)	231,992	(820,638)
Cash flows from financing activities:					
Proceeds from notes payable	-	2,350,000	-	-	2,350,000
Proceeds from mortgage loan payable	-	8,018,448	-	-	8,018,448
Payments on mortgage loan payable	-	(85,684)	-	-	(85,684)
Proceeds from issuing equity	-	1,000	-	-	1,000
Net cash provided by financing activities	-	10,283,764	-	-	10,283,764
Cash flows from investing activities:					
Purchase of investments	-	-	-	(2,521,180)	(2,521,180)
Sale of investments	-	-	798,187	2,519,191	3,317,378
Aquisitions of property and equipment	-	(9,755,823)	-	-	(9,755,823)
Net cash provided by (used in) investing activities	-	(9,755,823)	798,187	(1,989)	(8,959,625)
Cash transfers out	(22,500)	-	-	(500,000)	(522,500)
Cash and cash equivalents at beginning of year	-	-	1,587	270,004	271,591
Cash and cash equivalents at end of year	$ -	250,569	2,016	7	252,592
Cash paid during the year for:					
Interest	$ -	739,294	-	-	739,294

See accompanying independent auditors' report.

Report of Independent Auditor

Commission on Relief and Disaster Fund Activities, American Dental Association

We have audited the accompanying combining balance sheets of the American Dental Association Relief Fund and the American Dental Association Disaster Victims Emergency Loan Fund as of June 30, 1989 and 1988, and the related combining statements of revenues and expenses and change in fund balances and cash flows for the years then ended. These financial statements are the responsibility of the Association's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the combining financial statements referred to above present fairly, in all material respects, the combined and individual financial positions of the American Dental Association Relief Fund and the American Dental Association Disaster Victims Emergency Loan Fund as of June 30, 1989 and 1988, and the combined and individual results of their operations and their cash flows for the years then ended in conformity with generally accepted accounting principles.

Peat Marwick Main & Co.
Chicago, Illinois
September 19, 1989

American Dental Association Relief Fund and American Dental Association Disaster Victims Emergency Loan Fund

June 30, 1989 and 1988

Combining Balance Sheets

AMERICAN DENTAL ASSOCIATION RELIEF FUND
AND AMERICAN DENTAL ASSOCIATION DISASTER
VICTIMS EMERGENCY LOAN FUND

COMBINING BALANCE SHEETS

June 30, 1989 and 1988

	1989				1988			
	Relief Fund	Disaster Fund	Combining adjustments	Combined	Relief Fund	Disaster Fund	Combining adjustments	Combined
ASSETS								
Cash	$ 3,900	1,882		5,782	34,552	6,141		40,693
Interest and dividends receivable	82,884	-		82,884	80,276	-		80,276
Amounts due from Relief Fund	-	645,506	(645,506)	-	-	623,006	(623,006)	-
Amounts for grants due from constituent societies	-	-		-	15,481	-		15,481
Loans receivable, less reserve of $23,941 (1989 and 1988)	-	147,036		147,036	-	182,806		182,806
Pledges receivable	-	-		-	5,018	-		5,018
Prepaid expenses	863	-		863	903	-		903
Refundable income taxes (note 5)	-	-		-	-	30,068		30,068
Investments, at market (note 1)	7,444,359	-		7,444,359	6,895,110	-		6,895,110
Total assets	7,532,006	794,424	(645,506)	7,680,924	7,031,340	842,021	(623,006)	7,250,355
LIABILITIES AND FUND BALANCES								
Accrued liabilities	5,090	-		5,090	6,612	-		6,612
Amounts due to Disaster Fund	645,506	-	(645,506)	-	623,006	-	(623,006)	-
Amounts due to Health Foundation	4,436	-		4,436	-	-		-
Amounts due to American Dental Association	19,942	-		19,942	105,979	4,862		110,841
Amounts for grants due to constituent societies	3,269	-		3,269	-	-		-
Amounts payable to constituent societies	327,550	-		327,550	298,721	-		298,721
Income taxes payable (note 5)	-	6,794		6,794	-	6,106		6,106
Total liabilities	1,005,793	6,794	(645,506)	367,081	1,034,318	10,968	(623,006)	422,280
Fund balances	6,526,213	787,630	-	7,313,843	5,997,022	831,053	-	6,828,075
	$7,532,006	794,424	(645,506)	7,680,924	7,031,340	842,021	(623,006)	7,250,355

See accompanying notes to combining financial statements.

American Dental Association Relief Fund and American Dental Association Disaster Victims Emergency Loan Fund

Years ended June 30, 1989 and 1988

Combining Statements of Revenues and Expenses and Change in Fund Balances

AMERICAN DENTAL ASSOCIATION RELIEF FUND
AND AMERICAN DENTAL ASSOCIATION DISASTER
VICTIMS EMERGENCY LOAN FUND

COMBINING STATEMENTS OF REVENUES AND
EXPENSES AND CHANGE IN FUND BALANCES

Years ended June 30, 1989 and 1988

	1989			1988		
	Relief Fund	Disaster Fund	Combined	Relief Fund	Disaster Fund	Combined
OPERATING REVENUES						
Contributions	$ 315,412	-	315,412	320,291	-	320,291
Allocation of contributions to constituent societies	(258,140)	-	(258,140)	(231,631)	-	(231,631)
	57,272	-	57,272	88,660	-	88,660
Earnings on investments:						
Interest and dividends	526,556	-	526,556	499,305	-	499,305
Investment management fees and expenses	(25,746)	-	(25,746)	(27,167)	-	(27,167)
Net realized gains (losses)	(19,412)	-	(19,412)	183,165	-	183,165
Net unrealized appreciation (depreciation)	371,608	-	371,608	(566,344)	-	(566,344)
Interest on loans	-	7,459	7,459	-	4,734	4,734
Miscellaneous	-	-	-	-	1,000	1,000
Total operating revenues	910,278	7,459	917,737	177,619	5,734	183,353
OPERATING EXPENSES						
Grants	193,039	-	193,039	225,844	-	225,844
Fund-raising	83,645	-	83,645	91,372	-	91,372
General and administrative	104,403	-	104,403	88,779	-	88,779
Total operating expenses	381,087	-	381,087	405,995	-	405,995
Excess (deficiency) of operating revenues over operating expenses	529,191	7,459	536,650	(228,376)	5,734	(222,642)
Income taxes (note 5)	-	50,882	50,882	-	-	-
Excess (deficiency) of revenues over expenses	529,191	(43,423)	485,768	(228,376)	5,734	(222,642)
Fund balances at beginning of year	5,997,022	831,053	6,828,075	6,225,398	825,319	7,050,717
Fund balances at end of year	$6,526,213	787,630	7,313,843	5,997,022	831,053	6,828,075

See accompanying notes to combining financial statements.

American Dental Association Relief Fund and American Dental Association Disaster Victims Emergency Loan Fund

Years ended June 30, 1989 and 1988

Combining Statements of Cash Flows

AMERICAN DENTAL ASSOCIATION RELIEF FUND
AND AMERICAN DENTAL ASSOCIATION DISASTER
VICTIMS EMERGENCY LOAN FUND

COMBINING STATEMENTS OF CASH FLOWS

Years ended June 30, 1989 and 1988

	1989			1988		
	Relief Fund	Disaster Fund	Combined	Relief Fund	Disaster Fund	Combined
Cash flows from operating activities:						
Excess (deficiency) of revenues over expenses	$ 529,191	(43,423)	485,768	(228,376)	5,734	(222,642)
Adjustments to reconcile to net cash provided by (used in) operating activities:						
Unrealized (appreciation) depreciation on investments	(371,608)	-	(371,608)	566,344	-	566,344
Changes in assets and liabilities:						
Increase in interest and dividends receivable	(2,608)	-	(2,608)	(7,643)	-	(7,643)
Increase in amounts due from Relief Fund	-	(22,500)	(22,500)	-	(58,500)	(58,500)
(Increase) decrease in amounts for grants due from constituent societies	18,750	-	18,750	(3,297)	-	(3,297)
Decrease in loans receivable	-	35,770	35,770	-	61,808	61,808
(Increase) decrease in pledges receivable	5,018	-	5,018	(1)	-	(1)
Decrease in prepaid expenses	40	-	40	69	-	69
(Increase) decrease in refundable income taxes	-	30,068	30,068	-	(12,212)	(12,212)
Increase in investments	(177,641)	-	(177,641)	(468,272)	-	(468,272)
Increase (decrease) in accrued liabilities	(1,522)	-	(1,522)	962	-	962
Increase in amounts due to Disaster Fund	22,500	-	22,500	58,500	-	58,500
Increase in amounts due to Health Foundation	4,436	-	4,436	-	-	-
Increase (decrease) in amounts due to American Dental Association	(86,037)	(4,862)	(90,899)	107,348	4,862	112,210
Increase (decrease) in amounts payable to constituent societies	28,829	-	28,829	(22,157)	-	(22,157)
Increase in income taxes payable	-	688	688	-	1,656	1,656
Total adjustments	(559,843)	39,164	(520,679)	231,853	(2,386)	229,467
Net cash provided by (used in) operating activities	(30,652)	(4,259)	(34,911)	3,477	3,348	6,825
Cash at beginning of year	34,552	6,141	40,693	31,075	2,793	33,868
Cash at end of year	$ 3,900	1,882	5,782	34,552	6,141	40,693

See accompanying notes to combining financial statements.

American Dental Association Relief Fund and American Dental Association Disaster Victims Emergency Loan Fund

Notes to Combining Financial Statements, June 30, 1989 and 1988

1. Significant accounting policies

Basis of presentation

The American Dental Association Relief Fund (Relief Fund) was established by the American Dental Association (ADA) under the terms of an Indenture of Trust (Relief Trust) executed September 30, 1948. The Relief Fund renders financial aid to members of the dental profession and their dependents who, because of misfortune, age or other disabling conditions, are not wholly self-sustaining.

The American Dental Association Disaster Victims Emergency Loan Fund (Disaster Fund) was established by the ADA under the terms of an Indenture of Trust (Disaster Trust) executed November 15, 1972. The Disaster Fund provides emergency assistance in the form of interest free loans to dentists who are victims of natural disasters and whose resources have been seriously depleted.

The Relief and Disaster Trusts may be amended or terminated by action of the ADA. Upon termination, the Trust properties shall revert to the ADA to be used exclusively for charitable purposes. The Commission on Relief and Disaster Fund Activities (Commission), elected from the ADA membership, is the trustee for both funds.

In view of the fact that the Commission is the trustee for both funds, financial statements are presented on both an individual and a combined basis.

Investment and loan activities, which would otherwise be considered investing activities in the combining statements of cash flows, are presented as operating activities as they represent the normal operations of the funds.

Allocation of Relief Fund contributions

Allocation of Relief Fund contributions to the Disaster Fund is in accordance with annual quotas established by the Commission. There were no allocations of contributions for the years ended June 30, 1989 or 1988. Contributions are received from the ADA membership directly and through constituent societies.

The rules of the Relief Fund provide that refunds of contributions to constituent societies may be made if those societies have been established as charitable organizations having purposes consistent with that of the Relief Fund and that have been accorded tax-exempt status under the Internal Revenue Code. Prior to payment of any refund, constituent society relief funds are also required to submit annual financial statements. Once every five years, the financial statements submitted that year are required to be audited by a certified public accountant. Refunds in the amount of $69,416 at June 30, 1989 and $67,090 at June 30, 1988 (from prior years' Relief contributions) are payable to societies whose relief funds have not yet qualified for payment under rules of the Fund.

Investments

The Relief Fund portfolio consists of commercial paper, certificates of deposit, corporate bonds, U.S. Government obligations and common stocks. Investments are stated at approximate market, determined as follows:

(a) Securities traded on a national securities exchange are valued at the last reported sales price,

(b) Securities traded in the over-the-counter market are valued at the mean between the last bid and ask quotations,

(c) Securities traded principally among financial institutions and dealers are valued at a bid price determined from other published sources,

(d) U.S. treasury bills and certificates of deposit are valued at cost which approximates market less accrued interest,

(e) U.S. treasury bonds and notes are valued at market

and

(f) Commercial paper investments are valued at cost which approximates market.

Purchases and sales of securities are recorded on the settlement dates. Gains or losses on securities are based on specific identification of securities.

Revenue recognition

All income from investments is recognized on the accrual basis. Contributions are recognized when received by the Relief Fund. Interest income from Disaster Fund loans is recognized when received which is not materially different from recognition on the accrual basis.

Grant expense

Grants to relief recipients are recorded when the grant is paid. Obligations for future grant payments previously authorized by the Commission amounted to $97,125 at June 30, 1989 and $85,214 at June 30, 1988. Grants paid are shared equally by the Relief Fund and the recipient's state society.

2. Investments

Investments are composed of the following:

	1989		1988	
	Cost	Market	Cost	Market
Commercial paper	$ 922,271	922,271	1,110,791	1,110,791
Certificates of deposit	100,000	100,000	-	-
Corporate bonds	1,177,093	1,172,062	889,847	866,375
U.S. Government obligations	1,859,317	2,068,080	2,101,724	2,321,479
Common stocks	2,383,681	3,181,946	2,162,359	2,596,465
Total	$6,442,362	7,444,359	6,264,721	6,895,110

3. Related party transactions

The ADA provides administrative and financial support to the Relief and Disaster Funds. General and administrative expenses include allocations from the ADA and are borne entirely by the Relief Fund.

4. Loans receivable

Loans receivable consist of five-year, non-interest bearing loans to disaster victims. Interest, at annual rates of 6% on loans granted prior to April 1, 1980, 10% on loans granted between April 1, 1980 and March 31, 1981 and 12% on loans granted after that date, is payable on any amounts outstanding after the agreed term.

5. Income taxes

Relief Fund

The Relief Fund qualifies under Section 501(c)(3) of the Internal Revenue Code (Code) and, therefore, is exempt from Federal income taxes under Section 501(a) of the Code.

Disaster Fund

On November 11, 1975 the Internal Revenue Service (IRS) issued a letter of determination stating that the Disaster Fund was exempt from Federal income taxes under Section 501(c)(3) of the Code. On May 26, 1982, the IRS issued a letter of determination revoking the tax-exempt status of the Disaster Fund. On June 25, 1982, the Disaster Fund filed an appeal with the Regional Director of Appeals of the IRS to challenge the revocation. On May 14, 1985, the Regional Commissioner issued a letter of "final adverse determination" revoking the tax-exempt status of the Disaster Fund, retroactive to fiscal 1980. On August 12, 1985, the Disaster Fund filed a petition with the United States Claims Court (Court) to contest this determination and seek declaratory judgment. On May 18 and 19, 1988, the case of the American Dental Association Disaster Victims Emergency Loan Fund v. The United States of America was heard. On July 28, 1989, the Court ruled that the Disaster Fund did not qualify as a tax-exempt organization.

Pursuant to the revocation, the IRS had requested returns be filed by the Disaster Fund retroactively for fiscal years 1980 and subsequent. These returns reflected federal income taxes on its net investment income. At June 30, 1988 the cumulative amount of $30,068, which had been paid to the IRS during the appeal process, had been recorded as refundable income taxes in the accompanying combining financial statements, since the Commission, ADA management and counsel believed that the tax-exempt status of the Disaster Fund would be reinstated. As a result of the adverse court ruling, income tax expense of $50,882 was recorded for the year ended June 30, 1989.

Income tax expense is composed of the following:

Federal	
Amount recorded as refundable income taxes at June 30, 1988	$30,068
Amount paid during the year ended June 30, 1989	14,020
	44,088
State	
Amount payable at June 30, 1989 (for years ended June 30, 1980 through June 30, 1989)	6,794
	$50,882

American Dental Association

Supplemental Financial Information for the Year Ended December 31, 1989

SUMMARY OF REVENUE AND EXPENSE

1989 Actual and 1989 Budget
(UNAUDITED)

	1989 Year-End Actual		1989 Budget	
	Expense	Revenue	Expense	Revenue
Membership Dues		24,357,212		24,246,700
Miscellaneous Expense/Revenue	124,912	327,736	25,000	60,000
House/Board/Executive Director	2,951,507		2,510,900	
Div. of Editor & Publications	5,739,648	6,139,268	5,599,400	6,222,500
Div. of Legal Affairs	1,230,303	2,355	1,210,600	
Div. of Legislative Affairs	1,785,812		2,047,100	
Div. of Communications	2,791,739	751,882	2,347,200	148,500
Salable Materials Program	2,046,093	2,967,132	2,443,500	2,876,600
Div. of Membership & Marketing Services	2,704,340	272,845	2,637,500	350,600
Div. of Conference & Meeting Services	3,431,680	3,102,286	2,840,400	2,138,100
Div. of Finance	2,354,241	288,132	2,537,700	213,000
Headquarters Building	3,880,760	2,505,316	3,636,200	2,456,800
Div. of Business Affairs	2,833,094	327,378	2,688,400	407,400
Div. of Dental Practice	3,425,899	599,290	3,627,300	568,300
Div. of Education	3,543,461	1,982,344	3,548,600	1,791,900
Div. of Scientific Affairs (including ADA Health Foundation)	3,069,598	402,956	3,119,100	400,000
Grants to Related Health Groups	208,000		208,000	
Contingent Fund	400,138	3,900	324,000	
Income Taxes	780,000		405,000	
Capital-ADA & ADAHF	795,960		668,000	
Contribution to Investment Account			(226,700)	(317,700)
Total from Operations	44,097,185	44,030,032	42,197,200	41,562,700
Earnings From				
Operating Div. Investments			3,500	133,500
Reserve Div. Investments			17,000	191,500
Capital Formation Investments				330,000
Total	44,097,185	44,030,032	42,217,700	42,217,700
Net Revenues/(Expenses)		(67,153)		0

HOUSE/BOARD/EXECUTIVE DIRECTOR

1989 Actual and 1989 Budget
(UNAUDITED)

	1989 Year-End Actual		1989 Budget	
	Expense	Revenue	Expense	Revenue
Office of the Executive Director	995,715		889,500	
Board of Trustees				
Administrative	770,069		681,900	
FDI Meeting	141,845		131,700	
Annual Session	205,672		104,500	
Total	1,117,586	0	918,100	0
Office of the President	277,245		217,000	
Office of the President-Elect	147,442		132,500	
Office of the Immediate Past President	19,954		8,000	
House of Delegates	393,565		345,800	
Division Total	2,951,507	0	2,510,900	0

DIVISION OF EDITOR AND PUBLICATIONS

1989 Actual and 1989 Budget
(UNAUDITED)

	1989 Year-End Actual		1989 Budget	
	Expense	Revenue	Expense	Revenue
Office of the Editor	147,710		169,500	
JADA	2,894,359	3,515,359	2,777,600	3,583,300
ADA News	2,016,076	1,895,150	1,777,000	1,707,000
Dental Abstracts	203,085	375,096	241,500	275,000
Special Care in Dentistry	47,107	40,972	57,400	56,000
Dental Teamwork	431,311	312,691	576,400	601,200
Division Total	5,739,648	6,139,268	5,599,400	6,222,500

DIVISION OF LEGAL AFFAIRS

1989 Actual and 1989 Budget
(UNAUDITED)

	1989 Year-End Actual		1989 Budget	
	Expense	Revenue	Expense	Revenue
Office of Assistant Executive Dir.	1,031,486	1,755	973,700	
Council on Ethics, Bylaws & Judicial Affairs	102,988	600	121,000	
Contract Analysis Service	95,829		115,900	
Division Total	1,230,303	2,355	1,210,600	0

DIVISION OF LEGISLATIVE AFFAIRS

1989 Actual and 1989 Budget
(UNAUDITED)

	1989 Year-End Actual		1989 Budget	
	Expense	Revenue	Expense	Revenue
Washington Office	1,183,225		1,416,600	
Council on Government Affairs and Federal Dental Services	37,264		36,200	
ADPAC - Administrative	291,913		281,800	
Department of State Government Affairs	273,410		312,500	
Division Total	1,785,812	0	2,047,100	0

DIVISION OF COMMUNICATIONS

1989 Actual and 1989 Budget
(UNAUDITED)

	1989 Year-End Actual		1989 Budget	
	Expense	Revenue	Expense	Revenue
Office of Assistant Executive Dir.	176,640		178,900	
Public Information/Education				
Administrative	195,738		186,300	
Consumer Affairs	199,163		217,000	
Special Promotions	220,137		232,300	
Total	615,038		635,600	
Department of Professional Communications				
Administrative	98,144		103,500	
Communications Services	278,933	119,132	346,700	118,500
Total	377,077	119,132	450,200	118,500
Media & Audiovisual Services				
Administrative	53,220		59,000	
Audiovisual Services	480,525	26,218	469,900	30,000
Media Relations	218,571		217,200	
Total	752,316	26,218	746,100	30,000
Design Services Department				
Administrative	330,668		336,400	
Design Projects				
Total	330,668		336,400	
Corporate Film Support	59,064	59,064		
Corporate Sponsored Brochures	168,603	200,000		
Consumer Guide - PSA	312,333	347,468		
Division Total	2,791,739	751,882	2,347,200	148,500

SALABLE MATERIALS PROGRAM

1989 Actual and 1989 Budget
(UNAUDITED)

	1989 Year-End Actual		1989 Budget	
Salable Materials Program	Expense	Revenue	Expense	Revenue
Administrative	652,032	69,989	931,300	60,000
Scientific Affairs Material	68,561	204,957	15,100	47,000
Appointment Book	67,287	155,257	43,500	140,200
ADA Directory	50,585	129,635	45,500	130,000
Index to Dental Literature	64,335	186,613	68,800	171,800
Dental Practice Materials	63,539	159,324	34,900	85,100
Dental Health Education Materials	609,007	1,636,088	780,800	1,735,000
Professional Office Materials	54,929	78,757	50,500	78,700
Audiovisual Material	47,087	229,876	96,400	283,500
Annual Session Vidoetapes	252	975		
Dental Career Material	7,731	11,556	7,100	8,800
Marketing Material	26,272	81,042	43,400	104,500
Dynamic Dental Strategies	9,327	23,063	20,200	32,000
Total	1,720,944	2,967,132	2,137,500	2,876,600
Order Processing/Fulfillment	325,149		306,000	
Program Total	2,046,093	2,967,132	2,443,500	2,876,600

DIVISION OF MEMBERSHIP AND MARKETING SERVICES

1989 Actual and 1989 Budget
(UNAUDITED)

	1989 Year-End Actual		1989 Budget	
	Expense	Revenue	Expense	Revenue
Office of Assistant Executive Dir.	180,488		167,200	
Department of Membership Development				
Administrative	108,070		110,500	
Recruitment & Retension Outreach	306,479	3,600	328,100	1,800
Project Emphasis	50,630			
Total	465,179	3,600	438,600	1,800
Commission on Young Professional	298,279		333,600	67,300
Marketing Services Dept.				
Administrative	115,106		127,100	
Seminars	414,904	259,178	331,700	267,700
Total	530,010	259,178	458,800	267,700
Department of Dental Society Services	212,178	10,067	225,400	13,800
Department of Membership	698,546		706,700	
WATS Line Services	319,660		307,200	
Division Total	2,704,340	272,845	2,637,500	350,600

DIVISION OF CONFERENCE AND MEETING SERVICES

1989 Actual and 1989 Budget
(UNAUDITED)

	1989 Year-End Actual		1989 Budget	
	Expense	Revenue	Expense	Revenue
Office of Assistant Executive Dir.	232,103	659,147	196,300	423,000
Council on ADA Sessions and International Relations				
CASIR Program	1,401,442	1,689,389	984,300	1,374,600
Administrative	115,211		104,500	
Total	1,516,653	1,689,389	1,088,800	1,374,600
Office of International Affairs	114,152	(250)	110,300	7,000
Annual Session - Administrative				
Annual Session Staff Travel	152,843		218,700	
President's Dinner Dance	94,361	70,236	50,000	50,000
Spouses' Luncheon	25,620	23,940	21,000	21,000
International Reception	29,028	20,000	21,500	21,000
Hularobics		750	3,600	4,500
Annual Session Hosting Activities	80,070		91,900	
Total	381,922	114,926	406,700	96,500
Scientific Session - Administrative				
Registered Clinics	22,580	98,810	25,000	51,000
Workshops	12,453	59,050	28,000	28,000
Cassette Tape Sales	14,314	44,520	8,000	43,000
Special Events	181,298	187,029		
Total	230,645	389,409	61,000	122,000
Department of Conference Services & Meeting Planning				
Conference Services	197,835		175,400	
Executive Dining Room	154,388	103,995	130,300	75,000
Audiovisual-Meeting Coordination	47,907		54,700	
Total	400,130	103,995	360,400	75,000
Bureau of Library Services				
Administrative	69,769		73,400	
Library Services	337,550	43,470	389,100	40,000
Indexing Services	115,458		154,400	
Total	522,777	43,470	616,900	40,000
Post Annual Session Tours	33,298	102,200		
Division Total	3,431,680	3,102,286	2,840,400	2,138,100

DIVISION OF FINANCE

1989 Actual and 1989 Budget
(UNAUDITED)

	1989 Year-End Actual		1989 Budget	
	Expense	Revenue	Expense	Revenue
Office of Assistant Executive Dir.	290,461	265,132	248,300	190,000
Office of the Controller	362,597		392,800	
Accounting Department	538,082	23,000	564,100	23,000
Central Administration				
Fringe Benefits	(52,009)		0	
Business Expense	751,924		831,100	
Total	699,915	0	831,100	0
Advertising Sales				
Administrative	363,019		399,100	
Dental Trade Relations & Advertising Coordination	100,167		102,300	
Total	463,186	0	501,400	0
Division Total	2,354,241	288,132	2,537,700	213,000
Headquarters Building	3,880,760	2,505,316	3,636,200	2,456,800

DIVISION OF BUSINESS AFFAIRS

1989 Actual and 1989 Budget
(UNAUDITED)

	1989 Year-End Actual		1989 Budget	
	Expense	Revenue	Expense	Revenue
Data Processing Department				
Administrative	1,400,497	(710)	1,392,500	
Mailing List	20,668	328,088	24,000	407,400
Total	1,421,165	327,378	1,416,500	407,400
Human Resources Department	666,087		504,600	
Director of Purchasing	96,651		100,700	
Director of Central Serv.	116,794		116,000	
Duplicating Department	180,889		197,100	
Shipping & Receiving Department	351,508		353,500	
Division Total	2,833,094	327,378	2,688,400	407,400

DIVISION OF DENTAL PRACTICE

1989 Actual and 1989 Budget
(UNAUDITED)

	1989 Year-End Actual		1989 Budget	
	Expense	Revenue	Expense	Revenue
Office of Assistant Executive Dir.	186,925		184,700	
Council on Dental Practice				
Administrative	239,870		240,900	
Practice Management Publications	26,593		29,800	
Options	110,251	108,000	115,000	115,000
Health of the Dentist	28,986		32,700	
Liaison Activities-Dent Organizations	28,262		34,000	
Total	433,962	108,000	452,400	115,000
Council on Dental Care Programs				
Administrative	236,467		251,300	9,500
Federal Care Delivery and Professional Review Systems	172,095	8,117	206,700	
Private Prepayment and Alternative Benefit Plans	216,038		325,300	
Purchaser Information Services	271,654	978	298,100	7,100
Total	896,254	9,095	1,081,400	16,600
Council on Community Health, Hospital, Institutional, and Medical Affairs				
Administrative	233,286		228,100	
Fed for Special Care Organizations	13,035		12,600	
Fluoridation & Preventive Health	105,210	4,947	102,600	3,700
Institutional and Interprofessional Affairs	81,609		107,100	
Access and Community Health	68,458	10,000	92,300	20,000
Total	501,598	14,947	542,700	23,700
Office of Quality Assurance	98,080		97,900	
Council on Insurance				
Administrative	361,603	361,603	405,000	405,000
Professional Liability Risk Management	121,223		134,200	
Retirement Program	78,378	78,378		
Total	561,204	439,981	539,200	405,000
Bureau of Economic and Behavioral Research	747,876	27,267	729,000	8,000
Division Total	3,425,899	599,290	3,627,300	568,300

DIVISION OF EDUCATION

1989 Actual and 1989 Budget
(UNAUDITED)

	1989 Year-End Actual		1989 Budget	
	Expense	Revenue	Expense	Revenue
Office of Assistant Executive Dir.	186,877		165,700	
Council on Dental Education				
Administrative	376,374		334,600	4,300
Accreditation	1,080,117	6,045	1,141,000	
Educational Measurements	679,085	486,886	748,200	453,000
Select Program	302,650	147,160	285,600	120,000
Total	2,438,226	640,091	2,509,400	577,300
National Board Exam.				
Commission on National Board	361,205	6,888	342,900	7,500
Dental Examination	420,712	1,006,795	382,300	908,600
Dental Hygiene Examination	136,441	328,570	148,300	298,500
Total	918,358	1,342,253	873,500	1,214,600
Division Total	3,543,461	1,982,344	3,548,600	1,791,900

DIVISION OF SCIENTIFIC AFFAIRS

1989 Actual and 1989 Budget
(UNAUDITED)

	1989 Year-End Actual		1989 Budget	
	Expense	Revenue	Expense	Revenue
Office of Assistant Executive Dir.	239,831		245,200	
Council on Dental Therapeutics	388,981		419,100	
Council on Dental Materials, Instruments & Equipment	830,014		874,100	
Council on Dental Research	125,106	24,735	130,800	
Division Total	1,583,932	24,735	1,669,200	0

DIVISION OF SCIENTIFIC AFFAIRS
(ADA HEALTH FOUNDATION)

1989 Actual and 1989 Budget
(UNAUDITED)

	1989 Year-End Actual		1989 Budget	
	Expense	Revenue	Expense	Revenue
Office of Sponsored Research	181,294		148,800	
Research Institute				
Office of the Director	10,775		9,600	
Toxicology	167,399		174,000	
Chemistry	171,317	240	171,000	
Total	349,491	240	354,600	0
Extramural Programs				
Instrument Facility	69,921		65,100	
Electron Optics Facility	39,907		39,400	
Animal Facility	44,517		44,300	
Total	154,345	0	148,800	0
Paffenbarger Research Center				
Office of the Director	228,705		233,000	
Clinical Research	75,353		72,600	
Dental Crystallography	80,425		81,100	
Dental Metallurgy	123,650		122,300	
Dental Chemistry	156,440		155,600	
Polymer Chemistry	135,963		133,100	
Total	800,536	0	797,700	0
Overhead on Government Grants		377,981		400,000
Division Total	1,485,666	378,221	1,449,900	400,000
Grand Total - Division of Scientific Affairs	3,069,598	402,956	3,119,100	400,000

1989 Contingent Fund

Board-Approved Allocations Compared with Actual

	Board Approved Allocations	Actual Expenses (Net)
House/Board/Executive Director		
Travel expenses for the Board of Trustees to attend the Third National Conference on the Young Dentist.	$ 15,300	$ 16,635
Additional funding for the implementation of a new voting system for the House of Delegates.[1]	$ 11,000	$ 11,000
Division of Editor & Publications		
Report of the Committee on Waste Disposal and an OSHA poster to be included in an issue of ADA News.	$ 30,000	$ 30,000
Division of Legislative Affairs		
National congressional contact program to block pending expansion of OSHA infection control rules.	$ 55,000	$ 41,279
Division of Communications		
Expansion of National Media Tours.	$ 11,200	$ 11,200
Conduct one-day Media Conference.	$ 40,000	$ 39,441
Addition of public service announcements for the 1990 National Children's Dental Health Month.	$ 40,000	$ 39,928
Distribution of a "televised press release" to television stations nationwide.	$ 45,000	$ 48,955
Production of a multi-image promotion for Annual Session.	$ 35,000	$ 33,728
Production of Dental Events Calendar and Planning Guide.	$ 73,900	$ 74,078
Promote sponsorship of activities by corporate contacts.	$ 4,500	$ 492
Division of Dental Practice		
Production of a revised manual on the peer review process.	$ 10,000	$ 12,537
Production and distribution of loss prevention materials.	$ 17,300	$ 11,052
Division of Education		
Conduct two-day dental auxiliary manpower conference. In addition, travel expenses for 15 CDP/CDE members to attend the National Conference on Dental Team Members.	$ 32,300	$ 35,584
Division of Scientific Affairs		
Conduct two-day meeting to investigate the diagnostic procedures and treatment modalities for temporomandibular disorders.	$ 2,000	$ 1,389
Grants		
Challenge grant to North Carolina Dental Society.[2]	$ 15,000	$ 15,000
Total Net Expense Allocation for 1989 Contingent Fund	$437,500	$422,238

[1]Board approved allocation of $11,000 was directly added to House/Board/Executive Director's budget.

[2]Board approved allocation of $15,000 was directly added to Grants to Related Health Groups' budget.

Appendix

Notes

Index to Resolutions

Res. 1	*Reports*:44	**Council on Community Health, Hospital, Institutional and Medical Affairs** National Fluoridation Commemorative Stamp
Res. 2	*Reports*:45	**Council on Community Health, Hospital, Institutional and Medical Affairs** Amendment of Association Policy on Smoking and Tobacco Use
Res. 3	*Reports*:49	**Council on Dental Care Programs** Conference on Dental Benefits Issues
Res. 4	*Reports*:51	**Council on Dental Care Programs** Use of Peer Review Process by Patients and Third-Party Payers
Res. 5	*Reports*:53	**Council on Dental Care Programs** Legislation Prohibiting Overbilling
Res. 6	*Reports*:54	**Council on Dental Care Programs** Definitions of Fraudulent and Abusive Practices in Dental Benefit Plans
Res. 7	*Reports*:55	**Council on Dental Care Programs** Explanation of Benefits Statement
Res. 8	*Reports*:55	**Council on Dental Care Programs** Bulk Benefit Payment Statements
Res. 9	*Reports*:56	**Council on Dental Care Programs** Opposition to Fraudulent and Abusive Practices Under Public and Private Dental Benefits Programs
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Res. 11	*Reports*:57	**Council on Dental Care Programs** Rescission of Policy on "Contract Dental Organizations"
Res. 12	*Reports*:58	**Council on Dental Care Programs** Unfair Legislation
Res. 13	*Reports*:58	**Council on Dental Care Programs** Policy on Assignment of Benefits
Res. 14	*Reports*:59	**Council on Dental Care Programs** Policy on Preauthorization Requirements
Res. 15	*Reports*:59	**Council on Dental Care Programs** Audits of Private Dental Offices by Third-Party Payers
Res. 16	*Reports*:60	**Council on Dental Care Programs** Policy on Fees
Res. 17	*Reports*:60	**Council on Dental Care Programs** Revision of "Guidelines on the Use of Radiographs in Dental Benefits Plans"
Res. 18	*Reports*:70	**Council on Dental Practice** Policy Statement on Prosthetic Care and Dental Laboratories
Res. 19	*Reports*:92	**Commission on Relief Fund Activities** Amendment to the ADA Relief Fund "Indenture of Trust"
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