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AMERICAN DENTAL ASSOCIATION

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SUPPLEMENT TWO

TO ANNUAL REPORTS AND RESOLUTIONS

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Report of President

JOSEPH P. CAPPUCCIO

Mr. Speaker, Officers and staff of the American Dental Association, distinguished service recipient, my good friend, Dr. Lynch, Past Presidents of the Association, distinguished guests at the dais, delegates, alternates, my colleagues and friends of the dental profession.

I've come to say goodbye for a while. I have traveled many thousands of miles throughout the length and breadth of this country and abroad. I have represented you in many forums speaking to our positives and telling the real success story of American dentistry. It is then with a sense of deep gratitude and appreciation that I appear before you today to give my final report on my tenure as President.

To serve as President of the American Dental Association is a privilege and honor that very few men in our profession achieve. You have given me the opportunity to meet men of power and authority throughout the world. This is an experience that I will cherish for the rest of my days. During my travels, I met so many warm and wonderful people that made my journey worthwhile. To all of you who have given me your warm and cordial hospitality, I say thank you from the bottom of my heart. Everywhere there was welcome and respect for the office I represented. Rocella and I will be sustained over the years by the wonderful memories of our visits and travels. We have made friends throughout the world. These friends will be a constant reminder of some of the greatest experiences of our lives.

During my tenure as President, I had the opportunity of working with a wonderful staff and Board of Trustees. These dedicated individuals made it possible for my tenure to be most pleasant and fruitful. I owe so much to the many people for their cooperation, understanding and commitment. The years have been good to me because I have been blessed with a very loyal family and good health. I have lived a very full and wonderful life. Who could ask for anything more!

When I assumed the office of the Presidency last year, I pledged to you reform and assertive leadership. I pledged to you my total commitment and enthusiasm to the job ahead. It is my hope that I have fulfilled my pledge and that I have represented you well. I feel comfortable in the thought that I have carried out the duties of my office to the best of my ability. It is my hope that I have satisfied your expectations.

One of my pledges to this House of Delegates was to improve the internal management of the Association from top to bottom. There has been ample evidence that this has been done. There has been a change in the American Dental Association. We have appointed a new Executive Director of the Association in Dr. John Coady. There has been a restructuring of the administrative staff of the Association. There has been a major change in the legal department of the Association. We are now in the process of instituting M.I.S. under the direction of the staff, leadership and the Arthur Young Company. These changes were long overdue. It took the vision and guts of assertive leaders to make hard decisions. The Officers and Board were equal to the task. The Association owes the leadership a debt of gratitude and appreciation in turning the Association around. Your ADA is now a more sophisticated program-oriented Association. It is no longer a reactionary group.

We are offering changes to the functioning of this House of Delegates which should be well known to you at this time. The presentation and action on the budget will be new and responsive to your wishes. There is a new sense of unity, commitment and enthusiasm in the leadership and staff of the ADA. It is an exciting and exhilarating feeling of a great future for the Association.

I have met with the most powerful men in government, television and radio to carry our message. It was my privilege recently to meet with the President of the United States to talk about our concerns and desires. This meeting was one of the great thrills of my life.

During this past year, we were successful in settling our advertising case with the Federal Trade Commission and bringing you a new code of ethics for your consideration. As you know, we brought suit against the FTC on a freedom of information action. We are now being joined by other groups that are unhappy with the intrusion of FTC into our lives. We are supporting legislation to curtail the power of the FTC. It shall be done. I am convinced that legislation will pass to accomplish this.

We have worked hard to establish a better esprit de corps with our allied dental groups. I am happy to report that this has been done.

We have instructed the PEP Committee to establish programs and actions to help close the gap between

need and demand. It has been a year of change beyond our imagination.

As society and government challenge the present system of practice throughout the country, the question is—What is organized dentistry doing about this? This unrest is now in a profession which has never been challenged to the extent that it is today. Today there is a threat to dissolve the tripartite membership and structure of the ADA with a suit in Arizona, and the concern for the welfare of organized dentistry becomes apparent and realistic.

What is happening has shocked the profession into fear for our survival. The careers and livelihoods of dentists have been affected by rulings and warnings of the FTC. Federal Trade Commission rulings and supreme court decisions have led to a change in our *Principles of Ethics*. The results are that doors have been opened for entrepreneurs who with sophisticated marketing foresee an opportunity for the delivery of dentistry to areas of the population which have never been to see a dentist.

Obviously, the fears that arise come not from advertising or competition alone, but from quackery and charlatanism that had previously been associated with advertising dentists. You must answer the following questions—Do you want to stay the way you are or will you choose to bend or accommodate, or will you put your head in the sand and fail to adapt to the changing times and possibly lose the profession?

In the past, the strength of our profession has stemmed from its ability to grow, to change when necessary to meet the differing challenges of the years. The issues before us today continue to demand flexibility and willingness to adapt to social, political and economic reality. We are taking the initiative in accomplishing this change in a manner that we hope satisfies both our professional ideals and the public's concerns.

I'd like to share briefly with you some of the ways in which the American Dental Association is confronting several of these hard issues and working to influence change.

DENTURISM

Over the past few years, we have closely scrutinized, analyzed and agonized over the thrust denturists are making in many states. Two states, Maine and Arizona, now allow denturists to practice under the supervision of a dentist and a third state, Colorado, will soon be added to that list. Voters in Oregon in 1978 overwhelmingly passed a ballot measure allowing denturists to deal directly with the public without supervision. With that victory in their pockets, denturists in other states are seeking legitimacy through ballot initiatives.

The postmortem of the Oregon initiative has been completed and it reveals that, for many voters, the vote they cast was an economic and not a health care decision. The economic aspect of the issue—particularly in time of the dollar conscious consumer—has captured the attention of the public, the legislators and the media.

Our profession has belatedly come to recognize that access to quality, affordable dental care is really the core concern and the impetus behind denturist activity.

With dentistry's exclusive right to provide dental care also comes a responsibility that we be alert to dental health problems—of which access is one—and take the lead in suggesting remedies for those problems.

ACCESS TO CARE

Although our dental care system has done well over the years in improving the overall level of oral health, there still is a significant group of Americans who for one reason or another have not had access to dental care. Unless we improve access for this underserved group, we can be assured that other interested parties will attempt to fill the void.

Dental societies across the country, in establishing low cost dental care programs for the elderly, have usurped the key issue of the denturists' campaign and dealt them a serious blow. But our efforts to extend dental care services have not been limited to the provision of low cost care to the elderly. For the past several months, the American Dental Association has been immersed in the development of an extensive new effort aimed at meeting the needs of the poor and working poor, the handicapped and institutionalized, people living in remote areas and the uninsured workers.

Improving access will be the major focus of ADA programming cutting across all lines of Association activity. This program will require a long-term commitment not only from the profession but also will call upon government to fulfill its responsibility. The needs of the elderly and the poor will never be adequately met until the gaping omissions in our Medicare programs are addressed. Improving access to dental care must be a priority concern not only of dentistry but of government and society.

INSTITUTIONAL ADVERTISING

It is important that the Association consider very seriously embracing institutional advertising. This advertising should be of a professional nature developed at the national level by the ADA and adjusted with state and component level programs. We must be ready to commit dollars to an effective program of institutional advertising. This advertising could be printed media material or an electronic program. This is a program whose time has come. Let us have the fortitude and imagination to make this vital decision. If we do not assume an aggressive posture soon, these programs will be done by other people at the detriment of the American people and the profession. We must be sure, however, that these changes come about only after sufficient planning and deliberations with an eye to the future. If we are to preserve our ambitions and pride in our profession, then we must see to it that we are properly organized for the future. We must develop the necessary systems of research, education and dental practice to meet the demands of the 21st century.

Central to all your deliberations this week should be what is good for the patient. This is the spirit which I hope all of the delegates will keep foremost in their minds when policies and resolutions are considered during this week's deliberations.

A major issue and program that the House will consider will be a comprehensive report aimed toward providing increased access to dental care for the segments of our population who do not currently receive dental care. This proposal which has come to be known as the "Access Program" and its implementation within the next several years will have far reaching consequences.

NATIONAL HEALTH INSURANCE

In my travels around the country these past two years, the issue of national health insurance never fails to crop up. It is certainly a subject on the minds of our national leaders. A number of bills are pending in Congress, and it appears another year will pass with no agreement or compromise on a proposal. The escalating public sentiment against government inefficiency and intervention leads many to conclude that the United States will not have a comprehensive national health insurance program in the near future.

The ADA has adopted extensive guidelines for dentistry's position in a national health program and continuously provides input on legislation offered. However, we continue to contend that, until the government is willing to make a realistic commitment to provide essential health care services for the poor and the elderly, it is a misplacement of priorities to launch a broad full-scale federally financed program providing health benefits to others.

National Health Insurance is a bitter pill (that Americans) we shouldn't swallow. Proposing socialized medicine as the antidote to the high cost of health care is "like trying to solve the problems of the imperial presidency by establishing a monarchy."

STUDENT VOTE

Finally, in recent years, a representative of ASDA has been seated in the Association's House of Delegates, but has not had the right to vote. This year the House will consider a proposal to give full voting privileges to the ASDA representative.

The Board of Trustees has endorsed this proposal and I want you to know that I personally am firmly committed to this action. I feel that the students who are the future of our profession have earned the right to have a vote and full participating privileges in the House. They have waited a long time for you to say loud and clear, you are deserving of this trust and privilege. I am convinced that the students will use this privilege with great discretion and honor.

ETHICS

We have preserved the hallmarks of the profession. We have preserved the educational standards and the core elements of Section 18.

UNITY FRACTIONALIZATION

At this time, it is important for me to emphasize to you the importance of every member of our profession being actively concerned about the issues and about the future of dentistry itself. Equally important is the fact that the strength of our profession and its future hinges on all of us speaking as one voice.

Fractionalization within the profession will destroy us. I believe that the climate in the profession at this time is a healthy one. We have brought our act together so that we can fight the adversary from without—with positive programs and effective political action. Without this total commitment and almost with zeal of a missionary we will fail to preserve a great profession. I have pursued this objective as though I was in quest of the *Holy Grail!*

Frank Vanderlip said, "A conservative is a man who doesn't think that anything should be done for the first time"!

QUOTATION

"The real troublemate in our profession and American society is the silent one who never speaks upon issues, who never writes to his elected officials, who is quiet as a mouse. In his wish to offend nobody, he offends democracy. Democracy is threatened if all of us withhold our opinions, our ideas, our criticisms."

"Active participation in public matters is a responsibility for all."

"The silent troublemaker fails to understand this. In his worship of law and order he never dares to question an oppressive law, never distinguishes order from stagnation. He is an apostle of social decay not democracy."

Plato said, "The penalty good men pay for indifference to public affairs is to be ruled by evil men."

Voltaire said, "I disapprove of what you say, but I'll defend to my death your right to say it."

A common expression is, "The squeaky wheel gets the grease." In a democracy we need not be afraid of any man's ideas. If they are wrong, we may be sure that the people will reject them; if the ideas are worthwhile, no one can suppress them for long! I not only honor the meaning of democracy, I practice it. I challenge each of you as you face the future to do the same.

To quote St. Francis of Assisi, "Where there is disorder may we bring harmony, where there is error may be bring truth, where there is doubt may we bring faith, where there is dispair may we bring hope."

In closing, I wish to thank you once again for the great honor that you have paid me. I especially want to thank

my wife, Rocella, and my daughter, Mary Louise, for their loyalty and devotion during the past year. Without their cooperation and understanding, the road would have been a thorny one. To my dental family, the Officers, Board of Trustees and staff, I say with love and affection—I will miss you. To you my peers, I say thanks for the memories. To Larry Kerr, my colleague and friend of many years, I say best wishes for a very successful year. It has been a great team and I now feel very comfortable and secure that the presidency of the ADA will be in good hands. Larry and Hazel will make an excellent first family of dentistry. To John Coady, an executive director with class, competence and effectiveness, I say thank you for the privilege of serving with you as a team. We had a great year together. I wish John and his staff success in the years that lie ahead.

It is my hope that the future all goes well for all of us. I shall look forward to seeing many of you in the future. This afternoon will long live in my memory as one of the great moments of my life.

Supplemental Report of the Standing Committee on Rules and Order

Subsequent to the approval and publication of the Report of the House of Delegates Standing Committee on Rules and Order (*Supplement 1*:275), several items of business were submitted for consideration by the Committee. By means of a mail ballot, the following items of business were considered by the Committee and are presented for action by the House of Delegates.

Clarification of the Motion "Postpone Indefinitely": Owing to confusion that occurred in the House of Delegates last year, it was suggested that an editorial amendment be made in the explanation of the motion "postpone indefinitely." The Committee noted that the intent of the explanation has not been altered, but that additional clarification has been added. The Committee also noted that, since the intent has not changed, this editorial amendment has been included in the 1979 *Manual of the House of Delegates* and is clearly marked as a "proposed editorial amendment to provide clarification." Although editorial in nature, this amendment is being presented for confirmation by the House of Delegates. The Committee recommends approval of the following resolution.

79. Resolved, that the *Manual of the House of Delegates*, page 13, second paragraph, be amended by the insertion of the phrases "opens the main motion to debate. The main motion to which it is applied" following the phrase "The motion to postpone indefinitely is a subsidiary motion which" so that the amended paragraph shall read as follows:

> Alternately, a motion to reject or to postpone indefinitely a resolution is a subsidiary motion. The motion to reject is a subsidiary motion which may be debated but does not permit amendment of the resolution. The motion to postpone indefinitely is a subsidiary motion which *opens the main motion to debate. The main motion to which it is applied* may be debated, amended and have all other subsidiary motions applied against it, in order of preference. If the motion to reject is adopted, nothing is before the House and the issue is closed. If the motion to reject is defeated, a motion to adopt the resolution is then in order. After there has been a second of the motion to adopt, motions to amend, motions to substitute and like motions are in order. The motion to reject shall have precedence over the motions to amend and postpone indefinitely. All other privileged and subsidiary motions listed in *Sturgis Standard Code of Parliamentary Procedure, second edition* shall take precedence over a motion to reject.

The Chairman moves the adoption of Resolution 79.

Elimination of the Need for Seconding: The Committee was asked to consider the need for seconding of motions. The Committee agreed that, in view of the redundancy and perfunctory nature, the elimination of seconding would expedite the proceedings of the House of Delegates. Accordingly, the Committee recommends adoption of the following resolution.

80. Resolved, that the *Manual of the House of Delegates*, page 12, be amended after the section on "Presentation of Resolutions and Other Items of Business" by the addition of the following paragraph:

> *Seconding of Motions:* Following the proper movement of a motion, a second is not required.

and be it further

Resolved, that the *Manual of the House of Delegates*, pages 12 and 13, section entitled "Motions to Adopt, Postpone Indefinitely or Reject Resolutions" be amended to eliminate the references to "seconding" so that this section shall read as follows:

> After a motion to adopt has been made, the resolution is before the House for debate, amendment and final action. The motion to adopt is a main motion and a vote by the House disposes of the resolution.
>
> Alternately, a motion to reject or to postpone indefinitely a resolution is a subsidiary motion. The motion to reject is a subsidiary motion which may be debated but does not permit amendment of the resolution. The motion to postpone indefinitely is a subsidiary motion which *opens the main motion to debate. The main motion to which it is applied* may be debated, amended and have all other subsidiary motions applied against it, in order of preference.* If the motion to reject is adopted, nothing is before the House and the issue is closed. If the motion to reject is defeated, a motion to adopt the resolution is

then in order. Following the motion to adopt, motions to amend, motions to substitute and like motions are in order. The motion to reject shall have precedence over the motions to amend and postpone indefinitely. All other privileged and subsidiary motions listed in *Sturgis Standard Code of Parliamentary Procedure, second edition* shall take precedence over a motion to reject.

*Proposed editorial amendment to provide clarification.

The Chairman moves the adoption of Resolution 80.

Amendment of Delegate-Alternate Substitution Procedure: The Committee considered a proposed amendment to the delegate-alternate substitution procedure submitted by Dr. John T. Ziegler, member of the Committee. The suggested amendment would allow the individual delegate to select an alternate delegate to attend any meeting or portion of a meeting in the delegate's stead and complete the proper form enabling the alternate delegate to obtain the necessary admission card(s). The present procedure dictates that the chairman of the delegation is charged with the responsibility of the substitution procedure. The Committee considered the advantages presented by Dr. Ziegler, i.e., allowing the chairman of the delegation to attend to all his other responsibilities, full representation for all discussions and votes and use of the expertise of the entire delegation. The Committee also noted that the House of Delegates adopted the present system of substitution in 1974 (*Trans.1974*:597) persuant to a resolution submitted by the Florida Dental Association in 1973 (*Trans.1973*:636) and a year of study by the Board of Trustees, the House Standing Committee on Credentials and the Speaker and Immediate Past Speaker of the House of Delegates. The 1974 House, in its deliberations, agreed that relaxing the previous procedure to permit freer substitution of alternate delegates while maintaining a certain degree of control through the chairman of each constituent delegation was a favorable change.

The Committee recommends adoption of the following resolution:

81. Resolved, that the *Manual of the House of Delegates*, page 5, section entitled "Seating of Alternate Delegates" be amended by substitution to read as follows:

If a delegate wishes to substitute an alternate delegate from his/her delegation for him/her self during a meeting of the House of Delegates, the delegate must complete the appropriate delegate-alternate substitution form at the special registration desk. The delegate is required to sign the form and surrender his/her admission card for the meeting or meetings not attended before admission cards will be issued to the alternate delegate by the Committee on Credentials.

Substitution of alternate delegates may be made during all four meetings of the House of Delegates.

The Chairman moves the adoption of Resolution 81.

Items Referred by the Board of Trustees: Several recommendations were transmitted to the Committee in Report 6 of the Board of Trustees to the House of Delegates: Special Committee on the House of Delegates (*Supplement 1*:358). As noted in Report 6, the Special Committee was interested in eliminating as many non-business items as possible from the agenda of the House and abbreviating other items to provide more time for the critical deliberations of the House. The Committee on Rules and Order recommends the adoption of the following resolutions. (It should be noted that the intent of Resolution 82 has in recent years been accomplished, but without formal action.)

82. Resolved, that Reports of the Board of Trustees shall not be read aloud unless, in exceptional circumstances, the Speaker directs that such be done.

The Chairman moves the adoption of Resolution 82.

83. Resolved, that exploration be made of the feasibility of a special awards luncheon(s) on Sunday and/or Wednesday of the annual session week.

The Chairman moves the adoption of Resolution 83.

Supplemental Reports and Resolutions

SUBMITTED BY COUNCILS AND OTHER AGENCIES

COUNCIL ON DENTAL HEALTH AND HEALTH PLANNING SUPPLEMENTAL REPORT 1 TO HOUSE OF DELEGATES: REVISED STATEMENT ON PREVENTIVE DENTISTRY

In response to a growing demand for guidelines in establishing a preventive dental program, the Council's Committee on Preventive Dentistry held its first meeting on July 10, 1979 to discuss this and other issues relative to the Committee's function.

Since 1971, the Council has held official policy endorsing preventive procedures and supporting the concept of preventive dentistry. In 1973, the Coordinating Committee on Preventive Dentistry set forth a statement of philosophy and a procedural guideline. Working from this, the Committee on Preventive Dentistry drafted the following "Statement on Preventive Dentistry," which was accepted by the Council on Dental Health and Health Planning at its September 19–20, 1979 meeting.

Statement on Preventive Dentistry

The Council has long supported the concept of preventive dentistry and in 1971 adopted the following policy (*Trans.1971*:53):

> Preventive dentistry refers to procedures in dental practice and health programs which prevent the occurrence of oral diseases. Included in the range of preventive procedures are oral prophylaxis, topical application of fluorides, the use of space maintainers, the use of fluoride dentifrices, oral cytology, patient education including home care, and other techniques.

Preventive dentistry refers to procedures in the practice of dentistry and community health programs which prevent the occurrence of oral diseases and abnormalities. The prevention and control of oral disease is a shared responsibility of the practitioner, the patient and the community. Optimal oral health is possible for everyone and yet 98% of the population suffers some form of dental disease. The conscientious practice of preventive dentistry can lead to an overall improvement in oral health for the entire population.

The importance of effective preventive oral health practices in the dental office is recognized and the implementation of such programs in the care and treatment of every dental patient is encouraged. A wide range of procedures can be incorporated into a preventive dental program. Recommended procedures include:

Complete medical history and clinical diagnosis, including hard and soft tissue examination and occlusal evaluation.

Examination for oral manifestations of systemic diseases.

Oral prophylaxis with periodic recall, as indicated.

Topical fluoride applications, as indicated.

Prescription of supplemental dietary fluoride in fluoride-deficient areas.

Nutritional analysis and dietary counseling with regard to oral health and what promotes good dental health.

Laboratory tests to determine caries activity and susceptibility, as indicated.

Oral biopsy and cytology, as indicated.

An effective plaque control program to include individual oral hygiene instruction, toothbrushing technique, flossing technique, use of disclosing tablets or solutions, use of other cleaning devices and home care.

Use of pit and fissure sealants, as indicated.

Procedures to prevent or intercept malocclusion including habit control, use of space maintainers, prevention of premature loss of teeth.

Construction of mouth protectors for use in contact sports.

Patient education involving a discussion of good health and the cause of dental disease, and the distribution of health education literature and presentation of audiovisual materials.

The sharing of preventive responsibilities includes community health programs. These programs should include:

Community-Wide

Community water fluoridation—the single most effective preventive public health measure to protect against dental disease.

Control of the sale of confections in schools.

Public education.

Outreach programs to special population groups to provide preventive oral health care.

School-Wide

Fluoridation of the school water supply in areas low in fluoride and not served by a community water supply.

A self-applied fluoride program in schools, where indicated.

Oral health education programs in the schools.

Supervised oral hygiene instruction with regular reinforcement in the schools.

RESOLUTIONS

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

COUNCIL ON LEGISLATION AND WASHINGTON OFFICE SUPPLEMENTAL REPORT 2 TO HOUSE OF DELEGATES: LEGISLATIVE UPDATE

This report provides an update on the status of major legislation of interest to the dental profession as of September 20, 1979.

National Health Insurance: Senator Kennedy and Representative Waxman have introduced their new national health insurance proposal, the Health Care for All Americans Act (S. 1720, H.R. 5191). The proposal is based on the principles of universal coverage, comprehensive benefits, across-the-board cost controls, system reforms to promote HMOs, disease prevention and other goals, and quality controls. Only very limited dental benefits (primarily some oral surgery) would be covered. Although utilizing private insurers and HMOs to administer the program and employer-employee contributions to premiums as the primary financing mechanism, the bill retains many of the restrictive budgeting and administrative concepts originally outlined in Senator Kennedy's Health Security Act.

The Carter Administration is continuing in its effort to develop a national health insurance proposal. New HEW Secretary Harris is pushing for introduction of a bill as soon as possible. The most recent outline of the Administration plan includes dental benefits for low income children.

Representative Ullman, D-OR, and Senators Schweiker, R-PA, and Durenberger, R-MN, each have developed programs aimed at changing the tax laws to create incentives for reforms in the health delivery system.

Hearings by the House Commerce and Senate Human Resources Health Subcommittees on national health insurance can be expected this fall. The Senate Finance Committee also expects to return to its consideration of catastrophic health insurance proposals.

Child Health Assurance Program: The full House Commerce Committee has before it the CHAP proposal developed by its Health Subcommittee. Favorable Committee action is expected shortly. This bill contains most of the amendments recommended by the Association. Although the Senate Finance Committee has given final approval to its version of this legislation, S. 1204, efforts are underway to modify the proposal partly in response to actions of organizations such as the ADA to make basic improvements in the plan but also in response to budgetary considerations.

Medicare Amendments: The Senate has not yet brought to the floor legislation which includes ADA supported amendments to the Medicare program to authorize payments for covered services when provided by a dentist who is acting within the scope of his license and to reimburse for the costs of hospitalization which is necessary for the performance of a dental procedure. The House Ways and Means Health Subcommittee has given approval to identical amendments.

PSRO Amendments: The Senate Finance Committee approved amendments to the PSRO law also are awaiting floor action. The House Ways and Means Health Subcommittee has approved amendments to mandate dental membership on the National PSR Council and to authorize local PSRO membership for dentists at the option of the PSRO.

Federal Employees Dental Benefits: Representatives Charles H. Wilson, D-CA, and Gladys N. Spellman, D-MD, have introduced ADA developed legislation, H.R. 5151, to establish a dental benefits program for over 2 million civilian federal employees and their dependents. The proposed dental program is modeled after the existing Federal Employees Health Benefits program.

HEW Appropriations: House and Senate conferees have reached agreement on a fiscal year 1980 appropriation bill for the Department of Health, Education, and Welfare. As in past years, a major obstacle to final enactment of this bill is the need to resolve differences between the House and Senate over the issue of federal funding for abortions.

Proposed funding levels for selective programs of interest to dentistry include: NIDR—$68.3 million, an increase of $1.3 million over the current year; capitation grants for schools of medicine, osteopathy and dentistry—$69.7 million, a reduction of $26.3 million over that appropriated in fiscal year 1979; $16.5 million for student loans, an increase of $6.5 million; National Health Service Corps scholarships—$85.5 million, an increase of $10.5 million; and $4 million for dental TEAM and EFDA programs, the identical amount appropriated for fiscal year 1979.

Health Planning: The House and Senate are expected to approve shortly final legislation to extend the Health Planning and Resources Development Act for three years. Included in the final version is a partial exemption from health planning review for capital expenditures by HMOs.

Private dentist offices also would continue to be exempt. Certificates of need would be required for the purchase of major medical equipment located outside of an institution which is to be used for inpatients. Equipment subject to such certificate of need would be that costing $150,000 or more.

Hospital Cost Containment: Efforts are underway to reach a final resolution of the issue of hospital cost containment. Each of the four committees involved has taken a

different approach on the issue. The final outcome is still very much in doubt.

Tax Laws and Health Care: As indicated above in the discussion of national health insurance, there is a growing interest in amending the tax laws to effect health care reforms and ostensibly to promote competition in the health field. Freshman Senator David Durenberger, R-MN, has introduced S. 1485 which would provide that employer health insurance contributions could be deducted only up to the amount which is equivalent to that charged by a qualified HMO in the employer's area. In addition, the bill would require employers to offer at least three health benefits programs, two of which are to be HMOs. If no HMOs are available, the additional plans which must be offered could be those of private insurers but would have to utilize innovative methods for cost controls including capitation type payments, negotiated fees and similar mechanisms.

Federal Trade Commission: Due to mounting pressure, both the House and the Senate have postponed action on the FTC authorization bills, H.R. 2313 and S. 1020. In a highly unusual compromise maneuver, the House Appropriations Committee has reported a 45-day continuing resolution which would allow the FTC to continue its funding at existing levels; however, it would be temporarily barred from issuing new regulations or beginning new investigations until November 15 or when the FTC authorization controversy is resolved. This stopgap measure is expected to win Congressional approval so that both Houses can delay expected floor fights over the controversial FTC authorization legislation.

The Senate Commerce Subcommittee on Consumer has begun FTC oversight hearings focusing on the rule-making authority of the FTC under the Magnuson-Moss Act. The Association will be submitting a statement in the near future outlining the concerns of the dental profession regarding FTC jurisdiction over nonprofit professional associations and FTC rule-making authority in attempting to override State laws relating to licensure of health care practitioners, such as dentists.

Senator James McClure, R-ID, has introduced an amendment to preclude the FTC from overriding State laws relating to the legal, dental and medical professions or their respective state or national professional associations. Consideration of the McClure amendment is still closely linked to the continuing controversy over the FTC authorization legislation.

Radiation: The House Commerce Subcommittee on Oversight and Investigations has held hearings on "unnecessary exposure to radiation from medical and dental X-rays." According to the Subcommittee, the hearings were to "explore the extent and the adequacy of the training and education of the users of X-rays as well as those users' licensing and credentialing and the impact of those factors on the overutilization of X-rays." Dr. William E. Brown, chairman of the Association's Council on Dental Education, testified on behalf of the ADA. Dr. Brown presented a detailed review of activities and accreditation standards of the Association as well as the American Association of Dental Schools relating to the training of dental, dental hygiene and dental assistant students in the use of X-rays.

Educational Testing: The Association has testified before the House Education and Labor Subcommittee on Elementary, Secondary and Vocational Education on legislation to establish federal requirements for the disclosure of information by national testing organizations. In addition to citing the increased cost to dental school applicants which would result if the various requirements of the bill as applied to the dental admission testing program were enacted, Dr. James Graham, assistant secretary for the Association's Council on Dental Education, specifically objected to requirements of the legislation to disclose actual test questions. In particular, he pointed to the very limited means for testing manual dexterity and stated that if disclosure was required the manual dexterity aspects of the dental aptitude test would have to be discontinued.

Because of the current activities of the Association which comply with many of the disclosure objectives proposed in the bills and because of the damage caused to the effectiveness of the DAT if the disclosure requirements were enacted, Dr. Graham urged that the legislation not be adopted.

Saccharin: The House has adopted legislation to extend the moratorium on the FDA proposed ban of saccharin until June 30, 1981. No action has yet been taken by the Senate.

Building Temperatures: In response to Association testimony presented by Dr. R. L. Bowen, associate director of the ADA Health Foundation Research Unit at the National Bureau of Standards, the Department of Energy has granted an exemption for the offices of individual practicing dentists from a final regulation requiring that buildings can be cooled to no less than 78 degrees and heated to no more than 65 degrees. The exemptions must be requested by building operators.

Congress Considers New Federal Dental Pay Plan: Professional pay for military and Public Health Service dental officers would be improved significantly under legislation approved September 20 by the House Armed Services Committee. The bill, H.R. 5235, proposes to replace the existing system of special and continuation pays with a new program of financial incentives which, committee spokesmen indicate, is intended to bring federal health officer salaries more in line with civilian income levels. A House of Representatives floor vote on the measure is expected for October with Senate consideration to follow later in this Congress.

The uniformed service pay legislation is a product of a lengthy series of hearings which began in 1978. During that period, testimony was presented by Members of Congress, the military Surgeons General, representatives of the Defense Department and the American Dental Association. More than five separate new compensation plans were evaluated, including one introduced by the Administration which would have excluded dentistry from the statutory improvements proposed for medical corps officers.

As approved by the Armed Services Committee, the bill contains many of the features recommended by the ADA. For the first time, all special pays for dental officers would be fixed-in-law as entitlements. This is in contrast to the present, discretionary system allowing Defense and the Public Health Service to unilaterally limit amounts and eligibility for continuation pay. H.R. 5235 also authorizes substantial increases in special pay amounts for dental officers in the early career phases and further stipulates that these incentives shall be made available after three years of active duty. Military and PHS regulations have in the past precluded the awarding of continuation pay until the end of the sixth year of active service.

Mid-career and senior grade dental officers would also benefit under the legislation—in this instance as a result of an Association endorsed amendment approved unanimously in an earlier Subcommittee vote on the bill. The ADA amendment, which was sponsored by Representative Robert Mollohan, D-WVA, authorizes higher levels, over those contained in the original bill, of special pays for dental officers who have more than 10 years of service. As initially proposed, special pays for these dental corps officers would have peaked at the end of 10 years active duty and declined noticeably after the 14th year of service. Finally, the Committee bill directs that dental officers who successfully complete the general dentistry residency programs of the services shall be entitled to the same added bonus pays proposed for dental specialists in the uniformed services. The Chiefs of the military and Public Health Service dental corps have indicated that the new compensation program would, if enacted, have a positive impact on the ability of the services to recruit and retain dental officers.

Veterans Administration: The Veterans Administration has abandoned, for at least this session of Congress, further efforts to eliminate the VA's $45 million program of fee-based outpatient dental care. Under the program, in which services are provided mainly by private dental practitioners, a former member of the armed services may apply for the treatment of dental conditions which were not corrected while such individual was on active duty in the military.

An Administration backed measure (S. 741) to delete funding authority for the outpatient dental services was decisively rejected earlier this year by the Senate Committee on Veterans Affairs. Following this action, an attempt was made in legislation (S. 7) to place a ceiling on the annual amounts which the VA could expend for fee-based care. This proposal was defeated in a House-Senate conference committee with an agreement instead to require the VA to advise Congress whenever program costs exceed the 1978 cost levels.

Selective Service: The House of Representatives has rejected a provision in the 1980 Defense Authorization bill (H.R. 4040) requiring the selective service registration of all males who become 18 years of age after December 31, 1980. An amendment to that proposal, calling for the mandatory registration of all dentists and physicians who graduated after 1972, was set aside following the defeat of the selective service section of the legislation. Senate consideration of proposals to reinstitute some form of draft registration was to begin on September 21 with an unusual closed door executive session on the state of military preparedness. Senator Sam Nunn, D-GA, has urged the Senate to adopt a registration requirement similar to that defeated in the House.

STATE LEGISLATION

New York Adopts Controversial "Truth in Testing Law": The new law applies to aptitude tests used by post-secondary and professional schools for determining admission to those schools. The American Dental Association dental aptitude test is included. The law requires that the test agency disclose test results to the New York Commission on Education and to those who took the test on request. Litigation testing the constitutionality of the new law is expected.

Regulation of Prepayment Dental Plans: Prepayment dental plans not covered by existing laws regulating commercial health insurance or health service plans are now regulated under special statutes adopted in Indiana, New Mexico, South Carolina and Virginia. Arizona adopted a similar law about three years ago.

Colorado Joins Arizona and Maine in Authorizing Supervised Denture Care Auxiliary: The Colorado dental law was revised after a review by state "sunset" agencies. The new law creates a new denture care auxiliary to whom a licensed dentist may assign intraoral and extraoral tasks and procedures necessary for the construction of a full denture.

Revision of Florida Dental Law Follows "Sunset" Review: The new Florida law is not substantially different from its predecessor. Other than removing previous provisions restricting all advertising by dentists, the new law retains features such as registration of dental laboratories and standards for delegating functions to auxiliaries. The new advertising provision specifies the routine services that dentists may advertise.

RESOLUTIONS

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

COUNCIL ON PROSTHETIC SERVICES AND DENTAL LABORATORY RELATIONS SUPPLEMENTAL REPORT 2 TO HOUSE OF DELEGATES: LEGISLATIVE UPDATE AND COUNCIL ACTIONS

Meetings: The Council met in the Headquarters Building on September 17–18, 1979 to consider matters relating to Council activities.

Legislation to Establish Alternate Methods of Providing Denture Care: As of September 21, 1979, the following actions update the information in the Council's Supplemental Report 1.

California:

On July 13 the Attorney General assigned the following title and description to the initiative measure submitted by "Californians For Denturism":

> REGULATION OF PRACTICE OF DENTURISM. INITIATIVE STATUTORY AMENDMENT. Creates within State Board of Dental Examiners the Denturist Examining Committee consisting of nine members appointed by the Governor. Authorizes committee to examine license applicants; establish, within specified limits, and collect fees for issuance and renewal of licenses and approval of educational institutions and courses; and adopt rules and regulations regarding professional conduct of denturists. Specifies grounds on which committee may deny, suspend or revoke licenses. Establishes minimum eligibility requirements for examination applicants. Continuously appropriates collected fees to carry out purposes of the act. Financial impact: Adoption of initiative would not result in a substantial net change in state or local finances.

Georgia:

The Speaker of the House appointed a special committee to study the issue of denturism during the legislature's interim session. This committee has held two hearings. No bills were introduced during the 1979 legislative session. The legislature reconvenes in January 1980.

Itemization of Patient Invoices: Legislation requiring dentists to itemize the charges for laboratory costs on patient invoices has been introduced in Kansas (SB 608) in 1978 and in Pennsylvania (HB 793) in 1979; both bills were defeated. Similar legislation has also been introduced in recent years in Florida and Rhode Island. In addition, the San Francisco Regional Office of the Federal Trade Commission is considering a Trade Regulation Rule on this issue. Further, the National Association of Dental Laboratories is examining the issue at its annual meeting in October 1979 and will consider two resolutions recommending that itemization of laboratory charges on patient invoices be adopted as NADL policy.

The Council believes that a law forcing dentists to disclose laboratory costs is unnecessary and misleading since the manner in which prosthetic devices and dental appliances are delivered may vary. Placing emphasis on the laboratory phase by singling out this overhead cost would tend to confuse the patient rather than provide useful information. In this regard, an arbitrary rule or state law requiring itemization will not serve the needs of patients who have traditionally relied upon the professional judgment of the dentist to explain variations in treatment and clinical options.

In examining this issue, the Council on Prosthetic Services and Dental Laboratory Relations has concluded that itemization will achieve no justifiable end. The Council finds no validity to the claim that costs to the patient would be lowered nor that knowledge by the patient of laboratory costs would improve any aspect of the service. Mechanisms other than itemization, the Council believes, can more effectively and more easily accomplish patient education about the role of commercial dental laboratories in the delivery of dental care. A resolution opposing itemization of laboratory charges is presented at the end of this report.

RESOLUTION

71. Resolved, that the American Dental Association is opposed to legislation which would mandate that patient invoices contain an itemization of charges related to the dental treatment, including separation of commercial dental laboratory fees.

REPORT TO HOUSE OF DELEGATES OF THE ADA TASK FORCE ON THE PROHIBITION OF THE SALE OF CONFECTIONS IN SCHOOLS

The dental profession is greatly concerned with the rampant availability of sugar-rich snack foods on school campuses. Students frequently snacking on these foods are risking their oral health and establishing dangerous lifetime eating habits. In addition, excessive consumption of sugar plays a role in other disease, i.e., heart disease, diabetes and obesity, endangering general health status.

Background: The problem is widespread—almost every school in the country regularly sells sugar-rich food items to their students. A few states have taken positive action but many remain inactive, risking the oral health status of their students. Most comply only with the U.S. Department of Agriculture (USDA) National School Lunch Act regulations, restricting sales only through lunch period but allowing students to snack on sugary treats throughout the remainder of the school day. Many districts are unaware of the problem or maintain unenforced policy. The dimensions of the problem are enormous with far-reaching consequences.

Association Policy: For over 25 years, the American Dental Association has held policy encouraging the voluntary restriction of the consumption of sugared beverages and confections. In 1953, the Association's House of Delegates passed the following resolution (*Trans.1953*:225):

Resolved, that the Association recommend that dental societies call to the attention of school administrators the need for eliminating from the schools the sale of sweetened beverages and confections.

In 1973, this position was reaffirmed as follows (*Trans.1973*:660):

Resolved, that the Association reaffirm its long-standing policy that dental societies should call to the attention of school administrators and local government officials the need to protect both dental and general health by eliminating from the schools the sale of sweetened beverages and sugar-rich products in competition with nutritional foods provided in school food programs.

Underscoring this commitment to protect the health of schoolchildren, the Association's House of Delegates formed a task force in 1977 through the adoption of the following resolution (*Trans.1977*:906):

Resolved, that the American Dental Association establish a "National Task Force for the Prohibition of Sale of Confections in Schools," under the auspices of the Council on Dental Health, and be it further

Resolved, that the "Task Force" also seek changes in the School Lunch Act (federal) to eliminate the sale of confections as snacks in schools.

Responding to the directives of the House of Delegates, then Association President Frank P. Bowyer appointed the following members to the Task Force to operate under the auspices of the Council on Dental Health and Health Planning.

NATIONAL TASK FORCE FOR THE PROHIBITION OF THE SALE OF CONFECTIONS IN SCHOOLS

Members include: Naseeb L. Shory, D.D.S., chairman; director, Bureau of Dental Health, Alabama Department of Public Health, Montgomery, Alabama; Wilbert C. Fletke, D.D.S., member, Council on Dental Health and Health Planning, Lansing, Michigan; Margaret M. Hinkle, R.D., M.S., consultant, Council on Dental Health and Health Planning, Columbus, Ohio; Robert John, D.D.S., Belmont, California; and James Williams, D.D.S., Dallas.

Objectives: The Task Force was charged with the following objectives:

1. To identify those areas of the country which prohibit the sale of confections in schools.
2. To develop initiatives by which the American Dental Association can stimulate action at the local level to prohibit the sale of confections in additional schools.
3. To develop guidelines for dental societies to use in cooperating with nondental organizations to achieve this goal.
4. To establish a methodology for cooperating with other organizations to pursue federal legislation to eliminate the sale of confections in schools nationwide.

Meetings: The Task Force held its first meeting on April 13, 1978 at the Association Headquarters building in Chicago. At this meeting, a position statement was drafted along with a proposed plan of action for carrying out the charges assigned to the Task Force. Contacts were made with allied organizations and a national survey was initiated.

The Task Force met again on November 9–10, 1978 to further discuss their activities. Plans for devoting a portion of the 29th Annual National Dental Health Conference in April 1979 to the school confection issue were begun. Updates on the ongoing programs relating to the Task Force were presented as well as the details of the survey which was mailed in the fall.

On April 4, 1979, the Task Force brought together approximately twenty representatives of allied health professional organizations to discuss the confection problem in schools and solicit some support. The need to coordinate efforts with other interested groups was stressed. This meeting served as the first step in formally establishing a liaison with these organizations.

The final meeting of the Task Force was held on May 18, 1979 at which time the outline for the final report was approved and final recommendations to the Council

on Dental Health and Health Planning were drafted. Discussion of the future of school food programs and the anticipated USDA regulations ensued.

Position Statement: The position statement of the Task Force was drafted at the onset and approved by the Council on Dental Health and Health Planning at their meeting of November 20–21, 1978.

Position Statement
National Task Force for the Prohibition
of the Sale of Confections in Schools

Tooth decay is a leading health problem of American schoolchildren. The spread of dental disease is all but universal, affecting 98% of the population.

Although not a life-endangering disease, tooth decay can be inconvenient, incapacitating and expensive. It can cause pain, infection, facial disfigurement and chewing and speech impairments.

Because tooth decay does not heal like other diseases, prevention is of paramount importance in management of this disease. The availability of fluoride in drinking water or other supplementation, good oral hygiene including regular brushing with a fluoride dentifrice and flossing, regular visits to the dentist and eating a balanced diet including avoidance of between-meal sugar-rich snacks all contribute to the prevention of tooth decay in children.

A sugar-rich diet contributes to the development of acid-producing bacteria. These bacteria produce dental plaque that sticks to the teeth. The plaque shelters bacteria that metabolize carbohydrates to form acid and thus dental caries. From numerous studies, it has been substantially determined that dental caries is directly related to the frequency of carbohydrate intake and the length of time sugary foods remain in the mouth.

For this reason, the American Dental Association has for 25 years recommended the voluntary restriction of the consumption of sweetened beverages and confections. It has particularly urged the elimination of the sale of such products in schools. Their availability can compete with school food programs, hinder the effectiveness of nutrition and dental health education and create faulty eating habits that can last a lifetime.

Underscoring its commitment, the Association in 1978 created a National Task Force for the Prohibition of the Sale of Confections in Schools. The five-member Task Force operates under the auspices of the Council on Dental Health and Health Planning. Its objectives are to (1) identify those areas of the country which have prohibited the sale of confections in schools, (2) develop a set of initiatives by which the Association can stimulate action at the local level to prohibit the sale of confections in additional schools, (3) develop guidelines for dental societies to use in cooperating with nondental organizations to accomplish this goal and (4) establish methodology whereby the Association can cooperate with other organizations to pursue federal legislation to eliminate the sale of confections in schools throughout the country.

The Task Force recognizes that elimination of the sale of confections in schools is a complex problem. In addition to the obvious benefits for dental health, nutritional, economic and psychological factors must be considered. It understands that proposed bans of the sale of confections in schools may face stiff opposition, not only from students and parents, but from vendors who fear lost profits or even removal of their machines from schools. School administrators, who depend on sales of confections to produce revenue for extramural activities not covered by the regular school budget, may also resist.

Therefore, the Task Force recommends the following strategy for removing confections from schools:

1. Keep the focus on "confections." A confection is an item for human consumption that contains readily fermentable sugar, provides calories predominantly and is of limited nutritional value.
2. When referring to snacks available or sold in schools, avoid the term "junk foods." The term "confections" has been shown to be less confusing.
3. Advocate the consumption of more nutritious snacks such as milk, cheese, nuts, fresh fruits and vegetables and pure fruit juices.
4. Use persuasion and reasoning instead of dogmatic edicts. Often students and parents will help initiate changes if reasoning is properly explained. *Moderation is essential.*
5. Provide dentists and other professionals with technical resource persons.

Publicity: In order to promote the concept of the Task Force and gain public support, several publicity items were developed to educate professionals and lay people on the need for a campaign to improve the nutrition offered in schools.

1. The "Good Nutrition Campaign Kit" was first developed in 1977 to provide leadership material for local campaigns to eliminate confection sales in schools. The kit contains public education literature, scientific articles, a proposed plan of action, endorsements and support information from other organizations as well as the Task Force. The kit has periodically been revised to include updated material.
2. Articles published about the Task Force and its efforts appeared in the *Leadership Bulletin, ADA News* and publications of supportive organizations.
3. Supporting articles written by members of the Task Force and Association staff appeared in several different professional publications to further promote the campaign.
4. A new version of the pamphlet "Are You Selling Tooth Decay?" is to be developed with the cooperation of the Bureau of Health Education and Audiovisual Services. The new pamphlet will expand on the existing piece to include leadership ideas and act as a trigger piece for decision-makers in the country.

Annual Session, 1978: With a grant from the McDonald's Corporation, the Task Force sponsored a scientific session entitled "Is It a School or a Candy Store? Implementing a School Confection Ban" at the American Dental Association's annual meeting in Anaheim, California, on October 25, 1978. The program included speakers from national organizations and local communities with successful experiences and supportive policies.

29th Annual National Dental Health Conference: On April 2–4, 1979, the Council on Dental Health and Health Planning sponsored its 29th National Dental Health Conference in the Headquarters Building in Chicago. Included on the program for the morning of April 4 was a presentation entitled "Sweet Snacks . . . No! The Campaign for Dental Health," addressing the problem of confection sales in schools. Representatives of dentistry, nutrition, school administration and local support

groups spoke on school snack food sales and suggested courses of action for concerned individuals to take in improving the nutrition of schoolchildren.

Meeting the Objectives: 1. To identify those areas of the country which prohibit the sale of confections in schools:

In an effort to identify the scope of the problem of confection sales in schools and discover some successful programs, the Task Force conducted a national survey initiated in the fall of 1978. Questionnaires were developed with the assistance of the Bureau of Economic and Behavioral Research and sent to all state superintendents of schools, constituent society executive directors, state dental directors, officers and constituent/component dental health education chairmen of the Women's Auxiliary (WAADA), and to 30 executive directors of allied national organizations.

In addition, questionnaires were distributed at the 1978 scientific session in Anaheim, California, "Is It a School or a Candy Store? Implementing a School Confection Ban." Input also was encouraged through articles appearing in various Association publications.

A follow-up survey of those people referred during the initial mailing was conducted in February 1979. The mean response frequency for the entire survey was 70%, with information from at least one source submitted for each of the 50 states and the U.S. territories.

The results of the survey, compiled in May 1979, showed that only six states had any statewide action to restrict the sale of confections in schools beyond the U.S. Department of Agriculture's provision for competitive food sales. Most of the states complied with the USDA regulation that other foods not be sold to compete with the federally funded School Lunch Program but that confections and snacks can be available throughout the remainder of the school day. The majority of states left the responsibility for action up to local option, with minimal local activity occurring around the country. The survey demonstrated the need for stirring up grassroots support to implement some changes in the diet of schoolchildren to protect them against the risks of harmful snacking habits (see Appendix I).

2. To develop initiatives by which the American Dental Association can stimulate action at the local level to prohibit the sale of confections in additional schools:

The formation of the National Task Force and the launching of a formal campaign to better the snack items available in schools created a heightened level of public awareness and concern about the problem. In an era of nutrition-consciousness, parents quickly became sensitive to the impact of daily dietary habits on their child's health status.

Included in the "Good Nutrition Campaign Kit" is a Plan of Action—a suggested outline for initiating a program of change in the snack foods offered in schools.

Steps outlined are as follows:

— Inform and involve dentists, dietitians, dental and nutrition related groups and other interested individuals.

— Analyze the past situation. A valid assessment of the political climate and any previous attempts to limit confection sales is very useful.

— Present the nutrition and dental health objectives and rationale to key school leaders. Involve as many school organizations as possible and appeal to their sense of responsibility for the students' health.

— Develop a plan of public relations. A powerful public education campaign can have tremendous impact.

— Develop a time schedule with the school for implementation.

— Arrange for dental and nutrition professionals to educate administrators, teachers and food personnel. Introducing the change through careful explanation will reduce any opposition the personnel might have toward the changes and clear up some of the questions that might remain.

— Implement the campaign.

— Evaluate the campaign. Feedback from *all* sources should be obtained — students, vendors, administrators, teachers, food service personnel and parents.

— Give recognition to program coordinators, school administrators, food service personnel and classroom teachers for their support.

— Make changes for the next year's program based on this experience and suggestions offered by others.

3. To develop guidelines for dental societies to use in cooperating with nondental organizations to achieve this goal:

To outline a strategy aimed at a common goal, the Task Force called a meeting on April 4, 1979 inviting representatives from various allied organizations to participate and share the details of their efforts to date. Participants at the meeting agreed that an ongoing body of concerned professionals must be maintained to monitor local progress in the campaign. Their course of action would be determined by the final regulations published by the U.S. Department of Agriculture.

In working with these organizations, the Task Force determined several major points:

— The concept of overall general health must be the focus. Dental professionals can emphasize the need for controlling snacking frequency for improved dental health, but the total health of the student population must be the ultimate goal.

— Comprehensive health education must be reinforced. Dental health education should be included as a major component.

— The voice of the professional community is much stronger when united through all of the disciplines. Nutritionists, dentists, physicians and nurses carry a power-

ful public image and together can produce a broad-based impact.

— Arguments must be backed by scientific research. In the case of dental disease, the damaging effects of frequent consumption of sweetened foods can be well documented.

— Dental societies should first obtain the support of these allied organizations at the state and local level before attempting to carry on the campaign alone.

To assist state and local dental societies in pursuing a change in the school food program, the Task Force developed suggested legislation for introduction at the state level. Such a model can be used to enact statewide action to change food policy in all schools but, as with all bills, should be modified to meet each state's specific requirements (see Appendix II).

4. To establish a methodology for cooperating with other organizations to pursue federal legislation to eliminate the sale of confections in schools nationwide:

The federal government has long been involved in nutrition programs for the betterment of the population at large. Supplemental feeding programs are just one of the means through which the government hopes to raise the nutritional status of all Americans to a level adequate to support good general health.

In 1966, Congress passed the National School Lunch and Child Nutrition Act. This made provisions for a federal school lunch program to supply a hot, nutritious meal to students in participating schools.

In 1970, Congress authorized the U.S. Department of Agriculture to regulate food sales competing with the school lunch program, but amended the act to permit competitive food sales if profits contribute to the school or school organizations in 1972.

At the time that the American Dental Association formed its National Task Force for the Prohibition of the Sale of Confections in Schools, Congress again amended the act to give the USDA the authority to regulate competitive food sales with an emphasis on "nutrition." The USDA then published proposed regulations (*Federal Register*, April 25, 1978) to eliminate the sale of foods not approved by the Secretary of Agriculture in schools until after the last lunch period. The categories of foods proposed to be banned were: soda water, frozen desserts, candy and chewing gum. The Department of Agriculture supplied a definition of these food items. The Association submitted formal comment on these proposed regulations encouraging the elimination of additional sugar-rich confections and an extension of the ban to restrict sale of these items throughout the school day.

Public response to the proposed rule was overwhelming and, in December of 1978, the USDA withdrew its proposed regulations for the National School Lunch Program and invited the public comment on the issue through a series of hearings. This provided an excellent opportunity for the Association and allied organizations to be heard. Public hearings were scheduled in Nashville, Detroit and Seattle to begin in January 1979. Again, the Association submitted formal testimony (*Reports 1979*:111) and appeared before the USDA at the Nashville proceedings to deliver the testimony. Dr. Naseeb L. Shory, chairman of the Task Force, represented the Association, and a number of additional dental professionals offered testimony at each of the three hearing sites.

After much waiting, the USDA published their re-proposed regulations on competitive foods in the July 6, 1979 *Federal Register*. The newly proposed regulations would restrict the sale of "foods of minimal nutritional value" until after the last lunch period. Food items are considered "minimally nutritious" if they contain less than 5% of the Recommended Daily Allowance (USRDA) for eight basic nutrients in one serving or a 100 calorie portion. The nutrients to be required are: protein, vitamin A, ascorbic acid (vitamin C), niacin, riboflavin, thiamine, calcium and iron. Categories of foods restricted for sale until after the lunch period are: soda water, water ices, chewing gum and *certain* candies. Candies are subcategorized to include hard candies, jellies and gums, marshmallow candies, fondants, licorice, spun candies and candy coated popcorn. Nutrient analysis and ingredient listings of foods can be submitted to the Secretary of Agriculture for their acceptance for sale in schools.

In response to the re-proposed regulations, the Association and the Task Force submitted written comment strongly urging the USDA to reconsider the issue and make a meaningful final ruling (see Appendices III and IV). The final regulations are expected to go into effect January 1, 1980 and, as they stand, will allow the sale of all food items after the last lunch period and will permit the availability of acceptable foods throughout the school day. Under the weak definition of "foods of minimal nutritional value," it is possible that many confections and sugar-rich snack foods will be acceptable for sale through the entire day.

Funding the Campaign: Lack of funds to properly carry out a campaign to change the snack food choices available in schools has not presented a large problem since the program requires little financial support. Use of community resources to speak out for the program and local leaders to explain the health rationale requires only time and organization. The program itself will be its best spokesman once vendors see that profits can be maintained with the sale of nutritious foods, students feel the change in their physical status and parents see the drop in dental and medical expenses for their children.

Problems Encountered: Opposition may arise from various sources. Generally, parents of schoolchildren are very supportive of measures taken to protect their child's health. But school administrators, students and food vendors may present opposing arguments.

In many cases, school administrators feel that the elimination of the sale of confections will reduce sales

volume and cut revenue from fund-raising activities for school organizations and extracurricular projects. However, sale of nonfood items has been a tremendous success and the Task Force's survey cited book sales, magazine subscription drives, T-shirt sales and craft sales as alternatives to be considered. Potluck dinners and the sale of bread and fruit baskets also were successful examples. These points should be offered to the school administrator when discussing the program.

Student opposition is most likely to be heard. Secondary school students who feel they are old enough to determine their own dietary needs feel their personal rights have been violated. But a comprehensive health education program, showing the students the wise and unwise snack choices to make and the least harmful periods in which to eat sugar-rich foods, can change student attitude. Teenage girls concerned with weight problems and teenage boys concerned about athletic ability often find that the availability of nutritious snack food items is a welcome change and will select these foods instead of non-nutritive, sugary snacks. The opportunity to practice the principles of nutrition education offered in the classroom is a right of every student.

Vendors, too, will accept the program once profits are realized on the sale of nutritious items. Seasonal discounts on fresh fruits and vegetables can be used to profitable advantage. Profit margins will not be sacrificed with the inclusion of these healthy foods in the vending machines and, in fact, may increase considerably.

Conclusion: The American Dental Association will continue in its efforts to achieve those goals set forth by the National Task Force for the Prohibition of the Sale of Confections in Schools through the Council on Dental Health and Health Planning and related agencies. Plans have been made to join forces with several other groups established to promote meaningful local enforcement of the USDA regulations. The Association will continue to lend local assistance to dental societies and communities to limit confection sales in schools and provide for a sound nutrition program.

At their last meeting in May 1979, the Task Force set forth the following final recommendations:

1. The Task Force recommends that CDHHP continue dialogue with other agencies and organizations, provide leadership and stimulate action to further the goals of the Task Force, and continue plans for a consortium for long-term activities.

2. The Task Force recommends that BHEAS produce a new pamphlet focused on confection sales in schools to generate public interest and stimulate decision-makers regarding this issue.

3. The Task Force recommends that CDHHP and the Association reinforce and coordinate efforts with the USDA regulation for the National School Lunch Act.

4. The Task Force recommends that CDHHP and the Association continue to monitor state, federal and local action and legislation in concert with constituent and component societies on matters concerning school confection sales.

5. Considering that WAADA has taken confection sales in schools as its national priority, the Task Force encourages the Association to acknowledge and work closely with this group, offering continued support to actuate the Task Force's goals.

6. Acknowledging that voluntary action is preferable, the Task Force recommends, when necessary, that constituent and component societies support and/or seek any legislation to promote practices leading to improved dental health.

7. The Task Force recommends that more promotion of their efforts appear in the *JADA*, *ADA News*, *Leadership Bulletin* and other publications.

8. The Task Force recommends that BHEAS include promotion of their goals during National Children's Dental Health Week.

9. The Task Force recommends that PEP devote a larger portion of its training program to preventive dentistry and particularly the dietary modifications for oral health.

10. The Task Force recommends that CDHHP send promotional packets to the appropriate agency of each constituent dental society.

11. The Task Force recommends that CDHHP request state dental directors to deal with the appropriate agencies at the state level to meet the Task Force's goals.

12. The Task Force recommends that CDHHP maintain a clearinghouse of support data for the campaign to promote dental health and nutrition in schools and publicize the availability of this information for all those involved with a program.

13. (added July 1979) In light of USDA's most recent (July 6, 1979) proposed rule, the Task Force encourages the Association to go back to Congress and, in concert with other organizations, seek a more effective regulation for restricting confection sales in schools.

The campaign is not yet near its successful completion, but the Task Force has supplied the necessary leadership material for the dental profession's participation and has met its four charges. The continuing education of the public on effective methods to protect themselves against dental disease is an obligation of the profession, and the improvement of the health status of schoolchildren and the general population is a challenge that the Association will continue to accept.

At its September 1979 meeting CDHHP accepted the Task Force Report and recommendations. The Council will assign high priority to carrying on this effort based upon the recommendations of the Task Force.

RESOLUTIONS

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

APPENDIX I: SUMMARY OF PRELIMINARY SURVEY DATA

Groups surveyed: State Superintendents of Schools, Constituent Dental Society Executive Directors, State and Territorial Dental Directors and WAADA Constituent and Component Dental Health Education Chairmen.

1. States with some statewide action restricting the sale of confections in schools: Alabama (state accreditation), California (legislation), Kentucky (accreditation standard), Massachusetts (legislation), Ohio (legislation) and West Virginia (legislation).
2. States presently prohibiting the sale of foods in competition with the school lunch program only: Colorado, Florida, Georgia, Guam, Hawaii (vending machines can supplement the lunch program with fruit juice or nectar and carbonated beverages only), Illinois, Iowa, Kansas, Louisiana, Michigan, Minnesota, Mississippi, Nebraska, New Jersey, New Mexico, North Carolina, Oregon, Pennsylvania, Virginia and Wisconsin.
3. States with a policy regarding prohibition of the sale of confections in schools enforced at local option only: Arkansas, Idaho and New York.
4. States with some action pending: Colorado (legislation), Delaware (School Health Advisory Committee), Maine (legislative proposal) and New Jersey (legislation).
5. States where attempts to prohibit confections sales have been unsuccessful: Florida, Guam, Idaho, Indiana, Michigan, Missouri, Montana, New Hampshire, Rhode Island, South Dakota, Tennessee, Texas (ban rescinded in Dallas) and Washington.
6. States with no known action or regulation: American Samoa, Arizona, Maryland, Nevada, Panama Canal Zone, South Carolina, Utah, Virgin Islands and Wyoming.
7. No data, but supplied referrals: Alaska, Connecticut, District of Columbia, North Dakota, Oklahoma, South Carolina and Vermont.
8. No response: Puerto Rico, Trust Territory of the Pacific Islands.

In addition, various active local areas were found to be enforcing bans on a small scale in their school districts.

(November, 1978)

SUMMARY CHART

State	Statewide legislation	Restricted only around meals	Local action	Legislation pending	No action
Alabama	X				
Alaska			X		
American Samoa					X
Arizona					X
Arkansas	passed resolution				
California	X				
Colorado		X		X	
Connecticut		X	X		
Delaware	resolution submitted			X	
District of Columbia	board of education resolution				
Florida		X		X	
Georgia		X	X		
Guam		X	X		
Hawaii		X			
Idaho	local option				
Illinois		X			
Indiana			X		
Iowa		X	X		
Kansas		X			
Kentucky	X		X		
Louisiana		X	X		
Maine			X	X	
Maryland			X		
Massachusetts	X				
Michigan		X			
Minnesota		X			
Mississippi		X	X		
Missouri			X		
Montana	board of education policy				
Nebraska		X			
Nevada					X
New Hampshire					unsuccessful
New Jersey		X		X	
New Mexico		X			
New York	local option				
North Carolina		X			

North Dakota		X	X		
Ohio	X		X		
Oklahoma			X		
Oregon		X	X		
Panama Canal Zone					X
Pennsylvania		X			
Puerto Rico	secretary of education regulation		X		
Rhode Island		X			
South Carolina			X		
South Dakota					unsuccessful
Tennessee		X	X		
Texas			Dallas: rescinded		
Trust Territory of Pacific Islands					X
Utah					unsuccessful
Vermont			X		
Virgin Islands				possible proposal	
Virginia		X			
Washington			X	X	
West Virginia	X				
Wisconsin		X	X		
Wyoming					X

APPENDIX II: SUGGESTED LEGISLATION

BE IT ENACTED BY THE _____ and the _____ of the State of _____ :

1. The Legislature finds and declares that proper dietary habits and nutrition of children leads to better health and educational attainment. It is important that schools provide foods to children that offer the best nutritional value and reinforce nutrition education concepts provided at home and by the school.

In many instances, confection type foods and sweetened beverages and snacks are made available to children in school at times that may compete with foods served in school meal programs. Consumption of confection type foods, low in nutrition and high in sugar, other than during scheduled meal periods fosters dental decay, interferes with health education and induces faulty dietary habits that can last a lifetime.

2. The board, body or person in charge of each elementary or secondary school receiving public funds in this State shall prohibit the sale in such school, at times other than regularly scheduled meals, of confections, sweetened beverages and other foods declared to be low in nutrition by the state health agency or the United States Secretary of Agriculture. Confections are items for human consumption that contain readily fermentable sugar, provide calories predominantly and are of limited nutritional value. Confections include sugared items such as beverages, chocolate milk, fruit ades, pastries, cookies, ice cream, chewing gum, breath mints and cereal bars.

3. The board, body or person in charge of each elementary or secondary school receiving public funds in this State may, in lieu of confections and sweetened beverages, make available alternative foods with high nutritional value and low sugar content. Such foods include milk, cheese, nuts, fresh fruits and vegetables, pure fruit and vegetable juices and other nutritious foods approved by the state health agency or by the United States Secretary of Agriculture.

4. The board, body or person in charge of each elementary or secondary school receiving public funds in this State shall provide dietary nutrition education for its students.

5. This act shall take effect immediately.

APPENDIX III

August 28, 1979

Margaret O'K. Glavin
Director, School Programs Division
U.S. Department of Agriculture
Food and Nutrition Service
Washington, DC 20250

Dear Ms. Glavin:

The American Dental Association is pleased to have this opportunity to comment on the newly proposed regulations concerning the sale of foods in competition with the National School Lunch Program and the School Breakfast Program (*Federal Register* July 6, 1979).

The Association believes the proposed regulations are woefully inadequate, potentially detrimental to the health of children and certainly a contribution to the development of lifelong unhealthy eating habits. The promotion of sound oral health has long been a goal of the dental profession. As part of this effort, the Association has encouraged individuals to decrease the quantity and frequency of their ingestion of sweetened beverages and confections.

Because many of the snack foods available to schoolchildren contain high levels of sugar, the dental profession is particularly concerned about the ready availability of these types of foods in schools. Frequent consumption of fermentable carbohydrates is a primary cause of dental decay which is especially harmful to the dentition of children and young adults. The consequences of poor oral health can carry through to a lifetime of problems. The reduction of dietary sugar intake is

one means available to intercept effectively to prevent dental disease.

The Association feels that the school should provide a lifestyle model for its students, fostering good nutritional habits, and encourages the U.S. Department of Agriculture to strengthen its regulations dealing with competitive foods to enforce a more meaningful change in snack food consumption on school campuses. We are sadly disappointed in the proposed regulations and feel the health of our schoolchildren deserves more attention.

Specifically, the Association urges the extension of the restriction of sales of "foods of minimal nutritional value" throughout the entire school day. If students need only to wait until after the last lunch period to obtain these snack foods, they may forfeit the balanced nutrition offered through the School Lunch Program to purchase snacks later in the day.

In defining foods of "minimal nutritional value" the selected standard of five percent of USRDA for eight nutrients in a 100-calorie portion, is meaningless. The concern over such a standard is that industry will turn to fortification of all confection items to meet the minimum requirements, thereby "qualifying" them as nutritious and suitable for sale at any time of the school day. Such practices should be restricted.

Further, simply requiring the presence of certain nutrients in order to recognize the food as a "nutritious contribution to the diet" ignores the detrimental effects of overconsumption of other food components such as high levels of sugar, fat and sodium. Children should be protected from the unnecessary health risks associated with excessive intake of these dietary constituents.

Although the U.S. Department of Agriculture has made a good effort to address the problem of competitive food sales in the schools, they have failed to do so effectively. The American Dental Association feels that the oral health needs of today's schoolchildren must be given more attention. The availability of dentally harmful foods throughout the day when frequent consumption is proven to be detrimental to oral health, must be controlled with an aggressive and positive health education program and an effective model environment created within the school system.

In view of the ineffectiveness of the proposed regulations, the Association recommends that the matter be reconsidered to develop a stronger, more meaningful regulation.

Thank you for the opportunity to comment.

Sincerely,

Robert E. Lamb, DDS
Chairman
Council on Dental Health
and Health Planning

APPENDIX IV

August 28, 1979

Margaret O'K. Glavin
Director, School Programs Division
U.S. Department of Agriculture
Food and Nutrition Service
Washington, DC 20250

Dear Ms. Glavin:

On behalf of the National Task Force for the Prohibition of the Sale of Confections in Schools of the American Dental Association, I would like to offer the following comments concerning the proposed regulations to amend the National School Lunch Act as published in the *Federal Register* July 6, 1979.

The Task Force and the Association feel very strongly that the promotion of preventive dental health practices is crucial to the well-being of today's children now and in the future. The widespread problem of dental disease can be controlled through conscientious administration of a few basic daily modifications.

One effective method for reducing the incidence of dental caries is through modification of the diet. Children should be educated to prevent oral disease by examples set forth in the home *and* at school. The detrimental effects of unsound dietary practices, established in childhood, can extend throughout life causing needless pain, expense, and inconvenience.

Although the U.S. Department of Agriculture has spent a considerable amount of time reviewing testimony and drafting proposed regulations, their efforts still fall short of the mark, which should be to provide a healthful environment to all schoolchildren exemplifying the health education message expressed in the classroom. The holding of public hearings and the responsiveness of the USDA to public interest, made us hopeful that the newly proposed regulations would be more effective and meaningful in terms of their impact on the availability of confections on school campuses.

But not so. In fact, the original proposal, designed to restrict the sale of "candy" would have eliminated more confections than the newly defined "foods of minimal nutritional value" ruling. Further, restriction of baked goods and pastries is not at all addressed in the regulations, allowing continuing sale of these dentally harmful foods.

The selection of a five percent nutrient density standard is not meaningful, since industry can easily fortify the products to meet the minimum requirements. Restrictions should be placed on the use of fortifying preparations in order to avoid the fortification of every food item sold in schools.

Further, the requirement that certain nutrients be present in designated amounts, still ignores the problem of excessive consumption of food components that are not essential, for example, sugar, fat and sodium. The health hazards influenced by increased intake of these constituents cannot be ignored, especially when dealing with children. These risks, when established early in life, can cause lifelong complications.

The Task Force firmly feels that any restriction on sales of "foods of minimal nutritional value" should be extended throughout the entire school day. If the foods are made available in the afternoon, students will save their money until this time and then purchase non-nutritious foods, bypassing the hot lunch provided by the School Lunch Program. In this way, the schools are not creating a model environment for their students but instead are teaching them to postpone negative behavior until enforcing measures are no longer present.

The Task Force is generally disappointed in the weak regulations proposed by the U.S. Department of Agriculture and recommends that the issue be reconsidered for more effective final ruling.

Thank you for the opportunity to comment.

Sincerely,

Naseeb L. Shory, DDS
Chairman
National Task Force for the
Prohibition of the Sale of
Confections in Schools

Resolutions

SUBMITTED BY CONSTITUENT AND COMPONENT SOCIETIES AND OTHER AGENCIES

District of Columbia Dental Society

AMENDMENT OF "MANUAL OF HOUSE OF DELEGATES" REGARDING MOTION TO RECOMMIT OR REFER

The following resolution was adopted by the District of Columbia Dental Society on September 11, 1979 and transmitted under date of September 27, 1979 by Mr. Michael L. Cady, executive director.

75. Resolved, that the *Manual of the House of Delegates*, Rules of the House of Delegates, Motion to Recommit or Refer to an Agency, page 13, be amended by the addition of the following sentence:

> A motion to recommit or refer to an agency by a Reference Committee may be debated in accordance with the rules governing the debate of a main motion.

Indiana Dental Association

SUBSTITUTE FOR RESOLUTION 16

The following substitute for Resolution 16 (*Reports*:152) was adopted by the Indiana Dental Association's Board of Trustees on September 28, 1979 and transmitted under date of October 1, 1979 by Dr. John C. Gorman, secretary.

Background Statement: The Indiana Dental Association Board of Trustees agrees that the creation of a Commission on National Dental Examinations to replace the function of the Council on National Board Examinations is desirable. Further, the IDA Trustees agree that the American Association of Dental Examiners and the American Association of Dental Schools should be allowed to select rather than nominate members of the proposed Commission.

The IDA Trustees agree that the accountability of the proposed Commission would be even further enhanced by having representation from the American Dental Hygienists' Association, the American Student Dental Association and the general public.

However, the IDA Trustees believe the representatives from the ADHA, the ASDA and the general public should be nonvoting consultants to the proposed Commission. The IDA Trustees believe that input from the ADHA, ASDA and the general public can be helpful. However, final decision-making and voting should be vested in those representatives from the American Dental Association, American Association of Dental Examiners and American Association of Dental Schools serving on the proposed Commission. Therefore, the IDA Trustees recommend that the proposed Chapter XVI, Commission on National Board Examinations, *Section 20*, a. Nominations, items (4), (5) and (6) be amended by adding the word "consultant" after the word "One" in each case, to make the amended resolution read:

16S–1. Resolved, that Chapter IX, Councils and Commissions, Section 10, Name, of the *Bylaws*, be amended by deletion of the line "Council on National Board Examinations," and be it further

Resolved, that Chapter IX, Councils and Commissions, Section 20, Members, Selections, Nominations and Elections, of the *Bylaws*, be amended by deletion of Subsection C, Nominations and Elections for the Council on National Board Examinations, and redesignation of Subsection D to Subsection C and Subsection E to Subsection D, and be it further

Resolved, that Chapter IX, Councils and Commissions, Section 110, Duties, of the *Bylaws*, be amended by deletion of Subsection P, Council on National Board Examinations, and redesignation of Subsection Q to Subsection P and Subsection R to Subsection Q, and be it further

Resolved, that Chapter XVI, Scientific Session, of the *Bylaws*, be redesignated Chapter XVII; Chapter XVII, Publications, be redesignated Chapter XVIII; Chapter XVIII, Finances, be redesignated Chapter XIX; Chapter XIX, Women's Auxiliary to American Dental Association, be redesignated Chapter XX; Chapter XX, Indemnification, be redesignated Chapter XXI and Chapter XXI, Amendments, be redesignated Chapter XXII, and be it further

Resolved, that a new chapter, XVI, Commission on National Dental Examinations, be added to read as follows:

CHAPTER XVI. COMMISSION ON NATIONAL DENTAL EXAMINATIONS

Section 10. ESTABLISHMENT: The Association shall establish and support a Commission on National Dental Examinations.

Section 20. MEMBERS, SELECTIONS, NOMINATIONS AND ELECTIONS: The Commission on National Dental Examinations shall be composed of nine (9) members and three (3) consultants selected as follows:

a. NOMINATIONS

(1) Three (3) members shall be nominated by the Board of Trustees from the active or life members of this Association, no one of whom shall be a member of a faculty of a school of dentistry or a member of a state board of dental examiners.

(2) Three (3) members shall be selected by the American Association of Dental Examiners from the active membership of that body, no one of whom shall be a member of a faculty of a school of dentistry.

(3) Three (3) members shall be selected by the American Association of Dental Schools from its active membership. These members shall hold positions of professorial rank in dental schools accredited by this Association and shall not be members of any state board of dental examiners.

(4) One (1) consultant who is a dental hygienist shall be selected by the American Dental Hygienists' Association.

(5) One (1) consultant who is a public representative shall be selected by the Commission on National Dental Examinations.

(6) One (1) consultant who is a dental student shall be selected annually by the American Student Dental Association.

b. ELECTIONS. The three (3) members of the Commission on National Dental Examinations nominated by the Board of Trustees shall be elected by the House of Delegates from nominees selected in accordance with this section.

Section 30. DUTIES: The duties of the Commission shall be:

a. To provide and conduct written examinations, exclusive of clinical demonstrations, for the purpose of determining qualifications of dentists who seek license to practice in any state, district or dependency of the United States. Dental licensure is subject to the laws of the state, district or dependency and the conduct of all clinical examinations for licensure is reserved to the individual board of dental examiners.

b. To provide and conduct written examinations, exclusive of clinical demonstrations, for the purpose of determining qualifications of dental hygienists who seek license to practice in any state, district or dependency of the United States. Dental hygiene licensure is subject to the laws of the state, district or dependency and the conduct of all clinical examinations for licensure is reserved to the individual board of dental examiners.

c. To make rules and regulations for the conduct of examinations and the certification of successful candidates.

d. To serve as a resource for the dental profession in the development of written examinations.

and be it further

Resolved, that Chapter IX, Councils and Commissions, Section 30, Eligibility, Subsection B, of the *Bylaws*, be amended by substitution to read as follows:

B. A member of the Council on Dental Education or of the Commission on National Dental Examinations, who was selected by the American Association of Dental Examiners and who is no longer an active member of the American Association of Dental Examiners, may continue as a member of the council or commission for the balance of his term.

and be it further

Resolved, that Chapter IX, Councils and Commissions, Section 30, Eligibility, Subsection C, of the *Bylaws*, be amended by substitution to read as follows:

C. When a member of the Council on Dental Education or the Commission on National Dental Examinations, who was selected by the American Association of Dental Schools, shall cease to be a member of the faculty of a member school of that Association, his membership on either council shall terminate, and the President of the Association shall declare the position vacant.

and be it further

Resolved, that Chapter IX, Councils and Commissions, Section 60, Term of Office, of the *Bylaws*, be amended by addition of the phrase "and the dental student selected by the American Student Dental Association as a consultant to the Commission on National Dental Examinations shall be selected for a one (1) year term." to the end of the first sentence of that section, and addition of the phrase "and the dental student selected by the American Student Dental Association as a consultant to the Commission on National Dental Examinations shall be limited to one (1) term." to the end of the second sentence of that section, so that Section 60 shall read as follows:

Section 60. TERM OF OFFICE: The term of office of members of councils or commissions shall be three (3) years except that the physician nominated by the American Medical Association for membership on the Council on Legislation shall be elected for a one (1) year term and the dental student selected by the American Student Dental Association as a consultant to the Commission on National Dental Examinations shall be selected for a one (1) year term. The consecutive tenure of a member of a

council or commission shall be limited to two (2) terms of three (3) years each except that the physician nominated by the American Medical Association for membership on the Council on Legislation shall not be limited as to the number of consecutive one (1) year terms that he may serve and the dental student selected by the American Student Dental Association as a consultant to the Commission on National Dental Examinations shall be limited to one (1) term.

Indiana Dental Association

SUBSTITUTE FOR RESOLUTION 66

The following substitute resolution for Resolution 66 was adopted by the Indiana Dental Association's Board of Trustees on September 28, 1979 and transmitted under date of October 1, 1979 by Dr. John C. Gorman, secretary.

Background Statement: The Indiana Dental Association's Board of Trustees believes Resolution 66 is an appropriate step toward an orderly provision for the appointment of a substitute in the event a trustee must be absent for a session of the Board of Trustees. However, so the wording is perfectly clear and workable for all, the IDA Trustees believe that Resolution 66 should be amended. Therefore, be it

66S–1. Resolved, that Resolution 66 regarding Chapter VI, Board of Trustees, Section 70, Vacancy, of the *Bylaws*, be further amended by adding the words ", with the consent and agreement of the constituent society" after the words, "absentee is a member," to make the amended paragraph read as follows:

> In the event a trustee is absent for a session of the Board of Trustees the President may appoint an active or life member from the constituent society of which the absentee is a member, with the consent and agreement of the constituent society, unless such privilege is yielded by the constituent society, as a substitute to serve during the session.

Indiana Dental Association

AMENDMENT OF "MANUAL OF THE HOUSE OF DELEGATES" REGARDING MOTIONS TO ADOPT, POSTPONE INDEFINITELY OR REJECT RESOLUTIONS

The following resolution was adopted by the Indiana Dental Association's Board of Trustees on September 28, 1979 and transmitted under date of October 1, 1979 by Dr. John C. Gorman, secretary.

Background Statement: For a long time many delegates have felt that parliamentary procedure in the ADA House of Delegates is just too confusing. Veteran delegates say they can sometimes see their way through the confusion, but the confusion is always present. Others say they are tired of having to vote "yes" when they mean "no."

The paragraph entitled "Motions to Adopt, Postpone Indefinitely or Reject Resolutions" on pages 12 and 13 of the *Manual of the House of Delegates* forces the delegates to vote "yes" or "no" on the recommendation of the reference committee rather than "yes" or "no" on the resolution itself. Among the many delegates and in the huge facility that houses the meetings it is frequently difficult to determine if the delegate having the floor is speaking for or against the recommendation or the resolution. The normal benefits of parliamentary debate—the exchange of information and persuasion—are severely frustrated under these special rules of the House.

We believe the routine use of the motion "to postpone indefinitely" to defeat resolutions is a poor procedure and contributes to much of the confusion. *Sturgis* states that the purpose of the motion "to postpone indefinitely" is, "to suppress the motion without letting it come to a direct vote."

We are not persuaded by those within the ADA who maintain that the motion "to postpone indefinitely" is a soft way to defeat a resolution. It is, indeed, an indirect way to defeat a resolution, but we believe a direct defeat is more gentlemanly and more fair to the maker of the resolution. This is particularly true because the direct defeat follows open debate rather than suppressed or confused debate.

The motion "to reject" a resolution is not found in *Sturgis* or in any of the literature on standard parliamentary procedure. We have learned that it was "created" by someone within the ADA. The purpose of this creation remains a mystery to us because it is more logical to defeat a resolution by voting "no" on the resolution than to vote "yes" on a motion to reject it. The House special rules state that "the motion to reject is a subsidiary motion which may be debated but does not permit amendment of the resolution." It seems to have been designed to prevent normal parliamentary fair play.

If the offending paragraph describing these special rules is deleted from the *Manual*, the House would be governed by standard parliamentary procedure. The delegates could vote "yes" or "no" on the resolutions in most situations. Therefore, be it

74. Resolved, that the paragraph entitled "Motions to Adopt, Postpone Indefinitely or Reject Resolutions" on pages 12 and 13 of the *Manual of the House of Delegates* be deleted.

Michigan Dental Association

DEFINITION OF PRIVATE PRACTICE

The following resolution was adopted by the Michigan Dental Association and transmitted under date of September 28, 1979 by Dr. Wilbert C. Fletke, secretary.

Background Statement: The American Dental Association has long favored and promoted the private practice of dentistry. It has often stated that private practice has brought to this country the best oral health of any country in the world.

Although 87% of the dentists in the United States are private practitioners, the American Dental Association recognizes the place and the need for other delivery systems—it invites and encourages comparisons.

While we all feel we know what private practice is, we will be better advocates and encourage more meaningful comparisons if we can agree upon a precise definition.

Therefore, the following resolution is proposed:

72. Resolved, that the following definition of Private Practice be approved:

> *Private Practice:* The private practice of dentistry is the mode of delivery of oral health care in which a dentist is responsible for all aspects of the practice. In the private practice of dentistry, the patient maintains freedom of choice of dentist and the dentist freedom of choice of patient, without discriminating on the basis of race, color, creed or national origin.

Michigan Dental Association

DEFINITION OF "USUAL FEE"

The following resolution was adopted by the Michigan Dental Association and transmitted under the date of September 26, 1979 by Dr. Wilbert Fletke, secretary.

Background Statement: In 1973 Resolution 32–1973–H (*Trans.1973*:665) was adopted by the ADA House of Delegates. This defined Usual, Customary and Reasonable in their context to dental prepayment programs.

The portion of the resolution that follows deals only with the definition of "Usual" fee. The present definition adopted by the House nine years ago reads as follows:

> *Usual Fee:* The usual fee is that fee usually charged, for a given service, by an individual dentist to his private patient, i.e., his own usual fee.

For many years this definition responded to its need. However, in the last eighteen months modes of dental treatment and patterns of charging for services rendered have begun to change. These changes include the forgiving or waiving of co-payment to prepayment subscribers, or discounting the cost of dental treatment. Such changes may drastically alter third party reimbursement mechanisms.

Forgiving/discount dentist—is a dentist who waives the patient's co-payment required by third party dental contracts. His expected rationale is that by discounting patients' liability or waiving co-pays he will attract more clientele. New Jersey and Michigan have some instances of this form of practice.

Discounting or forgiving distorts and could even destroy the definition of usual fee, because the fee charged is not the fee collected or even anticipated as the fee to be collected.

The American Dental Association and its constituents have long supported and espoused the concept of patient financial interest as a method for insuring the maintenance of treatment received. Discounting, forgiving or waiving of co-payments leaving a patient with no financial interests destroys this concept of practice.

The Michigan Dental Association proposes a modification in the definition of "Usual" Fee which would place it back in context with third party reimbursement mechanism and maintain the concept of the UCR approach to reimbursement and patient financial interest.

76. Resolved, that the definition of Usual Fee (*Trans.1973*:668) be modified to read as follows:

> *Usual Fee:* A Usual Fee is the fee usually charged *and received* for a given service by an individual dentist, i.e., his own usual fee.

Tennessee Dental Association

ADA INPUT INTO INTERPRETATION AND IMPLEMENTATION OF LAWS

The following resolution was adopted by the Board of Trustees of the Tennessee Dental Association and transmitted under date of September 13, 1979 by Mr. David S. Horvat, executive director.

Background Statement: One aspect of our expressed interest in the health care of our fellow citizens is increased consultation with the lawmakers of our nation. The necessity for further consultation and definite follow-up has become apparent. Repeated instances of bureaucratic interpretation far afield from the intent of legislators who have introduced certain basic ideas and guided them into law require that the American Dental Association House of Delegates adopt the following resolution.

56. Resolved, that the American Dental Association through its appropriate agencies make every reasonable effort to increase the input of dentistry into the interpretation and implementation of laws that affect dentistry while being drafted into rules by federal agencies following their passage by Congress.

Washington State Dental Association

VETERANS ADMINISTRATION DENTAL FEES

The following resolution was adopted by the Washington State Dental Association and transmitted under date of October 5, 1979 by Dr. Donald E. Compaan, secretary.

Background Statement: The following resolution and background statement were submitted to the 1978 ADA House of Delegates:

> **Background Statement:** Under date of March 22, 1977, the Washington State Dental Association addressed a communication to the chief of dental service at the Seattle Veterans Administration expressing the belief that fees paid by the VA should keep pace with rising costs. The letter urged the VA to conduct a survey of dental fees in the state of Washington, and to adjust the VA dental fee schedule in accordance with the findings of the survey. Copies of the March 22, 1977 letter were sent to Dr. Albert J. Aaronian, assistant chief medical director for dentistry, Veterans Administration, Washington, D.C., and also to the Councils on Dental Care Programs and Federal Dental Services of the American Dental Association. No response of any kind has been received to date from either the chief of dental service at the Seattle VA hospital or from any of those to whom copies of the letter were sent, and no change has been made in the VA dental fee schedule for the state of Washington since May 1, 1976. Since the Washington State Dental Association believes it is important that VA dental fee schedules be continuously updated, the WSDA submits the following resolution for consideration: (Prior to withdrawal, this resolution was identified as Resolution 75.)
>
> **Resolved,** that the American Dental Association urge the Veterans Administration continuously to update the fees it pays for services of dentists in private practice so such fees will be commensurate with the value of the services provided.

This resolution was withdrawn in 1978 with the consent of the Washington delegation because of last minute correspondence from the Veterans Administration which led them to believe that the VA would comply with the intent of the resolution without any outside prompting. Although the Washington State Dental Association has no data base for a fee schedule, nor do we have any intention of developing one, the number of complaints currently being received by our state dental care committee concerning VA fees leads us to believe that the VA fee schedule is not on a par with the prevailing fees.

It has come to the attention of the Washington State Dental Association that the Health Insurance Association of America (HIAA) maintains a computerized data bank which stores member-derived statistics on usual, customary and reasonable charges for dental and medical services. It is understood (1) that data can only be used for claims administration purposes, but that everyone can subscribe to the system provided this restriction is observed, and (2) that the cost of using the system varies on the basis of the number of the subscriber's beneficiaries, with a minimum cost of $7,100 per year for two updates annually.

The Washington State Dental Association submits the following resolution for consideration by the 1979 House of Delegates of the American Dental Association:

101. Resolved, that the American Dental Association urge the Veterans Administration continuously to update the fees it pays for services of dentists in private practice so such fees will be commensurate with the value of the services provided, and be it further

Resolved, that it is additionally respectfully requested that the Veterans Administration provide documentation that such updating actually occurs, and be it further

Resolved, that the American Dental Association urge the Veterans Administration to make use of the data bank operated by the Health Insurance Association of America.

First Trustee District

INCLUSION OF HEALTH MAINTENANCE ORGANIZATIONS IN THE CERTIFICATE OF NEED REQUIREMENT

The following resolution was adopted by the First Trustee District and submitted on October 4, 1979 by Ms. Audrey S. Nelson, administrative secretary, New Hampshire Dental Association.

Background: The Public Health Planning Act, P.L. 96–79, which was signed into law in October 1979, effectively exempts health maintenance organizations from certificate of need requirements applicable to other health institutions, such as hospitals, thus providing HMOs unfair advantage over other institutional forms of delivery.

Therefore, to provide policy for the Association in seeking to correct this inequity, the First Trustee District submits the following resolution:

88. Resolved, that the appropriate agency of the American Dental Association take the necessary steps to ensure that selected health care delivery systems, such as health maintenance organizations, do not receive unfair advantage over other forms of health care delivery systems by being relieved of the requirement of certificate of need.

First Trustee District

REMOVAL OF SUPPORT FOR FEE-FOR-SERVICE DENTISTRY APPENDED TO HEALTH MAINTENANCE ORGANIZATIONS

The following resolution was adopted by the First Trustee District and submitted on October 4, 1979 by Ms. Audrey S. Nelson, administrative secretary, New Hampshire Dental Association.

Background: Rather than develop a dental benefits plan on a prenegotiated and fixed periodic payment schedule for their enrollees, it appears that some health maintenance organizations are offering dental services to their enrollees and to the general public on a fee-for-service basis. When this situation exists within the administration of a federally subsidized health maintenance organization, it constitutes an inappropriate use of federal monies, inasmuch as the dental component does not represent an alternative to traditional dental practice. Additionally, such subsidies unfairly place the unsubsidized dental practitioner in a disadvantageous position. Therefore, the following resolution is submitted by the First Trustee District to direct the Association to attempt to remove federal government support for fee-for-service dental practices appended to health maintenance organizations.

89. Resolved, that the American Dental Association act to remove from federal support and encouragement such primary fee-for-service non-capitation, non-enrolled group dental programs appended to medical health maintenance organizations.

First Trustee District

INVOLVEMENT OF CONSTITUENT AND COMPONENT DENTAL SOCIETIES IN THE DESIGNATION OF SHORTAGE AREAS

The following resolution was adopted by the First Trustee District and submitted on October 4, 1979 by Ms. Audrey S. Nelson, administrative secretary, New Hampshire Dental Society.

Background: Knowing that local dental societies can be helpful to the U.S. Department of Health and Human Services in designation of shortage areas and implementing necessary and worthy programs, therefore be it

90. Resolved, that the appropriate agency of the Association contact and strive to implement a program whereby the geographically involved constituent and component societies shall be informed by the appropriate government agency of requests for designation of shortage areas at the time requests are received by HEW.

First Trustee District

SUBSTITUTE FOR RESOLUTION 127

The following substitute resolution for Resolution 127 was submitted on October 23, 1979 by Dr. Robert J. Zeoli, delegate, First Trustee District.

127S–1. Resolved, that appropriate agencies of the American Dental Association review a bill which has been introduced in the United States House of Representatives (H.R. 5151) which would authorize a dental benefit plan for civilian federal employees in order that amendments *be made in order to insure compliance with ADA policy* during Congressional consideration of this legislation.

Second Trustee District

SUSPENSION OF "LEADERSHIP BULLETIN"

The following resolution was adopted by the Second Trustee District at its October 6 and 7, 1979 caucus and transmitted under date of October 8, 1979 by Dr. Seymour L. Nash, executive director, Dental Society of the State of New York.

Background Statement: No thinking person will dispute the axiom that with the serious problems facing the profession increased and improved communications are essential. The Board of Trustees, responding to the need of the members of the association for news and information, has decided that the *ADA News* be published weekly.

It is interesting to note that under its new editorial leadership this newspaper has increased its readability and credibility, making for increased member interest.

Close perusal of the ADA's *Leadership Bulletin* reveals very little material that would not be appropriate to nor of importance to every ADA member. In addition, the *Bulletin* is mailed first class to insure its timeliness; the *ADA News* is sent via third class mail.

Should the *ADA News* become a weekly publication it seems not only impractical but wasteful to continue producing the *Leadership Bulletin*. Sound fiscal policies dictate that if all objectives for publishing the *Leadership Bulletin* are met by shifting the *ADA News* to a weekly publishing timetable, then any duplication of information and effort is a waste of ADA resources.

95. Resolved, that publication of the *Leadership Bulletin* be suspended and its editorial content be included in the weekly *ADA News*.

Fourth Trustee District

SUBSTITUTE FOR RESOLUTION 7

The following substitute resolution for Resolution 7 (*Supplement 1*:298) was transmitted on October 10, 1979 by Mr. Michael L. Cady, executive director, District of Columbia Dental Society.

7S-2. Resolved, that *Guidelines for Dentistry's Position in a National Health Program* continue to be used as the principal policy document upon which the Association's positions in these matters will be based, and be it further

Resolved, that the prototype dental components developed at the direction of the 1978 House of Delegates be received only as examples and shall not be used for any legislative purposes.

Fourth Trustee District

SUBSTITUTE FOR RESOLUTION 23

The following resolution was transmitted on October 10, 1979 by Mr. Michael L. Cady, executive director, District of Columbia Dental Society.

Whereas, a dentist who intends, when an insurance form is completed, to accept a third party payment under a co-payment plan as payment in full, and does not charge the patient's payment portion, is misrepresenting the true fee for his services, and

Whereas, is is unethical to commit a deliberate irregularity in billing, therefore, be it

23S-2. Resolved, that the appropriate agencies of the Association develop a statement outlining the legal implications of deliberate irregularity in billing of third party payment plans, and be it further

Resolved, that the Council on Bylaws and Judicial Affairs develop an advisory opinion to the *Principles of Ethics* consistent with these findings, and be it further

Resolved, that the statement and any opinion rendered be transmitted to the 1980 House of Delegates for their information.

Fourth Trustee District

SUBSTITUTE FOR RESOLUTION 24

The following substitute resolution for Resolution 24 (*Reports*:205) was transmitted on October 10, 1979 by Mr. Michael L. Cady, executive director, District of Columbia Dental Society.

24S-1. Resolved, that constituent dental societies be encouraged to support consumer legislation for protecting the public investment in dental care by regulating all prepaid dental delivery systems.

Fourth Trustee District

SUBSTITUTE FOR RESOLUTION 39

The following substitute resolution for Resolution 39 (*Supplement 1*:361) was transmitted on October 10, 1979 by Mr. Michael L. Cady, executive director, District of Columbia Dental Society.

Background Statement: The Fourth Trustee District recommends that Resolution 39 be amended by adding the following statement at the end "excluding the federal dental services." to make the amended resolution read:

39S-1. Resolved, that the American Dental Association recommends that all delegates be chosen by an elective process excluding the federal dental services.

Fourth Trustee District

SUBSTITUTE FOR RESOLUTION 55RC

The following substitute resolution for Resolution 55RC was submitted on October 23, 1979 by Mr. Michael L. Cady, executive director, District of Columbia Dental Society.

55RC–S–1. Resolved, that the House of Delegates approves the scope and direction of Report 5 on the Prevention and Control of Dental Disease Through Improved Access to Comprehensive Care and requests implementation of its recommendations through coordinated Association activity, and be it further

Resolved, that the report as amended be published with the recommended changes *after approval of the Board of Trustees.*

Fourth Trustee District

SUBSTITUTE FOR RESOLUTION 100B

The following substitute resolution for Resolution 100B was submitted on October 23, 1979 by Mr. Michael L. Cady, executive director, District of Columbia Dental Society.

100B–S–1. Resolved, that the House of Delegates of the American Dental Association does request the Board of Trustees to exercise unusual prudence and judgment in its decisions regarding the planned denture *service* study sponsored by the San Francisco Regional Office of the Federal Trade Commission.

Fourth Trustee District

DECLARATION OF THE 1980's AS "THE INTERNATIONAL DECADE FOR THE PREVENTION OF DENTAL DISEASE"

The following resolution was transmitted on October 10, 1979 by Mr. Michael L. Cady, executive director, District of Columbia Dental Society.

Background Statement: In the knowledge that dental disease is so very prevalent even though it is almost entirely preventable and that dental health education/motivation needs a considerably increased impetus which should be reinforced over a considerable period of time; proven community methods of prevention such as the fluoridation of domestic water supplies need additional promotion; and increased emphasis should be given to research into both currently accepted and additional preventive measures; it is logical to anticipate that an intensive campaign in all areas of preventive dentistry could achieve considerable success over a ten-year period.

The year 1980 will usher in a new decade and this turning point in the calendar provides an appropriate opportunity to give special national and international prominence to an all-out campaign for the prevention of dental disease. Therefore, be it

115. Resolved, that the American Dental Association, in support of the Health Commission of Victoria, declare the 1980's as "The International Decade for the Prevention of Dental Disease."

Fourth Trustee District

DEFINITION OF FEE-FOR-SERVICE PRIVATE PRACTICE

The following resolution was submitted on October 10, 1979 by Mr. Michael L. Cady, executive director, District of Columbia Dental Society.

Background Statement: Under the traditional fee-for-service private practice mode for delivery of oral health care, consistent with the object of the Association, American dentists have provided a most effective service for their patients. Because of this, the preservation of this mode, as one among others, has been supported by the profession. It is imperative, therefore, that the traditional fee-for-service private practice of dentistry be defined. Therefore, be it

116. Resolved, that the following definition of the traditional fee-for-service private practice of dentistry be approved:

> The traditional fee-for-service private practice of dentistry, historically the basic and most prevalent method for delivery of oral health care, is a mode in which the dentist, as a solo practitioner or in a group, is ultimately responsible for all professional and business aspects of the practice. In this mode the charge to the patient is dictated by the particular service rendered, the patient maintains the freedom of choice of the dentist and the dentist has freedom of choice of patients.

Fourth Trustee District

AMENDMENT OF SECTION 1–D, EMERGENCY SERVICE, OF THE "REVISED PRINCIPLES OF ETHICS"

The following resolution was adopted by the Fourth Trustee District at its September 29, 1979 caucus and transmitted under date of October 10, 1979 by Mr. Michael L. Cady, executive director, District of Columbia Dental Society.

118. Resolved, that Section 1–D, Emergency Service, of the *Revised Principles of Ethics*, be amended to read as follows:

> *1–D Emergency Service*
>
> The dentist shall be obliged to make reasonable arrangements for the emergency care of his patients of record.
>
> The dentist shall be obliged when consulted in an emergency by a patient not of record to attend to the conditions leading to the emergency, *and, upon completion of such treatment, to return the patient, unless the patient expressly reveals a different preference, to his regular dentist.*

Fourth Trustee District

AMENDMENT OF SECTION 1–G, JUSTIFIABLE CRITICISM AND EXPERT TESTIMONY, OF THE "REVISED PRINCIPLES OF ETHICS"

The following resolution was adopted by the Fourth Trustee District at its September 29, 1979 caucus and transmitted under date of October 10, 1979 by Mr. Michael L. Cady, executive director, District of Columbia Dental Society.

119. Resolved, that Section 1–G, Justifiable Criticism and Expert Testimony, of the *Revised Principles of Ethics*, be amended by the deletion of the words "If there is evidence of such faulty treatment, the patient shall be informed" so the amended section will read as follows:

> *1–G Justifiable Criticism and Expert Testimony*
>
> The dentist shall be obliged to report to the appropriate reviewing agency instances of gross and/or continued faulty treatment by another dentist. (*Omission*) A dentist shall be obliged to refrain from commenting disparagingly without justification about the services of another dentist. The den-

tist shall provide expert testimony when that testimony is essential to a just and fair disposition of a judicial or administrative action.

Fourth Trustee District

AMENDMENT OF SECTION 1–E, CONSULTATION AND REFERRAL, OF THE "REVISED PRINCIPLES OF ETHICS"

The following resolution was adopted by the Fourth Trustee District at its September 29, 1979 caucus and transmitted under date of October 10, 1979 by Mr. Michael L. Cady, executive director, District of Columbia Dental Society.

120. Resolved, that Section 1–E, Consultation and Referral, of the *Revised Principles of Ethics*, be amended to read as follows:

1–E Consultation and Referral

The dentist shall be obliged to seek consultation, if possible, whenever the welfare of the patient will be safeguarded or advanced by utilizing those who have special skills, knowledge and experience.

When a patient visits or is referred to a specialist or consulting dentist for consultation:

1. The specialist or consulting dentist upon completion of his care shall return the patient, unless the patient expressly reveals a different preference, to the referring dentist, *or if none, to the dentist of record* for future care.
2. The specialist shall be obliged when there is no referring dentist and upon a completion of his treatment to inform the patient when there is a need for further dental care.

Fourth Trustee District

DENTAL FEES

The following resolution was adopted by the Fourth Trustee District and submitted on October 21, 1979 by Dr. Isreal Shulman, secretary-treasurer, Fourth Trustee District.

Background Statement: As a part of President Carter's Comprehensive and Coordinating Anti-Inflation Program, the professional sector has been singled out for special treatment.

The Council on Wage and Price Stability (CWPS), as the Agency responsible for monitoring compliance with the President's Voluntary Anti-Inflation Program, has ruled that professional fees are not a wage. Therefore, a separate price standard is to be applied to the fees of dentists, lawyers, accountants, engineers, architects and other professionals. The professional fees standard is in two parts; (1) the program year average change in fees, weighted by frequency and/or revenues, may not exceed 6.5%; and (2) the increase in the fees of any single service may not exceed 9.5%.

The following resolution is presented to express rejection of this type of discriminatory treatment.

121. Resolved, that the American Dental Association is unalterably opposed to any regulation that serves to discriminate with regard to the ability of professionals to charge a fair fee commensurate with the increase of living and cost of operation.

Fourth Trustee District

AMENDMENT OF SECTION 5A, ADVERTISING, OF THE "REVISED PRINCIPLES OF ETHICS"

The following resolution was adopted by the Fourth Trustee District and submitted on October 21, 1979 by Dr. Isreal Shulman, secretary-treasurer, Fourth Trustee District.

Background Statement: Every state has laws against false and misleading advertising, whether in dentistry or any professional or commercial activity. Since dental advertising is now legal, it serves no useful purpose to state that it is ethical to advertise, but not falsely. The following resolution is therefore introduced:

Whereas, the Bates-O'Steen decision of the U.S. Supreme Court, the activities of the FTC and various state agencies have all made dental advertising legal, and

Whereas, our *Principles of Ethics* does not mention either pro or con, many other aspects of our practices, such as manner of dress, speaking to patients, office decor, technical phases of clinical practice, billing methods, etc., and

Whereas, the highest code of behavior known to any of us, namely the decalogue, speaks only of "Thou shalt" or "Thou shalt not," but does not state "Thou mayest"; therefore, be it

122. Resolved, that the appropriate agency of the ADA discuss with the FTC the deletion of Section 5A on Advertising of our new *Principles of Ethics*.

Fifth Trustee District

SUBSTITUTE FOR RESOLUTION 20

The following substitute resolution for Resolution 20 (*Reports*:204) was adopted by the Fifth Trustee District at its October 6 and 7, 1979 caucus and transmitted under date of October 10, 1979 by Dr. Lewis Earle, secretary, Fifth Trustee District.

Background Statement: In order to insure a timely response to the intent of this resolution, an amendment is offered to add a reporting deadline to the House of Delegates in conjunction with the referral for study and report to the Board of Trustees. The substitute resolution to read:

20S–1. Resolved, that an appropriate Association council or committee study and define the term "routine procedures" as referred to in the American Dental Association *Principles of Ethics*, Section 12, and be it further
Resolved, that a progress report on this study and definition be made to the Board of Trustees at its 1980 Spring session and be reported back to the 1980 House of Delegates.

Fifth Trustee District

SUBSTITUTE FOR RESOLUTION 23

The following substitute resolution for Resolution 23 (*Supplement 1*:302) was adopted by the Fifth Trustee District at its October 6 and 7, 1979 caucus and transmitted under date of October 10, 1979 by Dr. Lewis Earle, secretary, Fifth Trustee District.

Background Statement: In order to insure a timely response to the intent of this resolution, an amendment is offered to add a reporting deadline to the House of Delegates. The substitute resolution to read:

23S–1. Resolved, that the appropriate agencies of the Association develop a statement describing the consequences of billing practices which may be inconsistent with both the civil and criminal laws, and be it further
Resolved, that the Council on Bylaws and Judicial Affairs be requested to consider developing advisory opinions consistent with this statement and a report of the statement and advisory opinions be reported to the 1980 House of Delegates.

Fifth Trustee District

SUBSTITUTE FOR RESOLUTION 38

The following substitute resolution for Resolution 38 (*Supplement 1*:288) was adopted by the Fifth Trustee District at its October 6 and 7, 1979 caucus and transmitted under date of October 10, 1979 by Dr. Lewis Earle, secretary, Fifth Trustee District:

Background Statement: Resolution 39 speaks to the study of cervical back strain only. Since there are a variety of occupational health hazards related to the practice of dentistry, a broader study of these hazards is proposed. The substitute resolution to read:

38S–1. Resolved, that the appropriate agency of the American Dental Association be requested to investigate those occupational health hazards related to the dental profession with the hope that proper preventive measures can be determined.

Fifth Trustee District

SUBSTITUTE FOR RESOLUTION 49

The following substitute resolution for Resolution 49 (*Supplement 1*:287) was adopted by the Fifth Trustee District at its October 6 and 7, 1979 caucus and transmitted under date of October 10, 1979 by Dr. Lewis Earle, secretary, Fifth Trustee District:

Background Statement: The initiation of discussions with various dental health insurance carriers in order to develop uniform procedures for the coordination of benefits should not place that coordination effort on the dentist or the dental office. The substitute resolution to read:

49S–1. Resolved, that the American Dental Association Council on Dental Care Programs initiate discussion with the Health Insurance Association of America, Delta Dental Plans Association, Blue Cross and Blue Shield Associations and with the Department of Health, Education, and Welfare (Medicaid) immediately to develop suitable inexpensive, uniform procedures for the Coordination of Benefits of Prepaid Dental Programs with the understanding that the coordination of benefits is not the responsibility of the dentist or the dental office, and be it further
Resolved, that the American Dental Association Council on Dental Care Programs disseminate these procedures to the constituent societies at the earliest possible time.

Fifth Trustee District

SUBSTITUTE FOR RESOLUTION 55

The following resolution was adopted by the Fifth Trustee District at its October 6 and 7, 1979 caucus and transmitted under date of October 10, 1979 by Dr. Lewis Earle, secretary, Fifth Trustee District:

Background Statement: A thorough review of Board Report 5 showed a number of areas which need further study, data verification and development. The concept of the document is agreed with; however, concern is expressed over what appears to be less than complete and thorough analysis of the total effect, both upon the targeted public and the profession. The credibility of certain data and statistics is strongly questioned and thus, their incorporation into the document as support for conclusions and program projections is questioned. Some statements emphasizing the inadequacies of the

profession could be construed as critical of dentistry and be used by those outside the profession to our discredit. More study and development are necessary. The Fifth Trustee District unanimously presents the following resolution:

55S–1. Resolved, that the American Dental Association House of Delegates approve neither the scope nor direction of Board of Trustees Report 5 on the "Prevention and Control of Dental Disease Through Improved Access to Comprehensive Care," and be it further
Resolved, that the Board of Trustees be directed to convene a workshop of board representation to develop a more representative document and report back to the 1980 House of Delegates.

Fifth Trustee District

SUBSTITUTE FOR RESOLUTION 55RC

The following substitute resolution for Resolution 55RC was adopted by the Fifth Trustee District at its caucus on October 23, 1979 and transmitted on October 23, 1979 by Dr. Lewis Earle, secretary.

55RC–S–2. Resolved, that the House of Delegates approve the scope and direction of Board Report 5, with the proposed revisions of the Reference Committee, on the *Prevention and Control of Dental Disease Through Improved Access to Comprehensive Care*, and be it further
Resolved, that the report be referred to a workshop, with at least one representative from each constituent society, this workshop to consider these proposed revisions, and be it further
Resolved, that the report of the workshop be submitted to the 1980 House of Delegates for consideration.

Fifth Trustee District

SUBSTITUTE FOR RESOLUTION 64

The following substitute resolution for Resolution 64 (*Supplement 1*:299) was adopted by the Fifth Trustee District at its October 6 and 7, 1979 caucus and transmitted under date of October 10, 1979 by Dr. Lewis Earle, secretary, Fifth Trustee District.

Background Statement: The Fifth Trustee District does not believe the Association and Board of Trustees have properly addressed the intent of Resolution 116H–1978. In order to ensure that proper attention be given to the Guidelines for Placement of a National Health Corps Dentist, firm direction is provided through the striking of the third resolving clause and the addition of two new resolving clauses. The substitute resolution to read:

64S–1. Resolved, that the component and constituent societies be encouraged, with the assistance of the American Dental Association, to identify areas in which true shortages of dentists exist, and be it further
Resolved, that the appropriate Association agencies be instructed to develop specific criteria for determining when a shortage actually exists, and be it further
Resolved, that areas identified through this process be matched with shortage areas identified under the National Health Service Corps program, and be it further
Resolved, that the American Dental Association Council on Legislation, with the full assistance of the American Dental Association's Washington office, and utilizing the policy statements of the American Dental Association, immediately draft corrective legislation to match dental needs, programmatic costs of the National Health Service Corps, and best use of our national dental resources and present this legislation to the Congress of the United States, and be it further
Resolved, that a full report of the draft legislation and its progress in Congress be given to the American Dental Association Board of Trustees and the House of Delegates in 1980.

Fifth Trustee District

SUBSTITUTE FOR RESOLUTION 64

The following substitute resolution for Resolution 64S–2 was submitted on October 23, 1979 by Dr. Lewis Earle, secretary.

Background Statement: Resolution 64S–2 should be amended by the addition of the last two resolving clauses from Resolution 64S–1 (Green:1313) to make the amended resolution read:

64S–3. Resolved, that the component and constituent societies be encouraged, with the assistance of the American Dental Association, to identify areas in which true shortages of dentists exist, and be it further
Resolved, that areas identified through this process be matched with shortage areas identified under the National Health Service Corps program, and be it further
Resolved, that with regard to areas which have been identified both by the dental profession and the National Health Service Corps the dental society in such areas be appropriately involved in the application to the National Health Service Corps for placement of a dentist after all attempts have been made to fill such needs from the available dentists in each state, and be it further
Resolved, that the American Dental Association Council on Legislation, with the full assistance of the American Dental Association's Washington office, and utilizing the policy statements of the American Dental Association, immediately draft corrective legislation to match dental needs, programmatic costs of the National Health Service Corps, and best use of our national dental resources and present this legislation to the Congress of

the United States, and be it further

Resolved, that a full report of the draft legislation and its progress in Congress be given to the American Dental Association Board of Trustees and the House of Delegates in 1980.

Fifth Trustee District

SUBSTITUTE FOR RESOLUTION 65

The following substitute resolution for Resolution 65 (*Supplement 1*:306) was adopted by the Fifth Trustee District at its October 6 and 7, 1979 caucus and transmitted under date of October 10, 1979 by Dr. Lewis Earle, secretary, Fifth Trustee District.

Background Statement: Current policy of the American Dental Association is to provide assistance to constituent associations when requested. This includes help after enactment of legislation which alters the delivery of dental care. However, it is strongly believed that no restrictions or provisions should be placed on the constituent dental association as a requirement to receive such American Dental Association resources and expertise, particularly in view of the varying state dental practice laws. Therefore, it is proposed that Resolution 65 be amended by striking the second resolving clause. The substitute resolution to read:

65S–1. Resolved, that if legislation is enacted which alters the delivery of dental care, the resources and expertise of the American Dental Association, including curriculum development assistance, should be made available if a direct request is received from a constituent dental association.

Fifth Trustee District

SUBSTITUTE FOR RESOLUTION 66

The following substitute resolution for Resolution 66 (*Supplement 1*:297) was adopted by the Fifth Trustee District at its October 6 and 7, 1979 caucus and transmitted under date of October 10, 1979 by Dr. Lewis Earle, secretary, Fifth Trustee District.

Background Statement: In the event of the absence of a Trustee, a qualified substitute should be appointed. Because of the difference in organization and operation of the various American Dental Association Districts and the single and multiple state composition of the Districts, a change in the current and proposed systems is encouraged. The District should designate the replacement for their Trustee. Therefore, an amendment to designate the chairman of the District caucus or delegation to the American Dental Association is proposed. The substitute resolution to read:

66S–2. Resolved, that Chapter VI, Board of Trustees, Section 70, Vacancy, of the *Bylaws*, be amended in the second paragraph by deleting the phrase "the President shall appoint an active or life member of the constituent society of which the absentee is a member as a" and substituting therefor the phrase, "the chairman of the District caucus or delegation, where such exists, shall be the" to make the amended paragraph read as follows:

> In the event a trustee is to be absent for an entire session of the Board of Trustees, the chairman of the District caucus or delegation, where such exists, shall be the substitute trustee to serve during that session.

Fifth Trustee District

AMENDMENT OF "MANUAL OF HOUSE OF DELEGATES" REGARDING CONDUCT OF REFERENCE COMMITTEE EXECUTIVE SESSION

The following resolution was adopted by the Fifth Trustee District at its October 6 and 7, 1979 caucus and transmitted under date of October 10, 1979 by Dr. Lewis Earle, secretary, Fifth Trustee District.

Background Statement: The American Dental Association Board of Trustees in Report 6 indicated a number of administrative amendments it had adopted changing the *Manual of the House of Delegates* (1979). One change deals with the persons who would be allowed and/or invited into the executive session of the reference committees. The deliberations of the reference committees should be based on the public testimony received during the hearings, and the "opening" of executive sessions to invited persons could tend to disenfranchise the testimony of the general members of the American Dental Association. Therefore, the following resolution is presented:

93. Resolved, that the *Manual of the House of Delegates*, page 20, section entitled "Conduct of Executive Session," be amended by deletion of that section and substitution therefor of the following:

> *Conduct of Executive Meeting:* After evidence and information have been received at the open hearing, the committee may retire to an executive meeting at which only the members, staff resource person and the committee secretary may be present. At this meeting, the committee reaches its decisions and prepares its report.

Fifth Trustee District

INDIVIDUAL TRUSTEE VOTES ON SPECIAL BOARD OF TRUSTEES REPORTS

The following resolution was adopted by the Fifth Trustee District at its October 6 and 7, 1979 caucus and transmitted under date of October 10, 1979 by Dr. Lewis Earle, secretary, Fifth Trustee District.

Background Statement: In order to have an enlightened American Dental Association electorate in selecting its officers and leaders, the voting record of the trustees on special Board reports and "white papers" espousing programs, direction and policy for the Association and the profession would be beneficial. It has been said that a candidate may "tell you what you want to hear." A voting record on the significant issues will tell the electorate what it needs to know about the positions taken by the candidate. The following resolution is presented:

94. Resolved, that on special American Dental Association Board of Trustees reports and "white papers" the individual Trustee votes be recorded and published in conjunction with the report or paper.

Fifth Trustee District

COMPARATIVE STUDY OF PUBLIC AND PRIVATE DENTAL CARE DELIVERY SYSTEMS

The following resolution was adopted by the Fifth Trustee District at its October 6 and 7, 1979 caucus and transmitted under date of October 10, 1979 by Dr. Lewis Earle, secretary, Fifth Trustee District.

Background Statement: The conclusion by the Board of Trustees that the current design of the research using the military services for comparison study should not be pursued, is accepted. However, the comparative study of public and private dental care delivery systems is necessary data and information for the dental profession. It is believed that an appropriate public delivery system can be identified for such a comparative study, e.g., Veterans Administration, Public Health. Therefore, the following resolution is presented:

96. Resolved, that the appropriate agencies of the American Dental Association proceed immediately with a study comparing the private dental delivery system and a dental delivery system in the public sector. High priority in the study should be given to:

—quality of care,
—comprehensiveness of care,
—general oral health of patients treated over a period of time,
—cost per encounter in relation to amount of dentistry done,

and be it further
Resolved, that those areas that can be identified but not fully documented actuarially should also receive prominent recognition in the study, and be it further
Resolved, that up to $250,000.00 be allocated from the general fund for this study.

Fifth Trustee District

SUBSTITUTE FOR RESOLUTION 96RC

The following substitute resolution for Resolution 96RC was adopted by the Fifth Trustee District at its caucus on October 23, 1979 and transmitted on October 23, 1979 by Dr. Lewis Earle, secretary.

96RC–S–2. Resolved, that the appropriate agencies of the Association conduct a comparative study of the relative cost and efficiency of providing dental care funded through the private sector and the public sector and report to the 1980 House of Delegates.

Fifth Trustee District

CHILD ABUSE

The following resolution was adopted by the Fifth Trustee District at its October 6 and 7, 1979 caucus and transmitted under date of October 10, 1979 by Dr. Lewis Earle, secretary, Fifth Trustee District.

Background Statement: We as dentists are in a unique position to make a significant contribution toward recognizing and limiting the incidence of child abuse. Our role in chairside and our rapport with the child allow us to observe at close quarters the clinical and psychological signs of this disease.

The year 1979 is celebrated as the International Year of the Child. What better way can we celebrate this than by giving increased attention to the problems affecting children? We must recognize our responsibility to detect and report incidences of child abuse, which is a disease that has become ever more prominantly a social and legal as well as professional concern. Whereas there are laws relating to this obligation already in some states, the following resolution is presented:

97. Resolved, that the American Dental Association encourage its members to be more mindful of incidences of child abuse, and be it further
Resolved, that an appropriate agency of the American Dental Association be instructed to disseminate information relating to the professional and legal aspects of this phenomenon.

Fifth Trustee District

REFERRAL OF RESOLUTIONS 2, 3, 9 AND 10 RELATING TO COMMISSIONS

The following resolution was adopted by the Fifth Trustee District at its October 6 and 7, 1979 caucus and transmitted under date of October 10, 1979 by Dr. Lewis Earle, secretary, Fifth Trustee District.

Background Statement: The American Dental Association *Bylaws* address various Commissions in different sections. For continuity of the *Bylaws* and statements relating to Commissions, one *Bylaws* chapter should be created on Commissions. To accomplish this consolidation, the proposed *Bylaws* changes relating to Commissions should be referred for study to the appropriate Association agency for report back to the 1980 House of Delegates.

102. Resolved, that the House of Delegates direct that resolutions 2, 3, 9 and 10 be referred to the appropriate Association agency for study and consolidation into one *Bylaws* chapter for presentation to the 1980 House of Delegates.

Fifth Trustee District

AMENDMENT OF SECTION 1-B, PATIENT'S RECORD, OF THE REVISED "PRINCIPLES OF ETHICS"

The following resolution was adopted by the Fifth Trustee District at its October 6 and 7, 1979 caucus and transmitted under date of October 10, 1979 by Dr. Lewis Earle, secretary, Fifth Trustee District.

Background Statement: The Fifth Trustee District believes the following amendment to the proposed American Dental Association *Principles of Ethics* will provide clarification and/or emphasis to the amended section.

The Fifth Trustee District recommends that paragraph 1-B, Patient's Records, be amended on line 43 by the addition of the phrase "with the patient's written permission" following the words "dental practitioner," and therefore submits the following resolution:

106. Resolved, that Section 1-B, Patient's Record, of the revised *Principles of Ethics* be amended to read as follows:

> The dentist is obliged to safeguard the confidentiality of his patient's records. The dentist shall maintain patient records in a manner consistent with the protection of the welfare of the patient. Upon request of a patient or another dental practitioner, *with the patient's written permission* a dentist shall provide any information that will be beneficial for the future treatment of that patient.

Fifth Trustee District

AMENDMENT OF SECTION 1-D, EMERGENCY SERVICE, OF THE REVISED "PRINCIPLES OF ETHICS"

The following resolution was adopted by the Fifth Trustee District at its October 6 and 7, 1979 caucus and transmitted under date of October 10, 1979 by Dr. Lewis Earle, secretary, Fifth Trustee District.

Background Statement: The Fifth Trustee District believes the following amendment to the proposed American Dental Association *Principles of Ethics* will provide clarification and/or emphasis to the amended section.

The Fifth Trustee District recommends that paragraph 1-D, Emergency Service, be amended on lines 60 and 61 by striking the phrase "attend to the conditions leading to the emergency" at the end of the section and inserting the phrase "make reasonable arrangements for the emergency care," and therefore submits the following resolution:

107. Resolved, that Section 1-D, Emergency Service, of the revised *Principles of Ethics* be amended to read as follows:

> The dentist shall be obliged to make reasonable arrangements for the emergency care of his patients of record.
>
> The dentist shall be obliged when consulted in an emergency by a patient not of record to *make reasonable arrangements for emergency care.*

Fifth Trustee District

AMENDMENT OF SECTION 5-C, ANNOUNCEMENT OF SPECIALIZATION AND LIMITATION OF PRACTICE, OF THE REVISED "PRINCIPLES OF ETHICS"

The following resolution was adopted by the Fifth Trustee District at its October 6 and 7, 1979 caucus and transmitted under date of October 10, 1979 by Dr. Lewis Earle, secretary, Fifth Trustee District.

Background Statement: The Fifth Trustee District believes the following amendment to the proposed American Dental Association *Principles of Ethics* will provide clarification and/or emphasis to the amended section.

The Fifth Trustee District recommends that Section 5-C, Announcement of Specialization and Limitation of Practice, Item 2, be amended on line 230 by adding the phrase "or have met existing requirements as specified by the appropriate Association agency," and therefore recommends the following resolution:

108. Resolved, that Section 5-C, Announcement of Specialization and Limitation of Practice, Item 2, of the revised *Principles of Ethics* be amended to read as follows:

2. The dentist must have successfully completed an educational program accredited by the Commission on Accreditation of Dental and Dental Auxiliary Educational Programs, two or more years in length, as specified by the Council on Dental Education or be a diplomate of a nationally recognized certifying board *or have met existing requirements as specified by the appropriate Association agency.*

Fifth Trustee District

REPORT 8 OF THE BOARD OF TRUSTEES: THE RELATIONSHIP BETWEEN DENTISTS AND DENTAL HYGIENISTS

The following resolution was adopted by the Fifth Trustee District at its October 21, 1979 caucus and transmitted under date of October 21, 1979 by Dr. Lewis Earle, secretary, Fifth Trustee District.

Background Statement: The relationship between dentists and dental hygienists is a cooperative effort to provide total oral health care for the patient. The integrated relationship that has traditionally existed between the dentist and the dental hygienist should be strengthened and perpetuated.

Resolution 159H adopted unanimously in 1977 (*Trans.1977*:971) states:

1977–159H. Resolved, that a dental hygienist by education and training is an auxiliary of the dental profession, and be it further

Resolved, that the dental hygienist shall work only under the general or direct supervision of a licensed dentist who is professionally and legally responsible for the total dental care of the patient, and be it further

Resolved, that the setting in which a dental hygienist may perform legally designated functions shall be only a treatment facility under the jurisdiction and supervision of a licensed dentist, and be it further

Resolved, that constituent societies, as an item of the highest priority, work with the state boards of dental examiners to ensure that supervisory and setting provisions of dental practice acts for the dental hygienist are structured consistently with these basic principles.

The response of the American Dental Association to the San Francisco Regional Office of the Federal Trade Commission on October 10, 1979 adequately stated our opposition to the proposal to allow dental hygienists to become Primary Care Providers.

Board Report 8 (*Supplement 1*:364) reflects a position of the Board of Trustees in conflict with the two above policies of the ADA and therefore the Fifth Trustee District submits the following resolution:

125. Resolved, that the House of Delegates of the American Dental Association reject Board Report 8 of the Board of Trustees (*Supplement 1*:364), The Relationship Between Dentists and Dental Hygienists, and be it further

Resolved, that any joint statement of the Relationship Between Dentists and Dental Hygienists reflect the *Transactions* of the 1977 House of Delegates and the response to the San Francisco FTC Office on October 10, 1979.

Eighth Trustee District

STUDY ON CAPITATION

The following resolution was submitted on October 23, 1979 by Dr. Robert H. Griffiths, trustee, on behalf of the Eighth Trustee District.

Background: The dental profession is concerned with the quality of care provided by all types of delivery systems. The capitation approach is relatively new and its impact on effectiveness of dental health care is not sufficiently known to the profession and to the public. The Eighth District therefore recommends that a study be conducted at an early date to provide information on capitation dental programs with special emphasis upon the impact on dental practice and financial risk involved.

131. Resolved, that the appropriate agency of the American Dental Association be directed to conduct a research study on the effects of capitation on the practice of dentistry and on the dental health of the patient and report the progress of this study to the 1980 House of Delegates.

Eighth Trustee District

MECHANISM TO IMPLEMENT SECTION 1-G OF REVISED "PRINCIPLES OF ETHICS"

The following resolution was submitted on October 23, 1979 by Dr. Robert H. Griffiths, Eighth District trustee, on behalf of the Eighth Trustee District.

Background: Section 1-G of the revised *Principles of Ethics* places a heavy burden on the shoulders of the individual practitioner. It also gives that practitioner no guidance or assistance in his compliance with that Section. Most constituent societies have a review mechanism to deal with complaints about a dentist's treatment. These procedures presently are weighted towards patient and third party complaints. It is realized that a complaint by a dentist about another dentist's treatment can be considered heavily judgmental. Thus, it is felt that a protocol should be created, outlining or suggesting those procedures that should be established by the American Dental Association, as adaptable by constituent societies, to facilitate proper presentation of a contention about another dentist's treatment to the ap-

propriate constituent review body.

It is the intent of this resolution to prevent unnecessary legal actions by aiding the dentist in bringing proper and complete evidence of instances of gross and/or continual faulty treatment to the review body. This should assist the constituent review body in its decision to act upon this evidence.

Whereas, the credibility of the profession as a self regulating body lies heavily in the spirit with which item 1-G is applied by the dentist, and

Whereas, item 1-G of the revised *Principles of Ethics* places a heavy burden upon the shoulders of the individual dentist, and

Whereas, the dentist is entitled to guidance by the American Dental Association in complying with the code of ethics, be it

132. Resolved, that the Council on Bylaws and Judicial Affairs be instructed to create a proposal for a protocol, adaptable by the constituent societies and the appropriate ADA agencies, that the individual dentist may follow when reporting instances of gross and/or continual faulty treatment to a reviewing agency. This proposal to be brought to the 1980 House of Delegates for review.

Tenth Trustee District

SUBSTITUTE FOR RESOLUTION 47

The following amendment for Resolution 47 was submitted on October 23, 1979 by Dr. Bruce Keyworth, delegate.

Background Statement: Resolution 47 should be amended by the addition of the sentence "If both the offices of President and President-elect become vacant, the First Vice-President shall become President for the unexpired portion of the term." to make the amended resolution read:

47S–1. Resolved, that Chapter VII, Elective Officers, Section 70, Vacancies, of the *Bylaws*, be amended by substituting the following for the first and second sentences:

> In the event the office of President becomes vacant, the President-elect shall become President for the unexpired portion of the term plus the succeeding one-year term for which he was elected. *If both the offices of President and President-elect become vacant, the First Vice-President shall become President for the unexpired portion of the term.*

so that the amended Section 70 reads as follows:

> In the event the office of President becomes vacant, the President-elect shall become President for the unexpired portion of the term plus the succeeding one-year term for which he was elected. *If both the offices of President and President-elect become vacant, the First Vice-President shall become President for the unexpired portion of the term.* In the event the office of First Vice-President becomes vacant, the Second Vice-President shall become the First Vice-President for the unexpired portion of the term. A vacancy in the office of the Second Vice-President shall be filled by a majority vote of the Board of Trustees. In the event of a vacancy in the office of Speaker of the House of Delegates, the President, with approval of the Board of Trustees, shall appoint a Speaker *pro tem.* In the event the office of President-elect becomes vacant, the office of President for the ensuing year shall be filled at the next annual session of the House in the same manner as that provided for the nomination and election of elective officers, except that the ballot shall read "President for the Ensuing Year."

Tenth Trustee District

SUBSTITUTE FOR RESOLUTION 96RC

The following substitute resolution for Resolution 96RC was submitted on October 23, 1979 by Dr. Philip Maschka, delegate.

96RC–S–1. Resolved, that the Board of Trustees, through the appropriate agencies of the Association, continue to explore various methods of obtaining data relative to the cost efficiency of providing dental care through private practice, HMOs, and public clinics and conduct a study if necessary and feasible.

Eleventh Trustee District

DEVELOPMENT OF NEWSPAPER COLUMNS FOR USE BY COMPONENT AND CONSTITUENT SOCIETIES

The following resolution was adopted by the Eleventh Trustee District caucus on October 6, 1979 and transmitted under date of October 8, 1979 by Ms. Doris Arisman, executive secretary.

Whereas, newspaper columns about dentistry are an effective means of public relations, and

Whereas, some societies do not have the expertise or financial means to write individual columns, therefore be it

84. Resolved, that the ADA Bureau of Communications be requested to develop "camera-ready newspaper columns" on dental health, designed to capture the interest of the lay public, that can be made available to component and constituent dental societies and associations throughout the United States at no charge.

Eleventh Trustee District

TIMELY REMUNERATION OF SUBSCRIBERS AND PROVIDERS

The following resolution was adopted by the Eleventh Trustee District caucus on October 6, 1979 and transmitted under date of October 8, 1979 by Ms. Doris Arisman, executive secretary.

Background Statement: Most businesses require payment of credit debt within 30 days or economic penalties (interest) are imposed.

Patients covered by health care insurance resist direct payment to practitioners and prefer to wait for insurance payments. When insurance payments are more than 30 days in delivery, an economic loss is incurred by the patient who has paid the bill or the practitioner who is waiting for payment.

A substantial delay is incurred when dual coverage requires "coordination of benefits." If health care contractors were required to reimburse subscribers or providers within a definite time limit, greater effort would be made by carriers to solve this problem. Therefore, be it

85. Resolved, that the ADA encourage the constituent associations to seek state legislation to require health care contractors to remunerate their subscribers or providers within 30 days after a receipt of a claim form containing appropriate information about the case, and be it further

Resolved, that the ADA recommend appropriate time limits for reimbursement of federally funded programs.

Eleventh Trustee District

INEQUITIES IN DESIGNATION OF MANPOWER SHORTAGE AREAS AND ASSIGNMENT OF NATIONAL HEALTH SERVICE CORPS PERSONNEL

The following resolution was adopted by the Eleventh Trustee District caucus on October 6, 1979 and transmitted under date of October 8, 1979 by Ms. Doris Arisman, executive secretary.

86. Resolved, that the ADA House of Delegates direct the Council on Legislation to actively seek legislative action to correct the inequities in the designation of manpower shortage areas and the assignment of NHSC personnel, and be it further

Resolved, that the ADA House of Delegates direct the Council on Dental Health and Health Planning to monitor the compliance of HEW with existing laws and policies in these areas and to seek corrective action where noncompliance is discovered.

Eleventh Trustee District

SUCCESSION TO ELECTIVE OFFICES

The following resolution was adopted by the Eleventh District caucus on October 6, 1979 and transmitted under date of October 8, 1979 by Ms. Doris Arisman, executive secretary.

Background Statement: We have been concerned with the structure of the American Dental Association in regard to succession to its presidency. The officers stipulated in Chapter VII of the *Bylaws* calls for a president, president-elect, first vice-president and second vice-president. The duties of the president as defined in the *Bylaws* are quite acceptable as are the duties of the president-elect. We are concerned, however, with the vice-presidents' as stated.

> a. To assist the President as requested.
>
> b. To serve as *ex officio* members of the House of Delegates without the right to vote.
>
> c. To serve as *ex officio* members of the Board of Trustees.
>
> d. To succeed to the office of President or First Vice President, as provided in this chapter of these *Bylaws*.

We know the demands placed upon the trustees of the American Dental Association. Some years ago, we were rather small and sufficiently organized. We reacted by the "seat of our pants" so to speak, and the demands upon the officers and trustees were relatively light. Today, the situation has changed. We have become a huge organization of well over 120,000 in number. Our budget annually runs in the neighborhood of $24 million. Many corporations much smaller would in no way treat the succession to the presidency as lightly as we do in the ADA.

Vast physical demands are forced upon trustees and officers of our organization. Trustees are forced to take as much as three months (possibly more) out of the year of active practice to perform their duties. The president-elect has to structure his time for two years of dedicated effort on behalf of this fine organization. The first vice-president, as currently provided, has only possibly days, weeks or months to prepare for this vital and important function as president of the ADA. Some have the mental capacity, experience and physical stamina to do this; others simply do not.

First vice-presidents have come and gone. Some have been well prepared, effective and fully informed. Others have been elected simply because of popularity, provincial status or because an area hasn't been represented for a long time. There have been times where the first or second vice-president positions have almost gone begging. Very seldom has there really been a political contest for these offices and this is not right.

Our organization should give serious thought to change. The first vice–president is but a "heartbeat" from the presidency. The possibility of an ill-prepared "thrust upon the scene" newcomer ascending to the position of chief executive is frightening. Bylaws of a number of dental organizations, most much smaller than ours, e.g., the Academy of Periodontology, have a more realistic line of succession. For instance, if we might quote from the *Constitution and Bylaws of the American Academy of Periodontology*:

> 1. The Vice President shall assume the duties of the President in the absence of both the President and President-elect.
> 2. He shall succeed automatically to the office of President-elect and then to the office of President.
> 3. He shall have a *vote* on the executive council floor. He shall assist the President and President-elect in performance of their duties. He shall be consulted on committee appointments.

There is a more logical solution to what we consider a problem. It would not be asking too much for the vice–president to start learning his duties, the structures of the ADA, and its problems two years before he assumes the presidency. If the *Bylaws* were changed, the office of vice–president would become *"the contest"* at our annual House of Delegates meeting. Qualified individuals would vie for this position knowing that they would proceed automatically to president-elect and president. It would bring out the *best* and they could be judged and elected by their peers. The second vice–president position would be retained as specified.

We would examine all aspects of succession and we might suggest for consideration the following paragraph to be added:

> 1. If the President should die (or be unable to perform the duties of president as determined by the Board of Trustees) the President-elect would assume the leadership. In the event the President should be stricken within the first three months of his term, the remaining nine months would constitute a full term for the succeeding President-elect. He would retire at the end of his period. After the first three months, if the President should be stricken, we would elevate the President-elect to the balance of the term, plus the full next year (his normal full term).
> 2. The First Vice President would move up according to need. He would become President-elect when the President became incapacitated or deceased. His succession would be subject to the same conditions governing the President-elect.
> 3. The Second Vice President would become the First Vice President but, without election, could not move onto the President-elect.
> 4. Any vacancies that developed would be filled by the elective process at the next meeting of the House of Delegates.

Therefore, be it

87. Resolved, that ADA *Bylaws*, Chapter VII, Elected Officers, Section 80 (Duties), Subsection B, (President-elect), paragraph (d) be amended to read as follows:

> d. To succeed to the office of President at the next annual session of the House of Delegates following his accession to President-elect. But if the President dies during office or is otherwise unable to carry out the duties of his office, the President-elect shall become President.
>
> If the President's death or incapacity to fulfill his office occurs within the first three months of his term, the remaining nine months shall constitute a full presidential term for the succeeding President-elect. If the President dies or is otherwise unable to carry out the duties of his office during the final nine months of his term, the succeeding President-elect shall serve the full term for which he was elected.

and be it further

Resolved, that Chapter VII, Elective Officers, Section 80 (Duties), Subsection C, (Vice Presidents), be amended to substitute "First Vice President" for "Vice Presidents" wherever the latter words appear and to substitute a new paragraph (d) as follows:

> d. To succeed to the office of President-elect at the next annual session of the House of Delegates following his election as First Vice President. Succession from First Vice President to President-elect shall not take place if the First Vice President achieved that office as a result of filling a vacancy in accordance with Section 70 of this chapter. Where there is no authorized succession to President-elect, that office shall be filled by election as provided in Chapter V, Section 140.

and be it further

Resolved, that Chapter VII, Elective Officers, Section 80 (Duties) be amended by adding a new subsection D. to read as follows:

D. SECOND VICE PRESIDENT. It shall be the duty of the Second Vice President:

> a. To assist the President as requested.
> b. To serve as *ex officio* member of the House of Delegates without the right to vote.
> c. To serve as *ex officio* member of the Board of Trustees.
> d. To succeed to the office of First Vice President in case of a vacancy in that office as provided in Section 70 of this chapter.

and be it further

Resolved, that Chapter VII, Elective Officers, Section 70 (Vacancies) be amended to read as follows:

Section 70. VACANCIES: If the office of President, President-elect or First Vice President becomes vacant, each shall be filled in accordance with the appropriate

provision of Section 80 of this chapter. A vacancy in the office of the Second Vice President shall be filled by a majority vote of the Board of Trustees. In the event of a vacancy in the office of Speaker of the House of Delegates, the President, with approval of the Board of Trustees, shall appoint a Speaker pro tem.

Eleventh Trustee District

SUBSTITUTE FOR RESOLUTION 54

The following substitute resolution for Resolution 54 was submitted on October 23, 1979 by Ms. Doris Arisman, executive secretary.

Background Statement: The dental student is a very important member of the dental family. The Eleventh Trustee District realizes that the earliest possible inclusion of the dental student into the affairs and deliberations of organized dentistry is important to all in the profession. Such activity would also encourage their membership in the Association.

However, it is felt that the proper place for initiation of most of that involvement and activity should be on the constituent and component levels of the Association.

Therefore, the Eleventh Trustee District supports the following substitute resolution:

54S–1. Resolved, that the American Dental Association strongly encourage constituent and component dental societies to formally involve dental students in the activities and official meetings of those societies.

Twelfth Trustee District

SUBSTITUTE FOR RESOLUTION 7

The following substitute resolution for Resolution 7 (*Supplement 1*:298) was submitted on October 11, 1979 by Dr. Robert B. Dixon, trustee.

7S-1. Resolved, that the prototype dental components developed at the direction of the 1978 House of Delegates demonstrated to the Council that prototype dental components are not effective instruments in legislative liaison and shall not be used for any legislative purposes so that *Guidelines for Dentistry's Position in a National Health Program* continue to be used as the principal policy document upon which the Association's positions in these matters will be based.

Twelfth Trustee District

SUBSTITUTE FOR RESOLUTION 43

The following resolution was adopted by the Twelfth Trustee District and submitted on October 11, 1979 by Robert B. Dixon.

43S–1. Resolved, that the *Manual of the House of Delegates* be amended by the addition of the following section:

> *Speaking Privileges:* The right to speak to issues before the House of Delegates is held—in addition to delegates—by officers of the Association; past presidents of the Association; council and commission chairmen and one representative of the American Student Dental Association. Secretaries and executive secretaries of constituent societies; council secretaries; commission secretaries; bureau directors and those members of the administrative staff holding general supervisory positions shall be present on the floor of the House of Delegates and shall be privileged to speak when called upon as a resource.

Twelfth Trustee District

SUBSTITUTE FOR RESOLUTION 48

The following substitute for Resolution 48 was submitted on October 23, 1979 by Dr. Tim Dobbins, delegate, Twelfth Trustee District.

48S–1. Resolved, that the *appropriate agencies* of the American Dental Association continue to take affirmative action on the following items:

> 1. Support legislation to limit the power and funding of the FTC.
> 2. Communicate and where practical combine efforts with other groups to challenge all rulings that are unfairly discriminatory to the dental profession.
> 3. Communicate with members of the American Dental Association as to the progress and effectiveness *of these actions.*

Twelfth Trustee District

SUBSTITUTE FOR RESOLUTION 64

The following substitute resolution was adopted August 7, 1979 by the Twelfth Trustee District and submitted October 11 by Trustee Robert B. Dixon.

Background: The Twelfth Trustee District is of the opinion that additional emphasis should be placed on the need to exhaust all possible available manpower resources from within each state before applications are made to the National Health Service Corps for placement of a dentist. Accordingly, the phrase ". . . after all attempts have been made to fill such needs from the available dentists in each state" has been added to Resolution 64B.

64S–2. Resolved, that the component and constituent societies be encouraged, with the assistance of the American Dental Association, to identify areas in which true shortages of dentists exist, and be it further
Resolved, that areas identified through this process be matched with shortage areas identified under the National Health Service Corps program, and be it further
Resolved, that with regard to areas which have been identified both by the dental profession and the National Health Service Corps the dental society in such areas be appropriately involved in the application to the National Health Service Corps for placement of a dentist after all attempts have been made to fill such needs from the available dentists in each state.

Twelfth Trustee District

CHANGE IN THE DESIGNATION OF "DENTAL MANPOWER SHORTAGE AREAS"

The following resolution was adopted by the Louisiana Dental Association and transmitted under date of October 3, 1979 by Milford L. Kathmann, secretary-treasurer. This resolution was also submitted by the Louisiana Dental Association and the New Orleans Dental Association.

Whereas, the term "Dental Manpower Shortage Area," which is used by the Secretary of HEW in assigning a National Health Service Corps dentist to an area of the country, erroneously distorts the facts. Many, if not most, of the so-called "shortage areas" are *not* short of dental manpower but rather they qualify under the specification that 30% of the population is poor. Designating such an area as being deficient in dental manpower is erroneous and misleading and should be corrected, and

Whereas, among the HSA criteria for designating a given geographic location as a shortage area is the following: dental manpower in contiguous areas are overutilized, excessively distant or inaccessible to the population of the area under consideration, and

Whereas, according to this criterion dental manpower in contiguous areas is considered to be inaccessible if more than 30% of the population in question have incomes below the poverty level, therefore be it

70. Resolved, that the appropriate agency of the ADA petition the Secretary of HEW to change the designation of "Dental Manpower Shortage Areas" to "Dental Manpower Shortage and/or Economically Deprived Areas."

Twelfth Trustee District

DEFINITION OF PRIVATE PRACTICE

The following resolution was adopted by the Twelfth Trustee District and submitted October 11 by Trustee Robert B. Dixon.

91. Resolved, that the following definition of private practice be approved:

> The private practice of dentistry is that dental practice which is designed to meet the dental needs of the public and in which the dentist is free to exercise complete control over all of its business and professional aspects; and in which the dentist conducts his practice in accordance with the provisions of the Dental Practice Act or Acts of the state or states in which he is practicing. A dentist who is professionally associated with and/or who is under the direction of a dentist who is in the private practice of dentistry is also considered to be in the private practice of dentistry.

Twelfth Trustee District

ORAL HEALTH GUIDELINES FOR LONG-TERM CARE FACILITIES

Background: To appropriately respond to the needs of their patients, elderly care centers are often in need of a consulting dentist to provide leadership for planning and developing oral health care programs. Accordingly, the Twelfth Trustee District has submitted the following resolution.

92. Resolved, that the Council on Dental Health and Health Planning develop dental health guidelines for long-term care facilities to identify the role of the consulting dentist, and be it further
Resolved, that such guidelines be transmitted to all constituent and component dental societies for program implementation at the component level under the supervision and direction of the Council on Dental Health of the constituent society.

Twelfth Trustee District

FEDERAL TRADE COMMISSION DENTURE STUDY

The following resolution was adopted by the Twelfth Trustee District and submitted on October 11, 1979 by Robert B. Dixon.

Background Statement: In July, the Board of Trustees announced that it had accepted an invitation of the San Francisco Regional Office of the Federal Trade Commission to participate in an evaluation of intraoral denture care by nondentists and dentists by providing guidance on selection of patients and the criteria to be used in the study. The evaluators are to be dentists, Canadian denturists and American denturists who are to evaluate dentures in a blind study. Some of the dentures are to have been made by dentists, some by Canadian denturists and some by American denturists.

This proposed program is seen to be not free of danger to the dental profession and may even be a means by which denturists may gain stature and prestige by assuming a position of authority equal to dentists.

The Twelfth Trustee District expresses its deepest gratitude to the Board of Trustees for its excellent administration of the Association's affairs and its confidence in the guidance provided by said Board. However, the Twelfth Trustee District wishes to express concern over the potential for harm to the image of dentistry and loss of confidence of the American Dental Association membership in its leadership which the FTC denture evaluation program could cause, therefore be it

100. Resolved, that the Board of Trustees is urged to exercise unusual prudence and judgment in its decisions regarding the planned denture study sponsored by the San Francisco Regional Office of the Federal Trade Commission.

Twelfth Trustee District

AMENDMENT OF CURRENT POSITION ON FLUORIDATION

The following resolution was adopted by the Twelfth Trustee District and was submitted on October 11, 1979 by Dr. Robert B. Dixon, trustee, Twelfth Trustee District.

Background Statement: The following Resolution 5H–1977 (*Trans.1977*:904) was adopted by the House of Delegates:

Resolved, that the American Dental Association reaffirm its position that all communal water supplies be adjusted to the optimal fluoride level, and be it further
Resolved, that the American Dental Association actively encourage the appropriate federal agencies to offer initial assistance grants-in-aid to communities wishing to adjust the fluoride content of the community's water supply to the optimal level.

The Twelfth Trustee District believes that this Association policy calling for all communal water supplies to be adjusted to the optimal fluoride level should be changed so that the Association's position states that only fluoride deficient water supplies need be adjusted. Accordingly, the following resolution is submitted to change the profession's position.

103. Resolved, that the American Dental Association supports the position that all communal water supplies that are below the optimum fluoride level be adjusted to optimum level, and be it further
Resolved, that the American Dental Association actively encourage the appropriate federal agencies to offer initial assistance grants-in-aid to communities wishing to adjust the fluoride content of the community's water supply to the optimal level, and be it further
Resolved, that Resolution 5H–1977 (*Trans.1979*:904) be rescinded.

Twelfth Trustee District

AMENDMENT OF "MANUAL OF HOUSE OF DELEGATES" —STANDING ORDER OF BUSINESS

The following resolution was adopted by the Twelfth Trustee District and was submitted on October 11, 1979 by Dr. Robert B. Dixon.

104. Resolved, that the *Manual of the House of Delegates* be amended by the addition of the following paragraph at the end of the section entitled "Rules of the House of Delegates."

> *Installation of New Officers and Trustees:* Installation ceremonies for new officers and trustees shall be a standing order of business at 11:30 AM on Thursday during the final meeting of the House of Delegates.

Twelfth Trustee District

ENVIRONMENTAL PROTECTION AGENCY DRINKING WATER REGULATIONS RELATING TO NATURALLY OCCURRING FLUORIDE

The following resolution was submitted on October 11, 1979 by Dr. Robert B. Dixon, trustee.

Background: Fluoride occurs naturally in many water supplies in the United States and is consumed daily in drinking water by millions of people without hazard to health. Both the American Dental Association and the American Medical Association have been active in promotion and support for fluoridation, and the benefits of fluoride in drinking water for the prevention of dental

caries are well understood and documented.

Recent Environmental Protection Agency Regulations have called attention to the natural fluoride content of water supplies in the United States. EPA has identified fluoride as a contaminant of drinking water and has established a safety level not to exceed two times the optimum level for the prevention of dental caries. The implication of the regulations is that a hazard to health exists when the contaminant levels of fluoride exceed two times the optimum. As it now stands, the water systems with fluoride concentrations above two times the optimum will be in violation of the EPA Regulations and will have to abandon their current water sources or install expensive defluoridation treatment equipment.

The following resolution is submitted to clarify the Association's position with respect to the Environmental Protection Agency's drinking water regulations relating to naturally occurring fluoride.

105. Resolved, that, based on present knowledge, it is the opinion of the American Dental Association that the natural fluoride levels in drinking water do not constitute a health hazard and therefore should not be classified as a contaminant, and be it further

Resolved, that the current maximum allowable level for fluoride under the Environmental Protection Agency Regulations is considered by the Association to be unrealistic and unreasonable because it is not based on carefully documented health consideration, and be it further

Resolved, that costs involved with the reduction of the fluoride content to the maximum allowable level are not economically justifiable on the basis of the protection of health, and be it further

Resolved, that the appropriate agencies of the Association enlist Congressional support for the Association's position and petition the Environmental Protection Agency to rescind or revise the provisions of the National Primary Drinking Water Regulations which are not in agreement with this new Association policy, and be it further

Resolved, that progress on this requested action be reported to the Board of Trustees.

Twelfth Trustee District

SUBSTITUTE FOR RESOLUTION 105B

The following substitute resolution for Resolution 105B was submitted on October 23, 1979 by Dr. James A. Saddoris, delegate.

105B–S–1. Resolved, that based on present knowledge, it is the opinion of the American Dental Association that the natural fluoride levels of drinking water in the United States do not constitute a health hazard, and be it further

Resolved, that the American Dental Association Washington office take immediate action through appropriate agencies to place a moratorium on Environmental Protection Agency "defluoridation" regulations, and be it further

Resolved, that progress on this requested action be reported to the Board of Trustees.

Twelfth Trustee District

SUBSTITUTE FOR RESOLUTION 106

The following resolution was adopted by the Twelfth Trustee District at its August 7, 1979 pre-caucus meeting and transmitted under date of October 11, 1979 by Dr. Robert Dixon, trustee.

Background: The Twelfth Trustee District suggests that paragraph 1-B, Patient's Records, be amended on line 42 by adding the word "written" between the words "upon" and "request," and striking the words "or another dental practitioner" in line 43.

106S–1. Resolved, that Section 1–B, Patient's Records, of the revised *Principles of Ethics* be amended to read as follows:

> The dentist is obliged to safeguard the confidentiality of his patient's records. The dentist shall maintain patient records in a manner consistent with the protection of the welfare of the patient. Upon *written* request of a patient (omission) a dentist shall provide any information that will be beneficial for the future treatment of that patient.

Twelfth Trustee District

AMENDMENT OF SECTION 1–G, JUSTIFIABLE CRITICISM AND EXPERT TESTIMONY, OF REVISED "PRINCIPLES OF ETHICS"

The following resolution was adopted by the Twelfth Trustee District at its August 7, 1979 pre-caucus meeting and transmitted under date of October 11, 1979 by Dr. Robert Dixon, trustee.

Background: The Twelfth Trustee District suggests that paragraph 1-G, Justifiable Criticism and Expert Testimony, be amended by changing the word "shall" to "should" in line 95 and "shall" to "may" in line 99.

109. Resolved, that Section 1-G, Justifiable Criticism and Expert Testimony, of the revised *Principles of Ethics* be amended to read as follows:

> *1-G Justifiable Criticism and Expert Testimony*
>
> The dentist shall be obliged to report to the ap-

propriate reviewing agency instances of gross and/or continual faulty treatment by another dentist. If there is evidence of such faulty treatment, the patient *should* be informed. A dentist shall be obliged to refrain from commenting disparagingly without justification about the services of another dentist. The dentist *may* provide expert testimony when that testimony is essential to a just and fair disposition of a judicial or administrative action.

Twelfth Trustee District

AMENDMENT OF SECTION 1-H, REBATE AND SPLIT FEES, OF REVISED "PRINCIPLES OF ETHICS"

The following resolution was adopted by the Twelfth Trustee District at its August 7, 1979 pre-caucus meeting and transmitted under date of October 11, 1979 by Dr. Robert Dixon, trustee.

Background: The Twelfth Trustee District suggests that paragraph 1-H, Rebate and Split Fees, be amended by eliminating the words "which are not disclosed to the patient" in lines 105 and 106.

110. Resolved, that Section 1-H, Rebate and Split Fees, of the revised *Principles of Ethics* be amended to read as follows:

1-H Rebate and Split Fees

The dentist shall not accept or tender "rebates" or "split fees" (*omission*).

Twelfth Trustee District

AMENDMENT OF SECTION 5, PROFESSIONAL ANNOUNCEMENT, OF REVISED "PRINCIPLES OF ETHICS"

The following resolution was adopted by the Twelfth Trustee District at its August 7, 1979 pre-caucus meeting and transmitted under date of October 11, 1979 by Dr. Robert Dixon, trustee.

Background: The Twelfth Trustee District suggests that paragraph 5, Professional Announcement, be amended by adding the words "or which is in conflict with the provisions of the State Dental Practice Act" in line 149.

111. Resolved, that Section 5, Professional Announcement, of the revised *Principles of Ethics* be amended to read as follows:

5 Professional Announcement. In order to properly serve the public, the dentist should represent himself in a manner that contributes to the esteem of the profession. The dentist should not misrepresent his training and competence in any way that would be false or misleading in any material respect *or which is in conflict with the provisions of the State Dental Practice Act.**

Twelfth Trustee District

AMENDMENT OF SECTION 5-B, NAME OF PRACTICE, OF REVISED "PRINCIPLES OF ETHICS"

The following resolution was adopted by the Twelfth Trustee District at its August 7, 1979 pre-caucus meeting and transmitted under date of October 11, 1979 by Dr. Robert Dixon, trustee.

Background: The Twelfth Trustee District suggests that the words "a dentist may practice only under the name which appears on his dental license" be inserted at the beginning of Section 5-B.

112. Resolved, that Section 5-B, Name of Practice, of the revised *Principles of Ethics* be amended to read as follows:

Section 5-B Name of Practice

A dentist may practice only under the name which appears on his dental license. Since the name under which a dentist conducts his practice may be a factor in the selection process of the patient, the use of a trade name or an assumed name that is false or misleading in any material respect is unethical.

Use of the name of a dentist no longer actively associated with the practice may be continued for a period not to exceed one year.

Twelfth Trustee District

TASK FORCE TO ADVISE CONSTITUENT SOCIETIES WITH ADMINISTRATIVE OR LEGISLATIVE PROBLEMS

The following resolution was adopted by the Twelfth Trustee District and submitted on October 7, 1979 by Mr. Carl C. Schmitthenner, recording secretary, Twelfth Trustee District.

123. Resolved, that the American Dental Association, through its various agencies, develop with appropriate legal staff a central source to advise constituent societies confronted or engaged with administrative or legislative problems. Such a task force would bring together, on call, the expertise of the Association on immediate matters peculiar or common to constituent societies.

Twelfth Trustee District

CHANGE IN HEALTH PROFESSIONS EDUCATIONAL ASSISTANCE ACT OF 1976—PUBLIC LAW 94-484

The following resolution was adopted by the Twelfth Trustee District and transmitted under the date of October 11, 1979 by Dr. Robert B. Dixon, trustee.

Background: The Twelfth Trustee District is of the opinion that the Health Professions Educational Assistance Act, Public Law 94-484, passed by Congress in 1976, should be amended to offer some workable, more realistic initiatives to help solve the problems that now exist with respect to manpower, licensure and funding. Additionally, it is believed that the existing legislation should be changed to directly involve the dental profession in the planning process to help solve the problems of access to care.

The 1976 legislation laid the groundwork for a substantial expansion of the National Health Service Corps (NHSC), liberalized the definition of Health Manpower Shortage Areas (HMSA) and expanded the number and type of health professionals available to the Corps. Since 1976 the number of designated dental HSMAs and NHSC dentists placed in those shortage areas has grown considerably and all this activity has taken place with little or no involvement of the dental profession. In an attempt to change this situation, the following resolution is proposed.

124. Resolved, that the appropriate agencies of the Association study alternatives to PL 94-484 in the areas of manpower, licensure and funding that could be introduced in Congress to change the thrust of the existing legislation to involve the dental profession in solving the problems of access to dental care, and be it further
Resolved, that a report of the action called for in this resolution be submitted to the 1980 House of Delegates.

Thirteenth Trustee District

SUBSTITUTE FOR RESOLUTION 58

The following substitute resolution for Resolution 58 was submitted on October 24, 1979 by Dr. Dale Redig, executive director, California Dental Association.

Background Statement: The Thirteenth Trustee District recommends that Resolution 58 be amended by the addition of a second resolving clause to make the amended resolution read:

58S-1. Resolved, that the Council on Legislation explore appropriate amendments to the Keogh Law to permit self-employed persons to act as trustees for their own approved Keogh Plans, and be it further
Resolved, that in order to reflect increases in the cost of living, the Council seek legislation to increase the current limit on tax deferrals for contribution to retirement programs for self-employed individuals and their employees.

Thirteenth Trustee District

INCLUSION OF DENTAL SERVICES IN CATASTROPHIC HEALTH INSURANCE LEGISLATION

The following resolution was adopted by the Thirteenth Trustee District and submitted on October 10, 1979 by Dr. Dale F. Redig, executive director, California Dental Association.

Background Information: The California Dental Association supports the intent of Resolution 60 as presented by the ADA Board of Trustees, but believes that the concept of national health insurance should be expanded to include catastrophic health insurance, since the ADA does not currently have specific policy in this area.

The United States Congress is currently considering legislation dealing with catastrophic health insurance, and dentistry is only included to a minimal extent. The California Dental Association believes that dentistry should be included as a covered service in any catastrophic legislation in order to avoid the dilution of dental care being provided to those who receive benefits under such legislation. The current legislation pending before Congress takes into account only a portion of dentistry—some oral surgery services—and does not provide the patient the services of a dentist, but rather leaves the treatment with a physician or his employee.

To avoid the erosion of primary dental care services to a patient receiving benefits in connection with catastrophic illness, the California Dental Association urges the American Dental Association to seek to include dental services in any legislation dealing with catastrophic health insurance.

99. Resolved, that expenses incurred for dental services be taken into account on the same basis as expenses incurred for medical services in meeting the deductible imposed by legislation providing for catastrophic health insurance plans.

Fourteenth Trustee District

SUBSTITUTE FOR RESOLUTION 50

The following substitute resolution for Resolution 50 was submitted on October 23, 1979 by Mrs. Helen Gibbs, secretary, Fourteenth Trustee District caucus.

Background: Resolution 50 should be amended by the deletion of the second resolving clause, and the addition

of the phrase, "and a mechanism be devised to report to the Council suspected abuses of the rules and regulations" to the end of the third resolving clause, the amended resolution to read as follows:

50S–1. Resolved, that a new research protocol be developed which could be used by the American Dental Association and constituent and component societies to document the need and demand for additional dental manpower, and be it further

Resolved, that the Council on Dental Health and Health Planning design an outline to assist component and constituent societies in giving expert, credible testimony to any individual HSA regarding the placement of NHSC dentists *and a mechanism be devised to report to the Council suspected abuses of the rules and regulations.*

Fourteenth Trustee District

FUNDING OF A STUDY OF THE COMPARATIVE EFFICIENCIES OF THE PUBLIC AND PRIVATE DENTAL DELIVERY SYSTEMS

The following resolution was submitted on October 23, 1979 by Mrs. Helen Gibbs, secretary, Fourteenth Trustee District caucus.

130. Resolved, that the Board of Trustees appropriate $250,000 to fund a study of the comparative efficiencies of the public and private dental delivery systems, and be it further

Resolved, that the Bureau of Economic and Behavioral Research make every effort to seek outside funding to cover as much of the above study costs as possible.

Delegate A. Edward Hall, Kansas

ADA PARTICIPATION IN 1980 MUSCULAR DYSTROPHY TELETHON

The following resolution was submitted by Delegate A. Edward Hall, Kansas, under date of September 28, 1979.

Background: During 1979, the Kansas State Dental Association worked cooperatively with the Kansas State Dental Laboratory Association at the latter's invitation on a campaign to collect scrap gold for presentation as gold bricks during the local telethon for the Muscular Dystrophy Association.

Although time constraints were extreme, over six thousand dollars were solicited and collected in the form of gold scraps which were presented in the form of a small gold brick. Public response to the effort has been very positive, while the cooperative effort helped improve the relations between the laboratory industry and the dental profession in Kansas. A resolution recommending this activity on a national level is, therefore, presented.

78. Resolved, that an appropriate Association agency determine the feasibility of the American Dental Association joining with other dentally related groups to secure contributions for the 1980 Muscular Dystrophy Telethon, and be it further

Resolved, that the Board of Trustees determine the manner in which the Association should participate.

Delegate Michael D. L. Weisenfeld, Michigan

MEDICAID ADMINISTRATION

The following resolution was transmitted under date of September 15, 1979 by Delegate Michael D. L. Weisenfeld, Michigan.

Background Statement: The administration of the Medicaid program through state agencies has created problems for the practicing dentist. The predetermination forms, billing invoices and payment mechanisms are all very complex. There is a high "error rate" which leads to rejection of the forms by the computer and nonpayment. This causes a decline in the number of dentists willing to participate in the program. It becomes a hardship for the patient to find a dentist willing to accept Medicaid patients.

Many dentists would like to be able to participate in the Medicaid program so that they might do their part in helping to solve societal problems. This could be accomplished with more responsible administration. If the state(s) would accept competitive bids for the administration of the dental portion of a Medicaid program, insurance companies and service corporations could compete for the contracts. This might lead to more responsive program administration.

68. Resolved, that the ADA actively encourage competitive bids from private carriers and service plans for the administration of the dental portion of state Medicaid programs through state and federal legislation, if necessary.

Delegate Michael D. L. Weisenfeld, Michigan

PUBLIC TESTIMONY

The following resolution was transmitted under date of September 15, 1979 by Delegate Michael D. L. Weisenfeld, Michigan.

Background Statement: It is most important that the views of organized dentistry be made public whenever the opportunity presents itself. On those occasions when there are public hearings related to issues that concern

dentistry, we should give testimony.

An example of this is the hearings by the U.S. Department of Agriculture on the sale of highly sugared foods in schools. The ADA gave testimony in one city, but the hearings were held in three cities.

The ADA should also encourage its constituent and component societies to give testimony in their areas. The news media will pick up such testimony as news which provides an excellent mechanism for public education.

69. Resolved, that the ADA encourage its component and constituent societies to give public testimony on dentally related issues at regional hearings of Congressional committees when such opportunities are available, and be it further

Resolved, that the ADA staff inform the component and constituent societies of such opportunities, and be it further

Resolved, that the ADA staff assist component and constituent societies with background material to develop such testimony.

Delegate Willis B. Irons, Minnesota

ACKNOWLEDGMENT OF WOMEN IN THE DENTAL PROFESSION

The following resolution was submitted by Delegate Willis B. Irons, Minnesota, under date of October 4, 1979.

Whereas, that number of women entering the dental profession as dentists is increasing steadily in the United States, and

Whereas, organized dentistry in the United States needs to encourage the total involvement of women dentists in all activities of the dental profession including membership and service in positions of leadership in the American Dental Association, and

Whereas, an effort should be made to correct the unintentional but far too common omission of the reference to women in the dental profession in statements in the meetings of the American Dental Association House of Delegates and Reference Committees including the written manual, speeches and in debates and discussions by the delegates and officers, therefore be it

77. Resolved, that as part of the encouragement for the participation of women dentists in organized dentistry, the officers, trustees, members and staff of the American Dental Association make a concerted effort to include in their written and verbal statements the appropriate acknowledgment of women in the dental profession.

Delegate Daniel W. Benton, Utah

SUBSTITUTE FOR RESOLUTION 49RC–1978

The following substitute for Resolution 49RC–1978 was submitted on October 23, 1979 by Delegate Daniel W. Benton, Utah.

Whereas, the word "disaster" in Resolution 49RC makes the resolution too restrictive and discriminatory, and

Whereas, constituent societies have no way to provide dues relief on the ADA level to members requesting and deserving relief for various justifiable needs such as terminal illness, incapacitating accidents, health and other problems, and

Whereas, the local component and constituent society is the best qualified to assess the needs of a member, and

Whereas, the officers of component and constituent societies are people of honor and integrity, the ADA can accept their certification of need for a deserving member, and

Whereas, a member would not need to then return to the ADA in the form of dues any monies he might receive from the ADA relief fund, and

Whereas, most component and constituent societies would feel the loss of any dues money from granting a waiver of dues more than the ADA, they would carefully consider the needs of the member, and

Whereas, Mr. Frank Ginn of ADA staff has indicated approximately 2,800 active ADA members dropped out this year for a multiplicity of reasons, and

Whereas, some of these members would have continued as active members and resumed paying dues if they had been granted dues relief, and

Whereas, over the long term this would probably return a dividend of increased membership and more dues for the ADA, we propose the following amended Resolution for 49RC–1978:

49RC–1978–S–1. Resolved, that Chapter 1, Membership, Section 50, Dues and Reinstatement, of the *Bylaws*, be amended by the addition of Subsection K to read as follows:

> K. Exempt Dues for Members Who Suffer Severe Financial Hardship. Those active members who have suffered hardship losses as certified by component and constituent society secretaries shall be excluded from the payment of the current year's membership dues provided they are also exempt from paying component and constituent dues.

Western Study Club of Combined Therapy

PEER REVIEW OF ALL CONTEMPLATED FULL MOUTH EXTRACTION CASES UNDER AGE OF TWENTY-FOUR

The following resolution was transmitted by the Western Study Club of Combined Therapy, Los Angeles, California.

Whereas, the longevity of life today demands that the retention of teeth and the prevention of extractions of the dentition become of primary concern to the dental profession, and

Whereas, early extractions of teeth under the age of twenty-four (the last year of skeletal growth) has in special cases been noted by some dental practitioners to result in extreme early loss of alveolar bone in the mandible and maxillae (upper and lower jaws) resulting in thirty–year–old dental and medical cripples for the rest of their projected natural life, making corrections of the condition a serious, expensive, involved surgical procedure (osseous and metal implants necessary), therefore be it

73. Resolved, that all contemplated full mouth extraction cases under the age of twenty-four require the consultation of peer review before these teeth are removed so that the total body skeletal matrix is not altered.

1978 RESOLUTIONS REFERRED TO 1979 HOUSE OF DELEGATES

Louisiana Dental Association

ANNUAL PROVISION OF PROFESSIONAL PROTECTOR PLAN DATA TO CONSTITUENT SOCIETIES

98–1978. Resolved, that the Council on Insurance provide to constituent societies the experience statistics, by state, relative to the Professional Protector Plan on an annual basis to include a breakdown for each category of insurance (i.e., professional liability, office liability, non-owned auto liability, personal injury liability and personal excess liability); also property coverage for operatories, and office equipment, records and money, in transit loss, accounts receivable, practice interruption and employee dishonesty (bond), and be it further

Resolved, that these figures be distributed to each constituent society on an annual basis, and be it

Resolved, that the Council on Insurance explain to the constituent societies, in detail, the reporting format of Chubb as to how reserves are calculated, how they are carried forward and credited and how the IBNR losses are computed.

Fifth Trustee District

USE OF TERMS "FAMILY DENTISTRY" AND "FAMILY DENTIST"

105–1978. Resolved, that the terms "Family Dentistry" and "Family Dentist" are not synonymous with the term "General Practice," and be it further

Resolved, that for the purpose of letterheads, business cards, etc., the terms "Family Practice" and "Family Dentistry" may not be ethically substituted for the term "General Practice."

Delegate W. Kelley Carr, Indiana

EXEMPT DUES FOR MEMBERS WITH DISASTER LOSSES

49RC–1978. Resolved, that Chapter I, Membership, Section 50, Dues and Reinstatement, Subsection A, Active Members, of the *Bylaws* be amended by the addition of the words "(except as provided in Subsection K)" following the words "The dues of active members" in the opening phrase of that subsection, so that Subsection A will read as follows:

> A. *Active Members.* The dues of active members (except as provided in Subsection K) shall be one hundred fifty dollars ($150.00) due January 1 of each year except that any dentist who is an active member of component and constituent societies of this Association and who is engaged full time in (1) an advanced training course of not less than one academic year's duration in an accredited school or residency program in areas neither recognized by the Association nor accredited by the Commission on Accreditation or (2) a residency program or advanced education program in areas recognized by the Association and in a program accredited by the Commission on Accreditation shall pay three dollars and fifty cents ($3.50) due on January 1 of each year until the December 31 following completion of such a residency or advanced education program.

and be it further

Resolved, that Chapter I, Membership, Section 50, Dues and Reinstatement, of the *Bylaws* be amended by the addition of Subsection K to read as follows:

> K. *Exempt Dues for Members with Disaster Losses.* Those active members who have suffered

disaster losses as certified by constituent society secretaries shall be excluded from the payment of one year's membership dues.

Delegate Daniel W. Benton, Utah

ACTIVE MEMBERS ENGAGED IN FULL-TIME CHARITABLE SERVICE (REDUCTION IN DUES)

58RC–1978. Resolved, that Chapter I, Membership, Section 50, Dues and Reinstatement, Subsection A, Active Members, of the *Bylaws* be amended by the deletion of the phrase "shall pay three dollars and fifty cents ($3.50) due on January 1 of each year until the December 31 following completion of such a residency or advanced education program" from the end of that subsection and substitution of the phrase "or (3) charitable service of not less than one year's duration for a charitable organization of more than three hundred (300) members with no income other than a cost of living allowance shall pay three dollars and fifty cents ($3.50) due on January 1 of each year until the December 31 following completion of such a residency, advanced education program or charitable service." therefor so that Subsection A will read as follows:

> A. *Active Members.* The dues of active members shall be one hundred fifty dollars ($150.00) due January 1 of each year except that any dentist who is an active member of component and constituent societies of this Association and who is engaged full time in (1) an advanced training course of not less than one academic year's duration in an accredited school or residency program in areas neither recognized by the Association nor accredited by the Commission on Accreditation or (2) a residency program or advanced education program in areas recognized by the Association and in a program accredited by the Commission on Accreditation or (3) charitable services of not less than one year's duration for a charitable organization of more than three hundred (300) members with no income other than a cost of living allowance shall pay three dollars and fifty cents ($3.50) due on January 1 of each year until the December 31 following completion of such a residency, advanced education program or charitable service.

American Association of Orthodontists

AMENDMENT OF SECTION 18 OF "PRINCIPLES OF ETHICS" [ANNOUNCEMENT OF LIMITATION OF PRACTICE— ADDITION OF "(DENTOFACIAL ORTHOPEDICS)"]

52–1978. Resolved, that Section 18 of the *Principles of Ethics* be amended so those dentists who ethically limit their practices to the special area of dentistry identified as orthodontics may further clarify the scope of their practice by the addition of the term "(dentofacial orthopedics)" in parentheses, so that the complete identification would read "orthodontics (dentofacial orthopedics)."

Reports of Board of Trustees TO HOUSE OF DELEGATES

SUPPLEMENTAL REPORT 5 OF BOARD OF TRUSTEES TO HOUSE OF DELEGATES: SPECIAL COMMITTEE TO REVIEW REPORT—PREVENTION AND CONTROL OF DENTAL DISEASE THROUGH IMPROVED ACCESS TO COMPREHENSIVE CARE

Background: The development of the report on Prevention and Control of Dental Disease Through Improved Access to Comprehensive Care has involved most of the agencies of the Association, Council members, members of the Board of Trustees and staff. In addition, related dental organizations had an opportunity to provide commentary on the trigger papers which were prepared as a part of the initiation of this project. As Board Report 5 (*Supplement 1*:324) indicates, the Board of Trustees considered the comments and advice received during its August 1979 Board meeting and developed the report which has been submitted to the House of Delegates.

In addition to submitting Board Report 5 to the House of Delegates, the Board of Trustees concurred that it would be valuable for the President to select a small committee to meet and discuss the overall impression of the access program and to develop ideas which might improve the project. Dr. Cappuccio named a special committee of nine dentists to review and comment on Board Report 5 as it was transmitted to the House of Delegates. The Committee was composed of several active Association representatives and representatives of several related dental organizations.

Meeting: The special Access Review Committee met on September 18, 1979. The membership of the committee included:

Dr. Joseph P. Cappuccio, chairman
Dr. Robert J. Cole, Florida
Dr. Frank A. Dolle, Maryland
Dr. Ralph R. Lopez, New Mexico
Dr. Harold L. Martin, Illinois
Dr. Charles J. Slagle, Connecticut
Dr. Otho R. Whiteneck II, Oklahoma
Dr. Tom Graber, Federation of Specialty Organizations
Dr. James E. Lassiter, Jr., National Dental Association
Dr. Alex J. McKechnie, Academy of General Dentistry

Also, Dr. John Coady, Dr. Thomas Ginley and Mr. Delmar Stauffer provided staff assistance.

General Comments: The Committee reviewed the report from the perspectives of both the validity of the assumptions as well as the appropriateness of the program which has been developed in relationship to current Association policy. The comments of the Committee are categorized into major areas with several recommendations. The special Committee wishes to inform the Board of Trustees and the House of Delegates concerning its critique of the major elements of the report. During its deliberations, the Committee was very supportive of the document but concluded that some recommendations should be forwarded to the Board of Trustees and the House of Delegates for consideration. Accordingly, recommendations and additional comments are included. It should be noted that no attempt has been made to rank or prioritize these additional comments.

Impression and Comments: The special Committee believes that the report *Prevention and Control of Dental Disease Through Improved Access to Comprehensive Care* is an excellent and timely initiation of a project which coincides both with consumer interest as well as the willingness of the dental profession to provide more care to more people. The Committee was enthusiastic about the overall initiative and concurred with the general scope and direction of Board Report 5. During the discussion, the Committee took special note of the thoroughness of the report and commended the Board of Trustees for all the work it had accomplished in preparing the document for transmittal to the House of Delegates. The report embodies a coordination effort that will require the extensive combined effort of the Association agencies, state dental societies, as well as related dental and nondental organizations. As the report stresses, it is a shared responsibility and one in which the profession is willing to provide the coordination and leadership but recognizes that without the as-

sistance of other groups it is not likely that the profession and the Association will be successful in achieving most of the goals. As Report 5 to the House of Delegates stresses, the effectiveness of the program will be directly correlated with the profession's recognition and willingness to deal with, on a priority basis, society's interest and concerns in health care delivery.

The report is structured around six target areas and contains 33 recommendations for continued Association activity. It is recognized by the Committee that although there are some recommendations that are more important than others, it is the critical mass or accumulation of recommendations that form the Association's philosophy and direction for program activity within the next several years. The Committee recognizes that many of the recommendations will help directly and indirectly in fostering a societal and professional attitude which places the need to provide comprehensive dental care as a foremost objective.

Committee Compliments: One of the initial discussions of the Committee related to the development of the comprehensive document in a relatively short period of time. The Committee was extremely complimentary of the Board of Trustees for initiating the development of this report and was similarly enthusiastic with the continued refinement of the report based on the input received from councils, agencies, related groups and staff. It was apparent to the Committee that the status of the report reflected the tremendous effort and priority given to this project during the last months.

Current Policy: As the recommendations indicate and the report notes, the access program was developed consistent with Association policy. The initial thrust of this program was to build Association activities around current policies. It is also recognized that the initiation of some of the recommendations will lead to further refinement and development of Association policy in areas where there is no policy or no clear direction established by the House of Delegates. In general, it was the belief that Association policies allow for the adequate establishment of access program activities and therefore, the initial thrust of the report relates to existing rather than new policy directions. It was noted that many Association agencies have begun efforts in several areas recommended in the report.

The Committee offers several recommendations for further consideration:

1. The length of the report may deter some practitioners and others from reading it in its entirety and therefore, a short summary of the contents should be prepared as a prologue to the report. A concise statement of the meaning of the report to the profession should be clearly stated.

2. The 33 recommended actions should be organized into four or five major programs for early implementation. Such programs should be highly visible and should be developed in cooperation with appropriate governmental agencies and advocacy groups.

3. Careful attention should be given to the complex economic barriers to care since many of the issues can be considered from an economic perspective.

4. Although the report contains references to the behavioral sciences, more emphasis should be placed on the need for incorporating behavioral science concepts and methodologies into the proposed dental health initiatives.

5. As alternate delivery systems are not readily understood, those sections of the report that deal with delivery systems should be developed to explain how dentists can adjust to change and to explain how the inherent flexibility of the present system will allow the profession to meet both the existing challenges and those of tomorrow.

6. Further implementation of licensure by credentials is urged. There is a general belief that the average practitioner strongly endorses licensure by credentials but too little is being done by organized dentistry to make this concept a reality.

7. Institutional advertising needs to be studied carefully for it may be a productive method of explaining the goals and objectives of an access program. Through the years, the profession has maintained a low profile with respect to its altruism, and has done so in the spirit of community service and professional obligation. Unfortunately, the Committee observed, this low profile has meant that most health planners have little or no understanding of the profession's activities designed to deliver care to the underprivileged/economically deprived.

8. The phrase "comprehensive care" needs to be defined.

9. The report recommendation directing the profession to seek allies throughout society, should be expanded to include consideration of subsidization for program activities of these other groups. For example, the Committee noted that at some time the profession may wish to underwrite or procure outside funds to meet the cost of initiating cooperative programs with advocacy groups for the elderly and the handicapped.

10. The recommendation calling for assistance to strengthen state and local dental health departments should be expanded to include assistance to agencies dealing with aging, the handicapped, and maternal and child health programs.

11. The Committee urges the staff to reorganize several of the statistical portions of the report into clear, concise, visual presentations through the use of descriptive statistics.

12. The item which calls for an exploration of the public school setting for providing health education, referral and oral prophylaxis for schoolchildren should be studied in conjunction with expanding the possibilities of support from community service groups such as Lions International. The Committee noted that service groups often welcome new programs to promote the health of children, to underwrite the cost of equipment and to operate or subsidize programs designed to transport pa-

tients. While this is true for children, the Committee also urges consideration of such programs for other population groups.

13. More emphasis should be placed on the development of survey methodologies to document the need for dental care for the homebound and the institutionalized.

14. The last sentence of paragraph three, column two (*Supplement 1*:337) should be deleted. The Committee noted the intent of the statement is obscure and perhaps insensitive to the complexities involved in the administration of dental practices.

15. Resequence for program priority the items listed on page 331 of *Supplement 1*, to stress item No. 2 as a first goal.

16. Since the access program provides a unique opportunity for the "private sector" to commit itself to a major contemporary consumer issue, *time is of the essence* and the Association should not delay any of its activities. Each individual dentist should actively support and promote pertinent aspects of the program.

SUPPLEMENTAL REPORT 7 OF BOARD OF TRUSTEES TO HOUSE OF DELEGATES: THE FEASIBILITY OF A COMPARATIVE STUDY OF PUBLIC AND PRIVATE DENTAL CARE DELIVERY SYSTEMS

Background: This report of the Board of Trustees is further comment called for by Report 7 of the Board of Trustees to the House of Delegates, The Feasibility of a Comparative Study of Public and Private Dental Care Delivery Systems (*Supplement 1*:362), and is presented: to inform the House of Delegates that a comparative study of the public and private dental care delivery systems is feasible; to describe the reasons for selecting the military as the public sector system to study; to document the results of the literature search completed for this issue; and to explain the action the Board intends to take with respect to Resolution 56H (*Trans.1977*:915) and Resolution 142H (*Trans.1978*:511).

In response to the directive, the Bureau of Economic and Behavioral Research (then, Bureau of Economic Research and Statistics) contacted the agencies of the public sector to determine the availability of comparative data and conducted a literature search for research reported on this topic. The results of this initial investigation were summarized in the 1978 Report 7 of the Board of Trustees to House of Delegates (*Supplement 1, 1978*:237). No studies were found to be reported in the literature at that time. Public sector clinics were determined to be not comparable due to a lack of centralized data gathering and poor record reliability. The Veterans Administration and the military offered more potential but the nature of these two segments of the public sector appeared to require a more complex research design and more thorough investigation of the actual availability of data.

The 1978 House of Delegates (*Trans.1978*:511) reaffirmed its interest in the comparative study of cost efficiency in the public and private sector, directed the Association to continue to investigate the feasibility of doing such a research project and requested that the feasibility of such a study and its estimated cost be reported to the Board of Trustees for funding at the earliest appropriate time.

Feasibility Determination: Contacts with numerous government agencies were made to explore potential data sources and cooperation for the comparative study. The nature of many programs immediately ruled out the possibility of a comparative study due to the lack of a private practice counterpart. However, some programs proved promising in terms of the richness of the data and the cooperation of the agency. An overall summary of the findings is presented below.

State Programs: Several state-based programs such as Head Start and Medicaid were reviewed. As with all state-based programs, there is no centralized data gathering system. Each state maintains its own record system which is not generally compatible with those of other states. Programs such as Head Start include a wide variety of systems with varying degrees of record reliability. It appears that state agencies cannot supply the Association with supporting documentation that would describe in detail some of the necessary study variables such as patient demographic information, duration of eligibility, number of eligible patients and project costs.

In view of the aforementioned deficiencies in state-based programs, efforts were turned toward more visible national level programs which have more advanced data reporting systems and supporting documents.

National-Based Programs: At the national level, four possible sources of data were identified: the Veterans Administration (VA), the Military, the National Health Service Corps and the Indian Health Service. During the search process, all were dismissed for one reason or another with the exception of the military.

The VA was approached early in the search. At the time, the VA offered a promising possibility since the VA offers services to patients through two modes, VA-based clinics and reimbursement through fee-for-service. Contact with the VA about a comparative study

was not promising. The VA indicated that it was proceeding with its own internal study. Moreover, it was found that the U.S. Government's General Accounting Office and Department of Health, Education, and Welfare were either engaged in or planning to pursue their own studies of the VA dental delivery systems. Although none of the projects promise to answer the Association's questions, VA interest in another large study of its program at this time is quite low.

From an added perspective, the VA data are not quite as useful for a comparative study as they initially seemed. The VA typically services patients for only one year after discharge on an outpatient basis. Since the VA is not at risk to the patient after the one-year period, the incentive to perform preventive procedures is much reduced. Moreover, it would be difficult to identify private dentists who limited their services to the same procedure mix that is commonly provided in VA clinics. Thus, the VA was eliminated on two counts, lack of comparable data and limited interest on the part of the VA in participating in such a study.

The Indian Health Service was contacted and very cooperative. The documentation released to the Association underscored the difficulties of identifying costs properly assigned to the dental delivery system. Moreover, the Indian Health Service was designed to provide care in areas where it is too expensive for the private sector to prosper—on rural reservations. A comparative study with the Indian Health Service is not considered feasible because the comparison of practices with completely different patient profiles would be meaningless and the costs of the dental sector are all but impossible to isolate from the appropriations. The possibility of the National Health Service Corps was reviewed especially in light of the fact that the Corps dentists deliver care much in the same manner as do private practitioners. However, it was determined that the National Health Service Corps is not an appropriate public program for a comparative study for the following reasons: the sites are young and thus data are available only on new practices; data available are not aggregated at a level which is useful for a comparison with the private sector; the Corps dentist frequently treats special populations rather than a cross section of patients; the Corps is subsidized through a variety of Federal programs as well as private contract funds and this multi-source funding makes careful cost assessment extremely difficult.

It should be noted that pursuant to House of Delegates Resolution 96H (*Trans.1978*:505) the Bureau of Economic and Behavioral Research is presently investigating the usability of Corps site data to describe the expense of operating individual Corps sites. Any comparisons that can be made with the private sector will be made under that directive.

The military dental sector offers several notable advantages over other public programs. While it does not represent the perfect program to which the private sector might be compared, it seems at this point to answer many of the questions that must be addressed and offers the best access to comparable data.

Several contacts were made within the Department of Defense and the data from the U.S. Army were examined in detail during a visit this summer to San Antonio, Texas. Examples of record reporting forms and data entries along with descriptions of computer facilities where data are stored were provided for staff review. The Army, as one alternative, keeps detailed monthly records on every clinic in the U.S. which include the number of visits, the number of treatments by procedure, the staff configuration, the clinic facilities and equipment, the personnel files for each staff member (including age, year of graduation, experience), hours of business, and demographic information describing the patients treated. Perhaps equally important, the army offers the expert advice of its own research staff that are familiar with the data and have engaged in their own internal research.

The ever present questions of data reliability remain with the military data just as they do with ADA data. The project may require validation procedures whereby samples of clinics used in the study are drawn for retrospective data evaluation. If necessary, patients would be contacted and services verified. Measurement error, if any, would then be recorded and included as a "deflator" of productivity figures. Such steps are not unique to this proposal.

Literature Review: After another year of literature search, results of a new research project became available in publications.

The published research in this area of inquiry is based upon evidence collected from the 1971–75 Chattanooga project which delivered dental care to children through three different delivery modes: a fixed public clinic, a mobile public clinic and public reimbursement of private dentists in the fee-for-service setting. In 1977, two articles were published from this project: "Expenditures for the Dental Care of Indigent Children in the Chattanooga Project, 1971–75," Neville Doherty and Sandra Vivian, *Journal of Public Health Dentistry*, Vol. 37, Summer 1977, and "Costs of Dental Care in Mobile Clinics," *Journal of Public Health Dentistry*, Vol. 37, Fall 1977. Both papers state that the fee-for-service setting was more expensive than the public sector. Earlier papers addressing the same issue were published by Neville Doherty and Ifikhar Hussain, "Costs of Providing Dental Services for Children in Public and Private Practices," *Health Services Research*, Vol. 10, Fall 1975, and by Neville Doherty and Sandra Vivian, "Cost of Publicly Financed Dental Care for Children in Three Different Types of Practice Settings," *Journal of Public Health Dentistry*, Vol. 88, Winter 1976.

With the reported result that the public sector is more cost-efficient than the fee-for-service setting, HEW awarded the University of Connecticut a research contract to determine the reasons behind the cost differences. Under Contract No. 231–77–0035, Neville

Doherty reports that the expense of the fee-for-service setting is attributed to the "unwarranted profits" enjoyed by private dentists.

> Analysis of the private dentist returns revealed that not all of the income received could be justified . . . large excess profits do accrue to these dentists. The overall expenditures of public funds could have been much lower had the public modes . . . been used more efficiently.

This two-volume research report now serves as a basis for several more papers to be published by Doherty.

The most disturbing result presented in the existing literature is the reported relative inefficiency of the fee-for-service sector. Doherty finds that costs incurred in the private sector run 100% ahead of comparable public costs. The reported key to the cost differences is in the incomes and salaries of the dentists themselves. According to Doherty's results, had private dentists earned only what salaried dentists were paid, the costs of the two sectors would have been essentially equal. Although Doherty's study is to be questioned, it is the only published material in this area and it does provide a clue as to the importance of dentists' salaries in cost comparisons.

Conclusions of Feasibility Study: At this time, except for the military, the availability and comparability of data in all public sectors are highly questionable. A comparative study using the military services is feasible and based on this finding, a proposed preliminary research design was developed and presented to the October Board of Trustees. This preliminary research protocol, "A Study of the Comparative Efficiencies of the Public and Private Dental Delivery Systems," is anticipated to take at least 18 months to complete and is estimated to cost $250,000.

The Board is generally in agreement with the need for economic research to describe the comparative efficiencies of the public and private delivery of dental services but is of the opinion that, though considered feasible, the proposed research using the military services for a comparative study is of questionable value and too costly to fund at the present time when considered in the context of other competing projects of greater immediacy. Accordingly, the Board recommends that no further action be taken at this time.

SUPPLEMENTAL REPORT 8 OF BOARD OF TRUSTEES TO HOUSE OF DELEGATES: THE RELATIONSHIP BETWEEN DENTISTS AND DENTAL HYGIENISTS

Background: The following report represents an edited version of Report 8 of the Board of Trustees which was originally developed as a result of a joint American Dental Hygienists' Association/American Dental Association Board of Trustees meeting in August. Although the ADA Board of Trustees approved a draft statement and agreed with the ADHA Board regarding stated principles, the ADHA Board of Trustees did not have an opportunity to review the final printed version of the draft since the ADHA Board had already adjourned its meeting. Although the ADA Board of Trustees approved the draft in August, the ADHA Board, upon reviewing the written draft, expressed some concern about the tone and repositioning of items within the report. The President of the ADHA requested that the President of the ADA convene a meeting with representatives of both Boards to edit further the statement so that it could be presented to the open hearing during the 1979 ADA annual session with the full endorsement of both Boards. Dr. Cappuccio agreed and appointed Dr. Bomba to join him in representing the ADA Board of Trustees. On September 25, 1979 a meeting was held at the ADA Headquarters with the following representatives:

Dr. Joseph Cappuccio, president
American Dental Association
Dr. John Bomba, trustee
American Dental Association
Ms. Kathleen Mast, president
American Dental Hygienists' Association
Ms. Jeri Yunker, president-elect
American Dental Hygienists' Association

On the basis of that meeting, a few changes occurred in the draft statement. The agreed upon changes are reflected in this edited version of Board Report 8.

EDITED REPORT 8

The Board is submitting the following joint American Dental Hygienists' Association/American Dental Association draft statement on "The Relationship Between Dentists and Dental Hygienists" which it approved with a resolution supporting the convening of an open hearing during the 1979 annual session to give the members of both Associations an opportunity to comment on the draft statement.

The Boards of Trustees of the American Dental Association and American Dental Hygienists' Association met in joint session during the August meeting to discuss and review the statement. The draft statement which follows reflects the discussion held during that meeting *and during a September meeting with representatives of both Associations*. While both Boards commend the joint committee for the work it has accomplished, the Boards believe members of each Associa-

tion should have the opportunity to provide comment on the statement while it is still in draft form.

The American Dental Hygienists' Association and the American Dental Association recognize that a joint approach is needed to address the future of dental hygiene. A committee consisting of eight members, four appointed by each Association, has considered this topic during seven days of meetings within the last year. A comprehensive review of research and policies served as background for the committee's position statement on the relationship between dentists and dental hygienists. Suggestions for clarification were made and the resulting statement follows. The italicized sections in the text of the statement reflect the changes. *The statement should be reviewed and considered in its entirety.*

The Relationship Between Dentists and Dental Hygienists

Dentists and dental hygienists must work together to prepare for the future dental needs of the American public. Both Associations agree that dental hygiene is and will continue to be an integral part of the *dental profession*, the dental health care delivery system and *the* state board licensure system. *Additionally, dental hygiene will continue to participate in the development of dental hygiene educational standards and the accreditation process.* Any separation of dental hygiene from dentistry would not be in the best interest of the public, dentistry or dental hygiene.

This statement does not discuss or relate to increasing the functions of dental hygiene. The issue of functions will need to be considered by both Associations in the future. Delegation of functions should be assigned to the existing personnel who are best qualified educationally to perform each function. The current dental health care team is capable of meeting the demands for care. No new category of dental personnel is needed.

The relationship between dentists and dental hygienists is conceptualized as a cooperative effort to provide total oral health care for the patient. The cooperation that exists between dentists and dental hygienists is characterized as the consulting, *deliberating, conferring* and advising that take place between the dentist and the dental hygienist in providing care for the patient. The cooperative relationship that has traditionally existed between the dentist and the dental hygienist should be strengthened and perpetuated.

The essential element of supervision is that the dentist is responsible for the total oral health care of the patient. It is important to emphasize the need to provide the patient with adequate dental supervision regardless of the provider or setting. Supervision of the patient's oral health care is more important to the public interest than supervision of specific delegated functions. Any future changes should assure the patient of adequate dental supervision.

In the current private practice setting, the dentist is responsible for diagnosis, treatment planning and supervising the patient's total oral health care. The dental hygienist is responsible for and exercises discretion in planning and delivering dental hygiene services. The patient is assured that hygiene services will be *compatible with* the treatment plan prescribed by the dentist. In the foreseeable future, the largest part of the dental care delivery system will be through traditional private practice and the dental hygienist will continue to serve in that setting. The Associations agree that the essential element of supervision is *the* responsibility for the total oral health care of the patient *and should remain with the dentist*; therefore, neither Association supports the total separation of the practice of dental hygiene services on an individual basis in private practice.

This statement addresses increased employment opportunities for dental hygienists in the health care delivery system. Dental hygienists could perform legally delegated functions for patients who *are* not receiving care in the present dental health care delivery system. There are settings where increased use of dental hygienists could help improve access to dental care, e.g., extended care facilities, institutions and hospitals, school-based preventive programs. Where it is unlikely that a dentist would be present for customary supervision of traditional and/or legal dental hygiene services, alternate methods of providing adequate patient supervision need to be developed. Provisions in policy must therefore be addressed for dental hygienists working in health care facilities which are not under the traditional jurisdiction of a dentist.

Reimbursement for dental hygiene services traditionally has been through the employing dentist and *is likely to* continue to be the principal form of compensation. However, if the dental hygienist is not employed directly by a dentist, different methods of compensation for dental hygiene services need to be developed. *Variance in future practice settings may affect the* method of financing programs and reimbursing dental hygienists. The issue of a direct reimbursement must be addressed in settings where compensation by a dentist is not probable.

Both Associations must cooperate to identify new approaches that will result in increased awareness of the need for dental services through public education and accessibility. *The dental hygienist by virtue of education is principally qualified to work with the dentist in preventing dental disease by educating the public and providing dental hygiene services to patients.* Future changes which may occur in the delivery of dental care should result in additional opportunities for both dental hygienists and dentists. As the demand for dental care increases, dentists and dental hygienists must be prepared for this challenge. The Associations also must seek to strengthen the cooperative efforts of all related professions *while affecting* change in the dental health care delivery system.

This statement has been endorsed as an interim document for transmittal by the Board of Trustees of both the American Dental Hygienists' Association and the American Dental Association and is being returned to the joint committee to allow that committee to convene an open hearing on October 22 during the annual meeting of both Associations.

The ADA Board of Trustees is transmitting this statement to the membership to enable all members to participate in this open hearing.

The additional information and comments received during this hearing will be considered by the joint committee during the ensuing year and a *final statement* will be presented to the House of Delegates of both Associations for consideration and approval in 1980.

REPORT 9 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: INSTITUTIONAL ADVERTISING

Preface: This report presents a proposal from the Board of Trustees to launch up to a $2 million institutional advertising program to stimulate utilization of dental services by the American public. The program includes a national print advertising campaign and a three-city test market of television commercials. If the House of Delegates supports the concept of a national advertising program, the funds would be taken from Association reserves.

As used in this report, the term "institutional advertising" refers to advertising by the Association on behalf of the nation's dental professionals. This is distinct from advertising by individual practitioners, group dental practices or dental clinics. Institutional advertising is used by associations and corporations for a variety of purposes: enhancing the image of the organization or the members it represents, correcting public misconceptions or increasing utilization of a service. The advertising program described in this report is designed to do the latter.

Introduction: Today in scattered pockets across the country, the profession is witnessing a new problem—perhaps more challenging than any encountered in recent years. Stated simply, dentists in some areas are not filling their appointment books. In those communities, there is serious concern that the supply of dentists exceeds public demand for regular, preventive dental care.

Following are some of the factors which may be contributing to the "busyness crisis." It is doubtful that any one of these factors alone is responsible for the decline in busyness of dental practices in some areas of the country. Rather, it is likely that they interact with one another for a combined effect.

Inflation: The insidious result of uncontrolled inflation is postponement of considered purchases, and the very first to be put off are those expenditures which are preventive in nature. Indeed, a recent study of family health practices and attitudes revealed one out of two American families has cut back on one or more health-related items in order to cope with inflation. Eleven percent of respondents indicated they are postponing or cutting back on dental checkups. Adding to the effects of inflation is the economic recession into which the nation began to slump during the third quarter of 1979. How long the recession will last or how severe it will be cannot be predicted at this time.

Fluoridation: A quarter century of community water fluoridation is just beginning to have a statistical impact on the nation's dental health. Recently, the Federal Center for Disease Control reported that an estimated 20% of teenagers in fluoridated communities are completely caries-free, about six times the number in nonfluoridated communities. This is a welcome impact for which the profession has fought hard in communities throughout the country.

Preventive Dentistry: Prevention has been the hallmark of dental practice for decades. Thanks to preventive emphasis in practice and better self-care at home, more patients are on preventive maintenance schedules than ever before. Because they are avoiding complex restorative work, regular patients spend less time in the dental chair. As a result, many dentists today may have more room in their appointment books for new patients. As with fluoridation, preventive dentistry is an innovation fostered and perpetuated by the profession to improve the oral health status of its patients.

Productivity: The shift to preventive emphasis in dental practice was accompanied by a dramatic increase in the productivity of the dental office. This, too, has allowed room in some appointment books for more patients. Increased productivity has resulted both from technical advances, such as fast-setting amalgams and the high-speed handpiece, and from innovations in the use of chairside dental auxiliaries. All of these advances were developed and promoted by the profession.

Manpower Supply and Distribution: There are two trends in dental manpower that may be contributing to the busyness problem. One is that the supply of dentists is growing despite an absence of any significant increase in public demand for dental services. A second is that the distribution of dentists ranges from overpopulation in some areas to undersupply in others.

In addition to the above factors, another must be underscored—widespread public apathy toward dental care. A recent public survey conducted by Opinion Research Corporation and the ADA Bureau of Economic and Behavioral Research showed that while 85% of respondents said a person should go to the dentist at least once a year, only 54% of them in 1977 actually did so. The chief reason why the remaining 46% did not, was that they simply "felt no need to go." Over the years, survey after survey has confirmed the finding that despite widespread public awareness of the efficacy of regular dental care, a large percentage of the public fails to translate this awareness into personal behavior. This is not to say that attempts to motivate people through public education do not work. Indeed, during the past two decades, the proportion of the public seeking dental care annually has climbed dramatically—from 40% in the 1950s to 54% today. Certainly, the massive ongoing public education efforts of several Association agencies have contributed to these gains.

In another report to this House of Delegates, the Board of Trustees describes its intention to move forward with a massive Association effort to achieve "Prevention and Control of Dental Disease Through Improved Access to Dental Care." With respect to this new effort, the Board believes the fact that each year little over half of the population visits a dentist is justification

alone for intensifying Association efforts to motivate more Americans to seek regular dental care for their families. However, two recent developments add a sense of urgency to this cause: (1) the fact that many regular dental patients now appear to be postponing dental visits because of difficult economic times and (2) the fact that dentists in many communities throughout the country can and want to treat more patients.

At its March session, the Board of Trustees directed staff to "develop a program to increase the public's awareness of the need for dental care." Pursuant to that directive, a framework for a total communications program to boost public demand for dental services has been developed. Under this framework, ongoing communications programs of the Association are being refocused and new programs are being formulated. As part of this effort, the Board commissioned a Chicago-based advertising agency to develop a proposal for an ADA-sponsored advertising program. The proposal was reviewed extensively by the Board at its October session and endorsed. Because of the large sums involved, the Board is requesting House approval of the concept and initiation of an institutional advertising program.

Why a National Advertising Campaign: In those areas of the country where dentists are not busy enough, ADA members are clamoring for action, and many are turning to organized dentistry for expedient measures to counteract the decline in patient loads. Adding to the concern of some practitioners is the fact that, particularly on the East and West coasts, dentist advertising has become more prevalent, and advertising for department store clinics is especially heavy. Many practitioners see advertising as a costly, but highly effective, marketing tool that is beyond the reach of the average dentist. The idea that the local or state society might sponsor advertising has stirred many practitioners to seek sponsorship of institutional advertising programs by their state and local societies.

In response, constituent and component societies in many affected areas are investigating institutional advertising programs, and several have gone forward with such programs. Advertising programs already implemented by dental societies will be reviewed later in this report. For some, this has meant an increase in membership dues, an assessment on the membership or both. Still other societies have turned to the ADA for answers.

Well aware of the growing ferment over institutional advertising, the ADA Board at its March session directed ADA staff to develop guidelines for institutional advertising by dental societies. Eventually these guidelines took shape as a comprehensive packet of materials which included, among other things, sample ads which the Board views as professionally, legally and esthetically acceptable. The packet was approved by the Board at its August session and mailed to all constituent societies immediately thereafter. Additional copies are available to all component societies upon request. In order that the House may have an opportunity to review the advertising guidelines, sample packets will be distributed to the delegates at the first business session, Sunday, October 21.

At its August session, the Board also initiated consideration of a national advertising campaign. There are a variety of concerns which prompted this:

The busyness crisis, though by no means national in scope, appears to be affecting substantial numbers of ADA members and also appears to be spreading. Originally, the crisis appeared to be confined to the East and West coasts, where large concentrations of ADA members reside. More recently, however, dentists in other regions of the country—particularly the Midwest—are experiencing a slowdown in busyness.

Not all state and local societies in affected areas have the resources to launch and sustain a high-impact institutional advertising campaign. Clearly, not all societies have large enough membership bases to adequately support an advertising campaign. Many that might be able to afford the cost of advertising might not be able to afford the additional cost of researching the effectiveness of the ads. Without some measurement of effectiveness, thousands of dollars may be wasted on advertising that fails to achieve the desired impact. The Association's national advertising campaign would include a substantial research component that would enable fine tuning to improve effectiveness. That research component is described later in this report.

The individual dentist's dollar would go much farther in a national campaign than in a regional or local campaign. The efficiencies of national vs. regional advertising are huge in most media. In magazines, they are enormous. For example, a national page in *Time* magazine reaches readers at a cost of $1.94 per thousand. A full-page ad in the Kansas edition of *Time* reaches readers at a cost of $4.85 per thousand. Therefore, ADA members would get more for their dollar from a national campaign than a campaign sponsored by their constituent society. In addition, those constituent and component societies that wish to augment the national campaign with local placements would avoid agency fees and would incur only the cost of the placements.

Advertising is an essential link in a total communications program to motivate more Americans to seek regular dental checkups. Advertising is not a panacea. Yet, it is an extremely important component in a total communications program to motivate more Americans to seek regular dental care. If used effectively, advertising can help motivate people to spend their money on a specific product or service. It offers what no other communications device can—absolute control over the message, the medium and the frequency of exposure. At the same time, it should be recognized that advertising will rarely change people's behavior except over time and at great cost. Despite the large expenditures involved, the Board believes the Association's program to motivate more people to seek regular checkups cannot fully achieve its objectives without a national advertis-

ing component.

The ADA should assume a leadership role in presenting a united approach to this problem which greatly concerns its members. The Board believes the Association would be remiss if it did not take prompt action to address what appears to be a growing crisis. The Board has taken steps already to provide expert counsel and guidance to those societies contemplating institutional advertising. Yet, unless the Association undertakes a national campaign, the burden of initiating advertising programs will be placed upon the shoulders of state or local societies. Many societies simply do not have funds to support such a campaign, and only a handful of constituent societies have the staff expertise to adequately evaluate the work of an advertising agency. In addition, serious legal risks can be involved. Perhaps most importantly, leaving the burden of advertising to constituents and components would represent a fragmented approach to what may well turn out to be a national problem.

A national advertising campaign augmented by state and local placements would have far greater impact upon the public than a variety of advertising messages sponsored by different state and local societies. Advertising works best when the same simple message is repeated over and over. A national campaign, obviously, would reach many more Americans far more efficiently than ad campaigns sponsored by state and local societies would collectively. But, perhaps the biggest advantage of a national campaign is that people's exposure to a single, focused message can be increased times over with supportive media and billboard placements by state and local societies.

Each of the above concerns figured in the Board's decision to propose a national advertising program. Details of that program are outlined later in this report. First, however, information is provided on two topics which give added perspective to the Board's decision to propose a national advertising program: (1) the number and types of advertising programs already being sponsored by state and local dental societies, allied dental organizations and various professional associations and (2) potential ramifications of ADA sponsorship of an institutional advertising program.

Advertising Programs of Other Dental and Professional Associations: During the past year, nearly a dozen state and local dental societies have seriously considered the possibility of institutional advertising. Several have actually initiated programs that range from outdoor advertising only (billboards and bumper stickers) to those that use television advertising as part of a total communications program. Research on the effectiveness of such programs also has varied. Some societies are simply measuring the impact of their advertisements on public attitudes about dental care, while others are measuring the impact on dental visits.

Perhaps the best measured of these dental society programs is one cosponsored by the California Dental Association and the Sacramento District Dental Society during the first half of 1979. The $70,000 project involved a six-month test of an integrated communications program that included a paid advertising component. The bottom-line objective of the project was to increase dental office visits. Included within the communications program were the following components: school screenings, preschool dental health education, a speakers bureau, spokesmen placement, media relations, dental office mailings to patients of record, a seminar on patient communications, billboards and 10-second "I.D." television commercials.

Research on the effectiveness of the program included three elements: (1) a public survey measuring awareness and attitudes before and after the campaign, (2) in-office patient views surveys conducted near the end of the campaign and (3) patient volume data collected from 100 dentists before, during and after the campaign. The results of the patient volume study showed a dramatic 7% to 10% increase in patient visits among dentists participating in the study. In dollars and cents that represents an increase of more than $2 million in business for Sacramento dentists. But while dental visits jumped significantly, the researchers found no measurable change in public attitudes toward dental care. Although the impact of the various components of the campaign on dental visits was not measured, the public survey and the in-office patient survey showed above average recall of the TV and billboard ads. Because the Sacramento pilot was so successful, the California Dental Association has approved $50,000 toward a similar $150,000 campaign in a second city in the state.

Allied dental organizations, too, are looking very hard at institutional advertising. The Academy of General Dentistry and the American Academy of Periodontology currently are conducting marketing studies, and the American Association of Orthodontists will launch a two-year, national advertising program in November at a cost of $2 million each year. Funds for the program will come from a dues increase and a membership assessment. The AAO program will utilize only print media in a paid advertising campaign, while at the same time expanding its existing public service announcement program in radio and television. The purpose of the campaign is twofold: (1) to inform the public that the function of the orthodontist is not just to improve people's appearances, but more importantly to improve their health, and (2) to inform parents of the need for children to have an orthodontic checkup. Hence, the message carried by the print advertising campaign is "We shape health, not just teeth."

In the first year, print ads will appear in *Better Homes and Gardens, Good Housekeeping, Parents, People* and *Reader's Digest* between the months of November and July. With a total of 23 insertions in these publications, the AAO estimates it will reach 75% of all parents an average of five times each. Research on the effectiveness of the AAO ads will concentrate on public awareness and attitude measurement. The AAO does not plan to measure any impact on patient visits.

Outside the field of dentistry, more and more professional associations are launching institutional advertising programs. Following are descriptions of just a few of these programs:

American Optometric Association: The AOA is in the second year of a two-year national advertising program designed to position the optometrist as the primary care provider for vision care. Funding for the $3 million program was provided through assessment on its membership. In its first year, the campaign included advertising on prime-time television. However, in the second year, only print advertising is being used.

American Medical Association: The AMA in 1978 ran an $800,000 print advertising program in major national news publications. The purpose of the eight-ad campaign was to "help provide a positive climate for the effective practice of medicine." Research on the eight-ad campaign was limited to readership studies.

American Bar Association: Because recently about 60% of state bar associations have become involved with advertising programs, the ABA has established a Commission on Advertising to study both the ad programs of state bars and those of other national professional associations. The Commission has hired an outside research firm to collect information concerning the purposes and perceived effectiveness of such programs. Results of the study will be available by year end. Of some 20 national professional associations contacted thus far, the firm has found that all are at least investigating the possibility of institutional advertising, and many have launched or intend to launch major advertising programs.

To sum up, professional associations—including dental societies—are spending hundreds of thousands of dollars on institutional advertising programs designed to achieve a wide variety of ends. The phenomenon of institutional advertising by professional associations is a relatively new one, and it is difficult to predict whether it is just a passing fad or a trend that is here to stay. It is interesting to note that with the exception of the CDA Sacramento pilot, none of the programs discussed used advertising for conventional purposes—namely, to sell a product or a service to the public. Instead, they attempted to enhance the image of the particular profession or correct some public misconception. The Board believes that because the ADA program—like the Sacramento pilot—uses advertising in a traditional, time-tested fashion, the expenditure of the large sums involved is even more justified than in some programs undertaken by other professional groups.

Potential Ramifications: Widespread institutional advertising by professional associations is so new that the full gamut of ramifications has not been exposed. There are three known potential risks of which the House should be aware. They are as follows:

Legal Vulnerability: Several federal agencies could be involved in the regulation of institutional advertising. The Federal Trade Commission Act prohibiting "unfair methods of competition and unfair or deceptive acts or practices" is applicable to institutional advertising. The Sherman Act, enforced by the Justice Department, also could apply to association advertising activities. This act is designed to assure equality of opportunity among business competitors and to protect the public from monopolies and combinations which destroy competition. If the mails are used as part of an advertising campaign, the Post Office also has a regulatory interest. Because improper use of the institutional advertising may involve serious legal risks, the Association has prepared "Guidelines on the Legal Parameters of Institutional Advertising" as part of the packet of materials developed for dental societies. Among the basic tenets of the legal guidelines are the following recommendations:

1. Any institutional advertising should be designed to encourage the use of professional services and not the patronage of individual dentists, members or otherwise.
2. No derogatory references to other types of delivery systems should be contained in the ads.
3. Advertisements should not specifically promote "private practice" or "traditional delivery systems."

The guidelines also recommend that legal counsel be consulted on the visual, audio and written content of the advertising.

IRS Audits: Improper use of institutional advertising also may prompt audits by the Internal Revenue Service that eventually could threaten the nonprofit status of the audited association. The IRS might question the propriety of professional associations conducting advertising campaigns on behalf of association members only or on behalf of only certain segments of the membership. At a recent gathering of public relations professionals from across the country, it was reported that the IRS plans to audit 1,100 associations and trade unions under Section 162 of the IRS code, which prohibits a tax deduction for activities designed to influence opinion on legislative or controversial matters. It was also reported that IRS may be interested in determining whether association paid advertising designed to increase the business of members is a legitimate tax-exempt activity.

Loss of Public Service Air Time: Currently, the Association receives about $14 million worth of free air time as a result of its $70,000 program of public service announcements (PSAs) for television. In addition, a new radio series of PSAs featuring national celebrities promises to net millions of dollars more in free air time. The ADA spots appear on the three major television networks and 550 out of approximately 700 television stations across the country. Surveys of the TV stations receiving the ADA messages show they are extremely well received. In the most recent survey, 94% of respondents said they broadcast the dental messages regularly.

There is no question that a paid advertising program—especially broadcast advertising—poses a serious threat to the $14 million the Association currently receives in network and local public service time. An outside media consultant who works with the Association recently queried public service executives from two national networks concerning the effect of advertising on PSA time. Although neither network had any written policy in this area, there was patent agreement as to the "unofficial policy." As one network executive put it: "If they buy network advertising, we pull their PSAs right off." Executives of both networks cited the same cases in point, the U.S. Navy and Army, which began national TV advertising programs and subsequently lost all network PSA time. The ADA now receives more than $2 million in network PSA air time each year. Many local stations, too, are likely to follow the example of the networks with regard to cancellation of PSA time.

At the same time, it must be recognized that television advertising is without question the most powerful and efficient marketing medium available. PSAs simply cannot accomplish what TV advertising can. Television can deliver numbers—increased sales—far more quickly than even print advertising. In fact, its impact is almost immediate. Furthermore, the content of advertising messages is by nature marketing-oriented and self-serving. Conversely, the nature of the public service market dictates that PSAs can in no way appear self-serving. Therefore, the ADA PSA spots cannot merchandise dental services to the public.

Perhaps the most important distinction between paid broadcast advertising and PSAs is the element of control. The Association has absolutely no control over the placement of its PSAs. When and how often they are broadcast depend entirely upon the whims of network and local programmers. The ADA spots have been shown at 1 AM, but they also have aired during the Superbowl and the Today and Tonight Shows. With television advertising, it is quite the opposite. The sponsor has total control over both message content and placements.

The potential loss of both network and local PSA time was a secondary consideration in the Board's decision to propose a cautious, test-market approach to television advertising. Other factors which figured in this decision are outlined later in this report.

The Proposed Advertising Program: Following is the Board's proposal for an advertising campaign that would be an integral part of the Association's total communications program to stimulate more Americans to seek regular dental care. The proposal calls for a national advertising program in print media and a three-city test market of television commercials. Created for the Association by Dawson, Johns and Black, a Chicago-based advertising agency, the proposed campaign could cost the Association up to $2 million in 1980. The bottom line of the ad program, of course, would be to increase dental visits. However, it must be recognized that a regular dental checkup is not a commodity purchased at the grocery store every week. Most people need a dental checkup only once or twice a year. Because of this, the advertising must be sustained over a minimum of two years in order to be effective. At the same time, the advertising cannot be expected to have a significant statistical impact on dental visits for at least one year.

The Campaign Concept: In designing the actual print and test-market television ads, Dawson, Johns and Black utilized the conceptual framework for a massive communications program to boost dental visits that was developed earlier this year by ADA staff. That framework cites two objectives for a total communications program:

1. To increase the value which the public places on oral health and preventive dental care.
2. To increase public awareness of and demand for dental prepayment programs.

Although the advertising campaign will be directed more toward achieving the first objective, the second objective also will be reflected in the campaign. Samples of the print advertisements are included in the advertising packet distributed to the House. Following is the ad agency's own description of the creative concepts behind the campaign:

Consumer Marketing Objective/Strategy: The objective of the advertising program is to increase the number of dental appointments by:

1. Increasing regularity of dental visits among current patients, and
2. Increasing the number of dental patients.

This objective, we believe, will be accomplished if we are successful in increasing the value the public places on dental care.

A secondary objective will be to increase the awareness of and demand for dental prepayment programs.

Consumer Communication Objective: The message we will concentrate on delivering should convince people that regular dental care will improve the overall quality of their lives as noted earlier.

The primary target market for this message will be adults first, and adults who are also parents, second. We will be trying to reach people who already know the value of dental care and usually go to the dentist but have been postponing their next visit. In addition, our target will include parents who know their children should have regular checkups but have been postponing the next appointment.

Thus, our most easily motivated market will be people who are already familiar with dental care. At the same time, the advertising message will be equally meaningful to those who are not currently dental patients.

Copy Strategy: The purpose of the advertising is to convince adults of all ages and walks of life that regular visits to the dentist will make them feel better about themselves.

Support for this claim will come from the fact that people always feel better about themselves when they take care of themselves, e.g., appearance is improved, teeth are healthier and future dental problems are prevented.

There are four critical ingredients in the advertising.

1. Feeling better about self. Major research, including studies by ADA, document the importance of the quality of life—from the standpoint of appearance, social acceptability and success in one's employment.

Lifestyle studies show: people want to feel good about themselves and they feel better about themselves when they take care of themselves. Regular dental care contributes to all of the above.

2. That certain radiant look. That's the look and feeling you have when one has that nice, self-confident feeling of having taken care of yourself. It's very similar to "Look, Mom, no cavities!"

3. Get it . . . regularly. A campaign like this needs a call to action, so the copy is as direct as possible.

4. The economic/cost mention. It's essential that people be reminded of dental costs in relevant terms they can understand.

Comparisons with other personal or household expenditures which are less likely to be postponed will position dental costs in a more familiar framework.

The question has been raised as to why the advertisements are not more "hard sell." In the agency's judgment, the way to "sell" dental care is the same way used to sell consumer products or other services—with a positive statement of what the consumer/patient will get for his money—in this case, a good feeling about being in good health.

Before the campaign is launched, the ads would undergo a series of pretests to gauge public reaction. The pretests provide an opportunity for troubleshooting any problems and for fine tuning copy for maximum effectiveness. The first pretest of the ADA ads demonstrated that they communicate the message exceptionally well. An unusually high rate of respondents—nearly 90%—properly identified the purpose of the ad—to encourage regular dental checkups.

National Print Media Plan: As was previously mentioned, there is tremendous agitation among a sizeable portion of the membership for an ADA-sponsored institutional advertising program. The Board has carefully weighed the reasons behind this sentiment and believes it is essential that the Association act with great expediency to launch such a program. Unfortunately, this poses a dilemma for the Association. Clearly, the membership wants a program that has national visibility. At the same time, it must be recognized that a full-scale advertising program in both print and broadcast media would cost the Association a minimum of $5 million and could cost up to $10 million. Although television is the most compelling advertising medium available, it is also by far the most costly. Magazine advertising is less costly and can achieve as much impact as television, but only after a longer period of time. In considering the various alternatives, the Board decided it was important to present to the House a media plan that answered the demands of the members, and yet did not overcommit Association funds to an unproven ad campaign. Therefore, the Board is proposing for House of Delegates' consideration a 1980 national advertising campaign in major consumer magazines and a three-city test market of television advertising. The Board believes this represents a rational, balanced approach to an experimental program.

Following are the specifics of the print media campaign:

Media Objectives

1. Provide advertising with sufficient reach and frequency to establish public awareness of our message.
2. Direct the advertising to adults, primarily women and secondarily men.
3. Concentrate the advertising into six months of the year to achieve greater impact during advertising periods.

Media Strategies

1. Utilize the national magazines which are most efficient in their delivery of readers.
2. Advertise in two periods:

   January, February, March, April
   August, September, October

   Spring and fall were selected because they represent periods of renewal in the minds of the American people. These are the times of year when the new fashion lines appear in department stores, when people plan vacations and think about back-to-school. By concentrating the advertising into these periods, it will help build dental office traffic when people are most likely to make appointments.

Selected Publications

The magazines selected for the ADA campaign are among the most well read in the world: *Reader's Digest, TV Guide, Time, Newsweek, Women's Day, Family Circle.* These magazines were selected from a list of 15 major publications on the basis of their female readership and overall cost per thousand. Newspapers and outdoor advertising were ruled out for the media plan because of high cost. For example, one full-page ad in newspapers in the top 200 U.S. markets would cost three-quarter million dollars alone.

A computer was used to determine the optimum number of insertions in each of the selected magazines. The computer was programmed to weight the plan 60% to the female adult audience and 40% to adult males, because women more often tend to be the family decision-maker for health care needs. A summary of the computer's optimum plan for the ADA program follows. This plan will reach 86% of the public on an average of six times per person.

Summary of media plan

Magazine	Number of insertions	Reach	Frequency
Reader's Digest	6		
TV Guide	7		
Newsweek	5	85.9%	6.05
Time	5		
Women's Day	5		
Family Circle	3		

Test Market of TV Ads: While television is the most potent marketing tool around, it is also by far the most costly. A national advertising program that emphasizes network television placements would cost the Association a minimum of $5 million a year and could cost up to $10 million annually. Furthermore, in order for the program to be effective, those spending levels would need to be sustained over a minimum of two years. Because of the enormous costs involved, the Board is proposing that television commercials be test marketed in three cities in conjunction with the 1980 national print campaign. The purpose of this test-market strategy would be twofold: (1) to evaluate whether television advertising would be worth the enormous expenditures involved on a national level and (2) to evaluate the impact of TV advertising on a more secondary consideration—the potential loss of several million dollars for free PSA time on local stations. The Board believes that the three-city test market is a rational approach to a delicate predicament.

The test market cities would be approximately equal in population—600,000+. Each city would be fairly representative of the national picture in terms of population demographics, family income, television viewing levels, economic variables and media availability and exposure levels. Combined, the test market areas would equal more than 2% of the national market and would provide a broad enough basis for a national projection.

The selected test markets also meet other desirable criteria. By using three cities, the chance of results based on atypical response is reduced. In addition, there is good geographic spread between test markets and each is fairly isolated from outside media influences that could cloud interpretation of results.

The combined impact of the national print placements and TV placements in the test markets would simulate the national equivalent of a $5 million advertising campaign in all media.

Research: Because the advertising program would involve a substantial outlay of Association funds, the Board has placed a premium upon evaluation of the advertising's effectiveness in stimulating dental visits. Consequently, both the national print campaign and the three-city test market of television advertising would include an extensive research component designed by Market Facts, Inc., a Chicago-based marketing research firm, and the ADA Bureau of Economic and Behavioral Research. Results of the research would be reported to the House and used to make adjustments in the future direction of the program.

Evaluation of the ADA advertising program would be based upon a national tracking study using a mail panel of 4,000 households. The study would use a proportionately larger sample of households in the three test-market cities. Essentially, the sample will be representative of all U.S. households but may be slightly weighted to the core target audience of the advertising—dental patients who have postponed or delayed checkups as a result of inflation. The large size of the sample would make it possible to detect small changes in the pattern of U.S. dental visits. The tracking study would measure the following: changes in number of dental visits, changes in public attitudes toward dental visits, the effectiveness of the advertising and attitude and behavior changes related to exposure to media carrying the campaign.

A benchmark survey that would provide a reference point for further measurement would be conducted immediately prior to the first ad placements in January 1980. Follow-up surveys would be conducted at six-month intervals and results from the first four months' advertising would be reported to the August Board of Trustees and to the 1980 House of Delegates. Concomitantly, the ADA Bureau of Economic and Behavioral Research would conduct a national survey of patient flow in dental offices. The first survey in January 1980 would serve as a baseline for yearly surveys. Two additional studies would be conducted in the test market cities. One would survey a representative sample of dentists to obtain information on patient flow. A second would measure the effect of paid advertising on the amount of time donated to public service messages on dental health.

According to Market Facts, a 2% to 3% annual increase in dental visits on a national level would represent a dramatic increase. The research experts also pointed out that if the economy takes a severe downward turn, simply maintaining the current level of dental visits would reflect positively on the advertising. To filter out the effects of economic shifts, the survey would include questions pertaining to the use of other preventive or discretionary services.

Summary: Previously, the Association has used advertising only in relatively small-scale efforts. In 1975, it published a 12-page advertising supplement in the *New York Times Magazine*. In 1977, it ran three ads, one time each, in *Time* and *Newsweek*. In both cases the advertising was designed to enhance the image of the profession. Never before has the Association used advertising for what advertising does best—selling a service to the public.

Today, a sizeable portion of the Association's membership perceives an urgent and immediate need to stimulate more Americans to seek regular dental care. In light of this, the Board of Trustees is committed to a total communications program in which the bottom line is

increased dental visits. Furthermore, the Board believes an institutional advertising campaign is fundamental to the success of this total communications effort.

As indicated earlier in this report, national, state and local dental societies are either advertising or seriously considering it. In order to make the total effort more productive, in order to assure maximum effectiveness can be realized for the dollars spent, the Association has invited all interested groups to a meeting in connection with the National Conference on Dental Public Relations November 11–12. In this way it is hoped that there can be some measure of cooperative coordination and that the total effect can be more beneficial for the profession and the public.

This report has documented strong membership sentiment for an institutional advertising program and the reasons that prompted it. In the Board's view, there is no question that an ADA-sponsored advertising campaign must be launched in 1980. However, advertising is an extremely costly undertaking and the Board believes such a program should be viewed as experimental. The Board believes the proposed advertising plan represents a balanced approach that meets the following criteria:

Provides the immediate national visibility that the members want.

Does not overcommit Association funds to an unproven ad campaign.

Provides an opportunity for evaluating the most cost-effective media mix for future year.

If adopted by the House, the advertising campaign would cost the Association up to $2 million in 1980. It must be recognized, however, that to properly evaluate the effectiveness of any ad program, a minimum two-year commitment is needed. Funds for the 1980 ad program would be placed in the budget of the Executive Director's Office and would be administered by the Board of Trustees. Following is one possible configuration of these expenditures. The Board could find it necessary to make adjustments and refinements in the budget configuration based upon early research results.

National media plan and test market plan 1980 budget

National print plan		
Media (magazines)	$1,483,000	
Production	143,000	
Research	50,000	
Production/inventory of promotion and merchandising	74,000	
Total national plan		$1,750,000
Test market plan (three cities)		
Media	$120,000	
Production of commercials	100,000	
Talent residuals	5,000	
Research effectiveness	25,000	
Total test market plan		$ 250,000
Total budget		$2,000,000

The following resolution is presented with the Board's recommendation that it be approved.

113. Resolved, that the Association adopt the concept of institutional advertising, and be it further

Resolved, that the Association initiate an institutional advertising program at a cost of up to $2 million in 1980.

REPORT 10 OF BOARD OF TRUSTEES TO HOUSE OF DELEGATES: FURTHER RECOMMENDATIONS ON REPORTS AND RESOLUTIONS

The following are comments of the Board of Trustees on reports and resolutions which will be considered by the House of Delegates.

Prosthetic Services and Dental Laboratory Relations, Council on, Supplemental Report 2—Legislative Update and Council Actions (*Supplement* 2:393/Resolution 71): The Board concurs with the Council and *recommends that Resolution 71 be adopted.*

District of Columbia Resolution on Amendment of "Manual of House of Delegates" Regarding Motion to Recommit or Refer (*Supplement* 2:402/Resolution 75): The Board reviewed Resolution 75 submitted by the District of Columbia Dental Society which recommends a change in the *Manual of the House of Delegates* to allow the motion to recommit or refer to an agency by a Reference Committee to be debated in accordance with the rules governing the debate of a motion. The Board had an extensive discussion relative to the merits of this proposal. The Board believes that a valid point can be made that unless the House has an opportunity to debate a resolution on its merits it may not be able to assess the motion to refer. However, the Board believes that the interests of the House, in terms of time and the expeditious handling of the voluminous work before it, can best be served by retaining the present procedure, as specified in *Sturgis*. Therefore, *the Board recommends that it be postponed indefinitely.*

Iowa Resolution on Contractual Obligations with HEW and Dental Educational Institutions—Substitute for Resolution 31 (*Supplement* 1:285/Resolution 31): The Board was advised by legal counsel that Resolution 31 could be interpreted as an instruction to the Association to intervene with governmental agencies to permit dental schools to limit increases in enrollment. Such activity by the American Dental Association could be regarded as restraining competition within the dental profession. Therefore, the *Board recommends the approval of Resolution 31B as a substitute for Resolution 31.*

31B. Resolved, that the American Dental Association seek reevaluation of the United States Department of Health, Education, and Welfare's contractual obligations existing with dental educational institutions through administrative and/or legislative procedures to minimize the adverse impact of those obligations on the quality of dental educational programs.

Indiana Resolution on the Creation of a Commission on National Dental Examinations—Substitute for Resolution 16 (*Supplement* 2:402/Resolution 16S–1): The Board believes that the voting representation included in the National Board proposal strengthens the profession's posture. It was noted that the National Board Examination Program revision closely parallels the restructure of many licensing jurisdictions which have broadened representation.

The Board is of the opinion that the National Board reorganization proposal, if adopted by the House of Delegates, would:

1. Strengthen the National Board position externally since all of the groups affected by the examinations would be included on the governing Commission.
2. Strengthen the National Board examinations' ability to withstand a challenge of a competing testing program.
3. Gain additional allies and structural validity in any potential challenge from other agencies regarding the autonomy, objectivity and accountability of the National Boards within the system of state licensure.

Admittedly, the Board is concerned with the profession retaining fair and legitimate involvement in the National Board Examination Program. It recognizes the philosophy expressed by the Indiana Resolution but believes that the consultant status for the broader representation will not sustain itself or provide needed strength to forthcoming challenges. *Therefore, the Board recommends that Resolution 16S–1 be postponed indefinitely.*

Indiana Resolution on Amendment of Chapter VI, Section 70, of the "Bylaws"—Board of Trustees—Substitute for Resolution 66 (*Supplement* 2:404/Resolution 66S–1) and **Fifth Trustee District Resolution on Amendment of Chapter VI, Section 70, of the "Bylaws"—Board of Trustees—Substitute for Resolution 66** (*Supplement* 2:413/Resolution 66S–2): The Board has carefully reviewed Resolution 66, Resolution 66S–1 transmitted by the Indiana Dental Association which would require the consent and agreement of the constituent society for an appointment of an active or life member to substitute for a trustee absent from a Board session, and Resolution 66S–2 transmitted by the Fifth Trustee District which would require such appointment to be the chairman of the district caucus or delegation, where such exists. The Board believes that the veto power which the Indiana proposal would grant to the constituent society could create logistical problems which might inhibit the work of the Board of Trustees. Therefore, *the Board recommends that Resolution 66S–1 be postponed indefinitely.* Further, the Board believes that Resolution 66S–2 would take away from the President of the Association his prerogative to select the substitute Trustee which, in his opinion, will best be able to accomplish the responsibilities of the Board. *Therefore, the Board recommends that Resolution 66S–2 be postponed indefinitely.*

Indiana Resolution on Amendment of "Manual of House of Delegates" Regarding Motions to Adopt, Postpone Indefinitely or Reject Resolutions (*Supplement* 2:404/Resolution 74): The Board has reviewed Resolution 74 submitted by the Indiana Dental Association which recommends the amendment of the *Manual of the House of Delegates* by the deletion of the paragraph entitled "Motions to Adopt, Postpone Indefinitely or Reject Resolutions." The Board notes that this matter has been debated previously in the House of Delegates. It should be noted, further, that the Speaker of the House sought the advice of others skilled in parliamentary procedure. The consensus is that the House would best be served by retaining its present utilization of the motion to postpone indefinitely. Therefore, the *Board recommends that Resolution 74 be postponed indefinitely.*

Michigan Resolution on Definition of Private Practice (*Supplement* 2:405/Resolution 72) and **Twelfth Trustee District Resolution on Definition of Private Practice** (*Supplement 2*: 421/Resolution 91): The Board of Trustees carefully considered the definitions of private practice offered by Michigan Dental Association Resolution 72 and Twelfth Trustee District Resolution 91 and observes that nothing contained in either definition obviates the concerns expressed by the Council on Dental Health and Health Planning and the Association's Chief Counsel in 1978 (*Supplement 1, 1978*:180). The Board believes, however, that a definition of private practice would be useful. In its discussion of this matter it received a number of additional suggestions, such as, "All practicing dentists who are not in the employ of the federal, state, county or local government or its commissions, bureaus or agencies or under contract thereto are in private practice." *It is the Board's recommendation that, in concert with study of the entire issue, both Michigan Resolution 72 and Twelfth Trustee District Resolution 91 be referred to the appropriate agency of the Association for study and report back to the 1980 House of Delegates.*

Michigan Resolution on Definition of "Usual Fee" (*Supplement* 2:405/Resolution 76): The Board of Trustees reviewed Michigan Resolution 76 calling for an amendment to the Association's definition of "Usual Fee" (*Trans.1973*:668) to include the concept of receipt of the fee usually charged and agrees that this amendment significantly improves the current definition. The Board wishes to amend this resolution by changing "usually" to "most frequently" and deleting "i.e., his own usual fee" in order to avoid defining a term by using the words in the term. *The Board, therefore, recommends that the amended resolution be adopted.*

76B. Resolved, that the definition of Usual Fee (*Trans.1973*:668) be modified to read as follows:

> *Usual Fee:* A Usual Fee is the fee most frequently charged *and received* for a given service by an individual dentist.

Tennessee Resolution on ADA Input into Interpretation and Implementation of Laws (*Supplement* 2:405/Resolution 56): The Board reviewed the background statement and Resolution 56 submitted by the Tennessee Dental Association. The Board appreciates the concern of the Tennessee Dental Association for insuring that the American Dental Association have an effective impact upon federal regulations implementing major health laws. The Washington Office has borne this responsibility in an excellent fashion and has reported the results of its efforts in the Washington Bulletin and other ADA media. *The Board, therefore, believes that Resolution 56 is redundant and recommends that it be postponed indefinitely.*

Washington Resolution on Veterans Administration Dental Fees (*Supplement* 2:406/Resolution 101): The Board believes that the objective of Resolution 101 might have better acceptance if its emphasis is more clearly identified with the military veterans' entitlement to quality dental care. *The Board recommends that the following substitute for Resolution 101 be adopted.*

101B. Resolved, that in order to insure that military veterans receive the dental benefits to which they are entitled, the Veterans Administration be urged to upgrade the outpatient program on a regular basis, including equitable adjustments in compensation paid to participating dentists.

First Trustee District Resolution on Inclusion of Health Maintenance Organizations in the Certificate of Need Requirement (*Supplement* 2:406/Resolution 88): The Board agrees that certificate of need requirements should be applied to the establishment of Health Maintenance Organizations and *recommends approval of Resolution 88.*

First Trustee District Resolution on Removal of Support for Fee-for-Service Dentistry Appended to Health Maintenance Organizations (*Supplement* 2:407/Resolution 89): The Board agrees with the intent of Resolution 89 as set forth in its preamble but believes that the language of the resolution requires clarification and *therefore recommends the following substitute resolution.*

89B. Resolved, that the American Dental Association seek legislative or administrative action to prohibit the use of federal funds by Health Maintenance Organizations to support dental care programs that are open to the general public on a fee-for-service basis.

First Trustee District Resolution on Involvement of Constituent and Component Dental Societies in the Designation of Shortage Areas (*Supplement* 2:407/Resolution 90): *The Board recommends approval of Resolution 90.*

Second Trustee District Resolution on Suspension of "Leadership Bulletin" (*Supplement* 2:407/Resolution 95): The Board of Trustees agrees with the intent of Resolution

95. When the *ADA News* becomes a weekly in 1980, the *Leadership Bulletin* should cease publication. However, the Executive Director has appointed a staff committee, chaired by the Association's Editor, to study the impact on all Association publications of a weekly *ADA News*. In addition to the *Leadership Bulletin*, this includes newsletters published by the Council on Dental Health and Health Planning, the Council on Dental Care Programs, the Washington Office, etc. This report will be presented to the Board of Trustees in December for action. Therefore, *the Board recommends that Resolution 95 be referred back to the Board of Trustees for action in December after it receives the special publication report.*

Fifth Trustee District Resolution on Request for Definition of "Routine Procedures"—Substitute for Resolution 20 (*Supplement* 2:410/Resolution 20S–1): The Board believes that its recommendation for referral of Resolution 20 to the Council on Bylaws and Judicial Affairs is the appropriate means for implementing Resolution 20. *The Board, therefore, recommends that Resolution 20S–1 be postponed indefinitely.*

Fifth Trustee District Resolution on Irregularity in Billings Submitted to Third Party Dental Plans—Substitute for Resolution 23 (*Supplement* 2:411/Resolution 23S–1): The Board approves of Resolution 23S–1 as a substitute for Resolution 23 and 23B and therefore *recommends that Resolution 23S–1 be substituted for Resolutions 23 and 23B and that the substitute resolution be adopted.*

Fifth Trustee District Resolution on Cervical Back Strain in Dentists—Substitute for Resolution 38 (*Supplement* 2:411/Resolution 38S–1): The Board is of the opinion that Fifth Trustee District Resolution 38S–1 that calls for an investigation and reporting of a variety of occupational hazards related to the practice of dentistry, while of merit, calls for a study that is substantially beyond the current personnel and budgetary capabilities of the Association. *Consequently, the Board recommends that Resolution 38S–1 be postponed indefinitely.*

Fifth Trustee District Resolution on Uniform Procedures for Coordination of Benefits of Prepaid Dental Programs—Substitute for Resolution 49 (*Supplement* 2:411/Resolution 49S–1): The Board of Trustees notes that the point made in Fifth Trustee District Resolution 49S–1 that responsibility for the coordination of benefits rests with carriers not dental offices is a valid one and *recommends that Resolution 49S–1 be substituted for Resolution 49* (*Supplement 1*:287) *and that the substitute resolution be approved.*

Fifth Trustee District Resolution on Workshop to Review Report 5—Prevention and Control of Dental Disease Through Improved Access to Comprehensive Care—Substitute for Resolution 55 (*Supplement* 2:411/Resolution 55S–1): The Board of Trustees reviewed and discussed at some length Fifth Trustee District Resolution 55S–1. The Board does not concur with the concerns raised regarding the thoroughness and completeness of Report 5 (*Supplement 1*:324) and is of the opinion that the Report has been carefully developed using acceptable data to describe present dental delivery systems. The acknowledgment of certain deficiencies has been stated for the purpose of establishing benchmarks for program evaluation and should not be considered out of context as open criticisms of the profession. *Accordingly, the Board supports Report 5 and recommends that Resolution 55S–1 be postponed indefinitely.*

Fifth Trustee District Resolution on National Health Service Corps Shortage Areas—Substitute for Resolution 64 and 64B (*Supplement* 2:412/Resolution 64S–1) and **Twelfth Trustee District Resolution on National Health Service Corps—Substitute for Resolution 64 and 64B** (*Supplement* 2:420/Resolution 64S–2): The Board of Trustees considered the Fifth Trustee District Substitute Resolution 64S–1 and the Twelfth Trustee District Substitute Resolution 64S–2 together, since each addresses Resolution 64B (*Supplement 1*:299). The Board agreed that Resolution 64S–2 further clarifies the initial resolution by adding the phrase "after all attempts have been made to fill such needs from the available dentists in each state" to the third resolving clause. The Board took particular note of testimony describing a highly successful dental manpower recruitment and placement program now available for this purpose at West Virginia University and is of the opinion that the policy statement embodied in Resolution 64S–2 appropriately addresses the need for such program implementation. The Board believes, however, that Substitute Resolution 64S–1 tends to specify implementation of efforts which are already underway within the Association and are being given the highest priority by the appropriate agencies of the Association. *Accordingly, the Board recommends that Resolution 64S–2 be substituted for Resolutions 64, 64B and 64S–1 and that Resolution 64S–2 be adopted.*

Fifth Trustee District Resolution on Clarification of Resolution 67H–1977 Regarding the Provision of Denture Treatment—Substitute for Resolution 65 (*Supplement* 2:413/Resolution 65S–1): The Board believes that Board Resolution 65 is preferable to Resolution 65S–1 submitted by the Fifth Trustee District as a substitute. It is essential, in the Board's opinion, that ADA policies be adhered to as far as feasible in the development of curriculum for any legislatively dictated change in the delivery of dental care. *The Board, therefore, recommends that Resolution 65S–1 be postponed indefinitely.*

Fifth Trustee District Resolution on Amendment of "Manual of House of Delegates" Regarding Conduct of Executive Session (Reference Committee) (*Supplement* 2:413/Resolution 93): The Board has reviewed Resolution 93 submitted by the Fifth Trustee District which would amend the *Manual of the House of Delegates*, Conduct of Executive Meeting, to restrict attendance at executive meetings of the

House reference committees to members of the committee, staff resource persons and the committee secretary. In evaluating this resolution, the Board noted the change in this section in the current *Manual of the House of Delegates*. The practice of the reference committees in the past has been to exercise their discretion in inviting persons to provide technical information to the committee while in executive session. The Board believes that the language change presented in the current *Manual* was merely an attempt to clarify, in writing, this past practice which is consistent with *Sturgis (Sturgis Standard Code of Parliamentary Procedure*, 2nd Edition, page 196). Nevertheless, the Board is sensitive to the concern of the House that this language change was not presented to the House for its consideration. The Board believes that this oversight should be corrected by bringing this matter to the House for its consideration. The language of Resolution 93 is exactly the same as that contained in the 1978 *Manual*. It is the intent of this resolution to prohibit anyone from attending the executive meeting of the House reference committee except those persons specified. By offering the language modifications contained in the current *Manual* as a substitute resolution for Resolution 93, the House will have the opportunity to select the manner in which it wishes the reference committee to conduct its business. By adopting the substitute resolution, the House will indicate a preference to allow the reference committee to exercise its discretion in inviting other persons. By defeating the substitute resolution and adopting Resolution 93, it will indicate its preference to prohibit the exercise of such discretion. Therefore, *the Board recommends that the following resolution be substituted for Resolution 93 and that the substitute resolution be adopted.*

93B. Resolved, that the *Manual of the House of Delegates*, page 20, section entitled "Conduct of Executive Session," read as follows:

> *Conduct of Executive Session:* After evidence and information have been received at the opening hearing, the committee shall retire to an executive session to reach its decisions. The report shall be prepared only on the basis of materials dictated by the committee and the committee is solely responsible for the report.
>
> The Executive Director shall designate members of staff to assist each reference committee to the degree that each committee shall request such assistance. Such staff may be at executive sessions at the pleasure of the committee.
>
> The committee is empowered to invite others into the executive session under such conditions as it may set if such invitations are, in the view of the committee, necessary for the proper discharge of its duties.
>
> When it wishes, the committee may exclude from executive session everyone except the members.

Fifth Trustee District Resolution on Individual Trustee Votes on Special Board of Trustee Reports (*Supplement* 2:414/Resolution 94): The Board carefully reviewed Resolution 94 submitted by the Fifth Trustee District which would require individual Trustee votes to be recorded and published in conjunction with Trustee reports and "white papers." The Board would point out that its responsibilities, as Trustees, are to the entire Association and not individual Trustee Districts. In the carrying out of its managerial responsibilities the Board must weigh the merits of proposed activities in light of the best interests of the entire membership. To do so, it must be as free as possible to make its judgments without undue regard to the political considerations of its decision. The recommendations contained in this proposal would tend to enhance the political factors and to inhibit the proper motivational factors. Therefore, *the Board recommends that Resolution 94 be postponed indefinitely.*

Fifth Trustee District Resolution on Comparative Study of Public and Private Dental Care Delivery Systems (*Supplement* 2:414/Resolution 96): The Board of Trustees reviewed Fifth Trustee District Resolution 96 in the context of Supplemental Report 7 of the Board of Trustees to the House of Delegates. The Board is generally in agreement with the need for economic research to describe the comparative efficiencies of the public and private delivery of dental services but is of the opinion that, though considered feasible, the proposed research using the military services for a comparative study is of questionable value and too costly to fund at the present time when considered in the context of other competing projects of greater immediacy. *Accordingly, the Board recommends that Resolution 96 be postponed indefinitely.*

Fifth Trustee District Resolution on Child Abuse (*Supplement* 2:414/Resolution 97): *The Board recommends approval of Resolution 97.*

Fifth Trustee District Resolution on Referral of Resolutions 2, 3, 9 and 10 Relating to Commissions (*Supplement* 2:415/Resolution 102): The Board recommends that Resolution 102 be divided into two separate resolutions, one dealing with action on Resolutions 2, 3, 9 and 10, and one dealing with consolidation of *Bylaw* provisions governing all ADA Commissions. The Board believes that Resolution 102a attempts to dispose of items that should be treated separately. Resolution 102a, in effect, resolves a motion to refer. That motion can be made at the time Resolutions 2, 3, 9 and 10 are presented for House action and *recommends that Resolution 102a be postponed indefinitely.*

102aB. Resolved, that Resolutions 2, 3, 9 and 10 be referred to the appropriate Association agency for study and report back to the 1980 House of Delegates.

The Board recommends that Resolution 102b be approved.

102bB. Resolved, that the Council on Bylaws and Judicial Affairs in its capacity as the Standing Committee on Constitution and Bylaws be requested to develop an appropriate *Bylaw* amendment consolidating all ADA Commissions within a single Chapter of the ADA *Bylaws* for submission to the 1980 House of Delegates.

Eleventh Trustee District Resolution on Development of Newspaper Columns for Use of Constituent and Component Dental Societies (*Supplement* 2:417/Resolution 84): The Board reviewed Resolution 84 and the request for the provision of "camera-ready newspaper columns" to dental societies. The Bureau of Communications now makes available to dental societies typed copies of 25 articles which can serve as the basis for a newspaper column. Additionally, the Bureau distributes a series of camera-ready cartoon messages on dentistry directly to newspapers. The latter has not previously been made available to dental societies. The Bureau reports that the vast majority of newspapers will not use camera-ready columns, simply because the type face will be visibly different from the type face used by an individual newspaper. Rather, these newspapers prefer to receive typed copy which they can set in the same type face used throughout the newspaper. The newspapers will use camera-ready cartoon copy, however.

For these reasons, *the Board of Trustees recommends a substitute resolution for Resolution 84.*

84B. Resolved, that the Bureau of Communications make available to all constituent and component dental societies typed newspaper columns and the camera-ready cartoon messages on dental health.

Eleventh Trustee District Resolution on Timely Remuneration of Subscribers and Providers (*Supplement* 2:418/Resolution 85): The Board is sympathetic to the problem which the Eleventh Trustee District Resolution 85 addresses but contends that the profession and its patients are better served by seeking to rectify administrative failings in dental benefits plans through the Association's Council on Dental Care Programs and counterpart agencies at the constituent society level, as is now being done, rather than by governmental fiat. *Accordingly, the Board recommends that this resolution be postponed indefinitely.*

Eleventh Trustee District Resolution on Inequities in Designation of Manpower Shortage Areas and Assignment of National Health Service Corps Personnel (*Supplement* 2:418/Resolution 86): Resolution 86 from the Eleventh Trustee District dealing with the National Health Service Corps is directly related to Resolution 64B which was submitted by the Council on Legislation and approved by the Board of Trustees which recommends a fundamental response to the problem associated with the NHSC. The Board recognizes the varied situations in which questionable and erroneous designations and assignments have been and are being made under the NHSC program and points out that the Officers and Trustees as well as staff have closely monitored the administration of the program and with mixed success have made intensive efforts to ameliorate the problems that have arisen. The Board assures the members of the House of Delegates that those efforts will be continued and strengthened in connection with the implementation of Resolution 64B and in furtherance of other Association policies such as Resolution 116H–1978 (*Trans. 1978*:503) and therefore believes that the intent of Resolution 86 can be carried out under existing Association policy. *The Board therefore recommends that Resolution 86 be postponed indefinitely.*

Eleventh Trustee District Resolution on Succession of Elected Offices (*Supplement* 2:418/Resolution 87): The Board has carefully reviewed Resolution 87 submitted by the Eleventh Trustee District requiring an amendment to the *Bylaws* to make the office of vice-president the ultimate successor to the office of President after serving a year as vice-president and a year as president-elect. The Board believes that this proposed amendment is of such import that it would be imprudent for the Board or the House to act on it without thorough study and evaluation by the Board. Therefore, *the Board recommends that Resolution 87 be referred to the Board of Trustees for study and recommendation to the 1980 House of Delegates.*

Twelfth Trustee District Resolution on Prototype Dental Components—Substitute for Resolution 7 (*Supplement* 2:420/Resolution 7S–1): In the view of the Board of Trustees, Resolution 7S–1 states even more forcefully than Resolution 7B (*Supplement 1*:298) the inadvisability of using prototype dental components in legislative liaison. *The Board recommends that Resolution 7S–1 be substituted for Resolution 7B and that the substitute resolution be approved.*

Twelfth Trustee District Resolution on Amendment of "Manual of House of Delegates"—Speaking Privileges—Substitute for Resolution 43 (*Supplement* 2:420/Resolution 43S–1): The Board has reviewed substitute Resolution 43S–1 submitted by the Twelfth Trustee District which amends the *Manual of the House of Delegates* by according speaking privileges, as resource persons, on the floor of the House of Delegates to secretaries and executive secretaries of constituent societies; council secretaries; commission secretaries; bureau directors and those members of the administrative staff holding general supervisory positions. The Board concurs with the Twelfth Trustee District and is of the opinion that this substitute resolution clarifies the intent of Resolution 43. Therefore, *the Board recommends that Resolution 43S–1 be adopted.*

Twelfth Trustee District Resolution on Change in Designation of Dental Manpower Shortage Areas (*Supplement* 2:421/Resolution 70): *The Board of Trustees recommends that Resolution 70 be adopted.*

Twelfth Trustee District Resolution on Oral Health Guidelines for Long-Term Care Facilities (*Supplement* 2:421/Resolution 92): The Board acknowledges the importance of the issue stated in the Twelfth Trustee District Resolution 92, but observes that significant efforts are now underway within the Association to address the overall problem of dental care in long-term care facilities. The Board was advised that a new Council on Dental Health and Health Planning manual titled *Oral Health Care for the Geriatric Patient in a Long-Term Care Facility* is being printed at this time. The Board also noted major references to this special population group in Report 5 (*Supplement 1*:324).

In view of these continuing efforts and noting that guidelines of this sort are frequently included in state and federal regulations governing Medicaid and Medicare programs, *the Board recommends that Resolution 92 be postponed indefinitely.*

Twelfth Trustee District Resolution on Federal Trade Commission Denture Study (*Supplement* 2:422/Resolution 100): The Board concurs with the intent of Resolution 100 but offers the following amendment to the resolution by substituting the words "Resolved, that the House of Delegates of the American Dental Association does request the Board of Trustees" for the words "Resolved, that the Board of Trustees is urged" and therefore *recommends that the following substitute resolution be adopted.*

100B. Resolved, that the House of Delegates of the American Dental Association does request the Board of Trustees to exercise unusual prudence and judgment in its decisions regarding the planned denture study sponsored by the San Francisco Regional Office of the Federal Trade Commission.

Twelfth Trustee District Resolution on Amendment of Current Position on Fluoridation (*Supplement* 2:422/Resolution 103): *The Board of Trustees recommends that Resolution 103 be adopted.*

Twelfth Trustee District Resolution on Amendment of "Manual of House of Delegates"—Standing Order of Business (*Supplement* 2:422/Resolution 104): The Board has reviewed Resolution 104 submitted by the Twelfth Trustee District which would amend the *Manual of the House of Delegates*, Rules of the House of Delegates, to make the installation ceremonies of new officers and trustees a standing order of business at 11:30 AM on Thursday, during the final meeting of the House of Delegates. The Board concurs with this resolution. Therefore, *the Board recommends that Resolution 104 be adopted.*

Twelfth Trustee District Resolution on Environmental Protection Agency Drinking Water Regulations Relating to Naturally Occurring Fluoride (*Supplement* 2:422/Resolution 105): The Board believes that the Twelfth Trustee District Resolution 105 should be rewritten for clarification and because some statements seem to be equivocal. *Therefore, the following resolution is offered with the recommendation that it be substituted for Resolution 105 and that the substitute resolution be adopted.*

105B. Resolved, that the appropriate agencies of the Association enlist Congressional support to petition the Environmental Protection Agency to desist from any action relative to naturally occurring fluorides in the National Primary Drinking Water Regulations, such as: (1) reduction of fluoride levels in some communities which may not be economically justified; (2) an inflexible position on the maximum allowable level for fluoride in drinking water; and (3) the classifying of fluoride as a contaminant or a hazard to health, until results are available from the research studies presently supported by the EPA to determine the level of fluorosis in communities with the above optimal levels of fluoride, and be it further

Resolved, that the ADA Washington Office take immediate action with appropriate agencies to place a moratorium on EPA's regulations, and be it further

Resolved, that progress on this requested action be reported to the Board of Trustees.

Thirteenth Trustee District Resolution on Inclusion of Dental Services in Catastrophic Health Insurance Legislation (*Supplement* 2:425/Resolution 99): *The Board agrees with Resolution 99 and recommends its approval.*

Delegate A. Edward Hall (Ka.) Resolution on ADA Participation in 1980 Muscular Dystrophy Telethon (*Supplement* 2:426/Resolution 78): The Board of Trustees sympathizes with the intent of Resolution 78 since it believes the Muscular Dystrophy Telethon is fully worthy of the support of all citizens. However, the Board notes that there are at least two other major telethons—for the Easter Seal Society and for Cerebral Palsy. Additionally, there is the question of the longstanding involvement of the Women's Auxiliary to the American Dental Association whose members are heavily involved in raising funds for scholarships and for the Relief Fund through gold and silver scrap drives. In light of these facts, *the Board recommends that Resolution 78 be postponed indefinitely.*

Delegate Willis B. Irons (Mn.) Resolution on Acknowledgment of Women in the Dental Profession (*Supplement* 2:427/Resolution 77): *The Board of Trustees supports the concept proposed in Resolution 77 and recommends that it be adopted.*

Delegate Michael D. L. Weisenfeld (Mi.) Resolution on Medicaid Administration (*Supplement* 2:426/Resolution 68): *The Board recommends approval of Resolution 68.*

Delegate Michael D. L. Weisenfeld (Mi.) Resolution on Public Testimony (*Supplement* 2:426/Resolution 69): The Board examined Resolution 69 and *recommends its approval.*

Academy of General Dentistry Resolution on Substitute for Resolution 105–1978—Use of Terms "Family Dentistry" and "Family Dentist" (*Supplement 1*:290/Resolution 44): During the August 1979 Board of Trustees meeting, the Academy of General Dentistry's resolution together with the Judicial Council's position on this matter were discussed. The Council agreed that the original Fifth Trustee District resolution 105–1978 be adopted. This resolution states that family dentistry and family dentists are not synonymous terms with general practice and should not be used as such in dentist advertisements or announcements. The Judicial Council, however, did concur with the opinion that the term "family dentist" could be used in public relations material and then presented in lower case type so as not to suggest that it is a specialty within dentistry (*Reports*:14).

During the August Board meeting, the Board of Trustees referred the resolutions for further study and report back to the Board at its October session. In reviewing this matter, the intention of both the Council on Bylaws and Judicial Affairs as well as the Board of Trustees is to prevent public misconception and the inadvertent establishment or creation of another specialty in dentistry entitled "family dentistry." The Council on Bylaws and Judicial Affairs is concerned that if dentists employ the term "family dentistry" as a substitute for general dentistry it will develop confusion and potential misconceptions regarding the individual announcement as a "family dentist."

Unquestionably, however, there is value in supporting the use of "family dentistry" in general public relations and advertising programs. It was noted that there are numerous publications, both national and state, that urge the public to visit their family dentist. Since the use of that phrase in the context of overall public relation programs has had a beneficial and endearing effect to the public because of its warmth and connotation, it is not the Judicial Council's purpose to strike that phrase from usage in publications and other public relations or advertising approaches encouraging the public to seek professional dental care. The Judicial Council has simply recommended that the phrase not be used in the context of announcement of services per se since it might imply a form of specialty status. The Board noted the value of having policy in both areas. As a result, *the Board offers the following resolution as a substitute for Resolution 105–1978 and 44 and recommends its adoption.*

44B. Resolved, that the term "Family Dentistry" and "Family Dentist" are not synonymous with the term "General Practice," and be it further

Resolved, that the use of the term "family dentist" is acceptable for public relations purposes.

Western Study Club of Combined Therapy Resolution on Peer Review of All Contemplated Full Mouth Extraction Cases Under Age of Twenty-Four (*Supplement* 2:428/Resolution 73): The Board carefully reviewed the Western Study Club's Resolution 73 which would require peer review of all contemplated complete mouth extraction cases under the age of twenty-four. Further, the Board was apprised of additional information provided by the Western Study Club to the effect that, if adopted, this requirement would be incorporated in the *Principles of Ethics*. In the absence of substantiation of the scope of the problem addressed in Resolution 73, the Board is unconvinced of the necessity for such policy. Additionally, in the Board's view (a view supported by Association Counsel) such a requirement would not be appropriate for inclusion in the *Principles of Ethics. Accordingly, the Board recommends that the resolution be postponed indefinitely.*

Board Resolution on Report to the House of Delegates of the ADA Task Force on the Prohibition of the Sale of Confections in Schools (Resolution 98): The Board of Trustees expresses appreciation and commendation to the Task Force for the excellence of the report, noting the emphasis on continuing and improving cooperation with other nondental organizations to accomplish the goals of the Association with respect to this issue. In order to further stress the importance of this effort, *the Board recommends approval of the following resolution.*

98. Resolved, that the Task Force on the Prohibition of the Sale of Confections in Schools be commended for its excellent report, and be it further

Resolved, that the Task Force report and its recommendations be transmitted to the Council on Dental Health and Health Planning with the request that the Council consider placing a high priority on the implementation of the Task Force recommendations.

FURTHER COMMENTS ON REVISED "PRINCIPLES OF ETHICS"

The Board of Trustees indicated that it would provide the House of Delegates additional comments concerning the suggested *Principles of Ethics*. In addition, several trustee district resolutions have been reviewed which present suggested amendments. The comments and resolutions pertaining to the *Principles of Ethics* are grouped for clarity purposes.

Fifth Trustee District Resolution on Amendment of Section 1–B on Patient's Record of the Revised "Principles of Ethics" (*Supplement* 2:415/Resolution 106) and **Twelfth Trustee District Resolution on Amendment of Section 1–B on Patient's Record of the Revised "Principles of Ethics"—Substitute for Resolution 106** (*Supplement* 2:423/Resolution 106S–1): The Board considered Resolution 106 submitted by the Fifth Trustee District and Resolution 106S–1 submitted by the Twelfth Trustee District which concern an amendment to Section 1–B, Patient's Record, of the revised *Principles of Ethics*.

While the Board understands the reason for requesting written patient permission for the release of records, it believes that such a requirement would be burdensome. It noted that the current practice of record release has worked effectively over the years and recommends

that it not be changed as a matter of ethics. On this basis, *the Board recommends that Section 1–B, Patient's Record, not be changed and that Resolutions 106 and 106S–1 be postponed indefinitely.*

Fifth Trustee District Resolution on Amendment of Section 1–D on Emergency Service of the Revised "Principles of Ethics" (*Supplement* 2:415/Resolution 107): The Board agrees with the amendment to Section 1–D, Emergency Service, presented by the Fifth Trustee District and recommends that paragraph 1–D, Emergency Service, of the revised *Principles of Ethics* be amended on lines 60 and 61 by striking the phrase "attend to the conditions leading to the emergency" at the end of the section and inserting the phrase "make reasonable arrangements for the emergency care." *The Board recommends that Resolution 107 be adopted.*

Twelfth Trustee District Resolution on Amendment of Section 1–G on Justifiable Criticism and Expert Testimony of the Revised "Principles of Ethics" (*Supplement* 2:423/Resolution 109): The Board agrees with the resolution submitted by the Fifth Trustee District to amend Section 1–G, Justifiable Criticism and Expert Testimony, of the revised *Principles of Ethics* and therefore *recommends that Resolution 109 be adopted.*

Twelfth Trustee District Resolution on Amendment of Section 1–H on Rebate and Split Fees of the Revised "Principles of Ethics" (*Supplement* 2:424/Resolution 110): The Board agrees with the amendment of Section 1–H of the revised *Principles of Ethics* proposed by the Twelfth Trustee District. The ethical propriety of splitting fees with other dentists or tendering rebates to them should not be treated as ethical only because the transactions are disclosed to the affected patients. *Therefore, the Board recommends that Resolution 110 be adopted.*

Twelfth Trustee District Resolution on Amendment of Section 5 on Professional Announcement of the Revised "Principles of Ethics" (*Supplement* 2:424/Resolution 111): The Board was advised by legal counsel that the amendment to Section 5 of the revised *Principles of Ethics* proposed by the Twelfth Trustee District would conflict with the Federal Trade Commission settlement order. The Association's *Principles of Ethics* may sanction only those announcements by dentists that are false and misleading in a material respect. State laws may further limit dentists' announcements and advertising under the United States Supreme Court decision. But the authority of state agencies, like boards of dentistry, to regulate other than false or misleading advertising is not available to private associations in the exercise of ethical restraints. *Therefore, the Board recommends that Resolution 111 be postponed indefinitely.*

Twelfth Trustee District Resolution on Amendment of Section 5–B on Name of Practice of the Revised "Principles of Ethics" (*Supplement* 2:424/Resolution 112): The Board was advised by legal counsel that the amendment to Section 5–B of the revised *Principles of Ethics* proposed by the Twelfth Trustee District conflicts with the Federal Trade Commission settlement order. The name of a practice falls within the general category of announcement of a practice. Ethical sanctions on practice announcements by private associations may be imposed only if those announcements are false or misleading in any material respect. Again, state laws may require dentists to identify their practices by use of their names as reflected in the licenses (Texas has such a law). But that kind of stricture may not be imposed by private associations. *Therefore, the Board recommends that Resolution 112 be postponed indefinitely.*

Fifth Trustee District Resolution on Amendment of Section 5–C on Announcement of Specialization and Limitation of Practice of the Revised "Principles of Ethics" (*Supplement* 2:415/Resolution 108): The Board considered the resolution submitted by the Fifth Trustee District to amend Section 5–C, Announcement of Specialization and Limitation of Practice, Item 2, line 230, by adding the phrase "or have met existing requirements as specified by the appropriate Association agency."

The Board believes that the additional phrase should not be added since it is unnecessary. Proposed Section 5–C is consistent with current Association policy which stipulates that successful completion of an accredited educational program and/or specialty certificate are the only ways in which practitioners may choose to begin announcing as a specialist. *All* practitioners who meet other previous existing criteria and announced limitation of practice are *unaffected* by this section of the *Principles of Ethics*. Previous Association policy protects practitioners who met the existing requirements. Section 5–C deals with a dentist who chooses to announce, not a dentist who has already announced, consistent with the policy of the Association at the time of announcement.

Since there are not any other existing requirements for annoucement as a specialist and the previously announced specialists are protected, *the Board recommends that Resolution 108 be postponed indefinitely.*

Board Resolution on Amendment of Section 5–C, Announcement of Specialization and Limitation of Practice, of the Revised "Principles of Ethics" (Resolution 114): *The Board strongly suggests an amendment to Section 5–C of the revised "Principles of Ethics"* proposed by Dr. Clemens. The amendment clarifies the essential purpose of that section of the *Principles* that defines the ethical obligation of both general dentists and specialists in announcing their scope of practices.

114. Resolved, that Section 5–C of the proposed revised *Principles of Ethics* be amended by inserting the following sentence at the beginning of the section to read as follows:

5–C Announcement of Specialization and Limitation of Practice

This section and Section 5–D are designed to help the public make an informed selection between the practitioner who has completed an accredited program beyond the dental degree and a practitioner who has not completed such a program.

to make the amended Section 5–C, lines 168 through 212, read as follows:

5–C Announcement of Specialization and Limitation of Practice

This Section and Section 5–D are designed to help the public make an informed selection between the practitioner who has completed an accredited program beyond the dental degree and a practitioner who has not completed such a program.

The special areas of dental practice approved by the American Dental Association and the designation for ethical specialty announcement and limitation of practice are: dental public health, endodontics, oral pathology, oral and maxillofacial surgery, orthodontics, pedodontics (dentistry for children), periodontics and prosthodontics.

A dentist who chooses to announce specialization shall limit the practice exclusively to the announced special area(s) of dental practice, provided at the time of the announcement the dentist has met in each approved specialty for which he announces the existing educational requirements and standards set forth by the American Dental Association.

A dentist who uses his eligibility to announce as a specialist to make the public believe that specialty services rendered in the dental office are being rendered by qualified specialists when such is not the case is engaged in unethical conduct. The burden of responsibility is on the specialist to avoid any inference that general practitioners who are associated with the specialist are qualified to announce themselves as specialists.

Board of Trustees Resolution on Substitution for Section 5–D on General Practitioner Announcement of Services of the Revised "Principles of Ethics" (Resolution 117): During the August 1979 Board of Trustees meeting, the Board reviewed the proposed revision of the former Section 18 of the *Principles of Ethics* presented by the Council on Bylaws and Judicial Affairs. An extended discussion occurred relative to this matter. Essentially, many of the Board members were concerned with the provisions that allow the general dentist to advertise the availability of services. Specifically, the proposed Section 5D, *General Practitioner Announcement of Services*, represented the major area of controversy. The Board concurred that the educational standards for *specialty announcement* should be preserved and individuals who do not meet those profession-established specialty qualifications should not advertise in any way which might mislead the public into believing that those individuals have achieved a specialty qualification.

However, the Board of Trustees recommended that Section 5D be restudied and presented to the Board of Trustees during its October meeting for further review and comment. The major elements of debate which occurred during the August meeting focused on the restriction in the use of "practice limited to" without providing the generalist with a substitute mechanism for advertising the availability of services. It was believed by many Board members that this was unduly restrictive and should not be reinforced in the proposed new *Principles of Ethics*. The Board, however, was similarly concerned that it should not undermine Section 18 of the *Principles of Ethics*. The Board's concern is that this section is a public protection policy which requires those dentists who claim specialty expertise to have completed satisfactorily the profession's educational requirements.

Based on the Board's concern and upon additional review, *the Board submits Resolution 117 with the recommendation that it be adopted.*

117. Resolved, that Section 5–D, General Practitioner Announcement of Services, of the revised *Principles of Ethics* be deleted and substituted with the following language so that it reads as follows:

5–D General Practitioner Announcement of Services

The general dentist who wishes to announce the services available or the restriction of services available in his practice is permitted to announce the availability of those services so long as he avoids using the phrases that express or imply specialty qualification or specialization. The dentist shall avoid announcing the availability of services in any way that would be false or misleading in any material respect. The phrase "practice limited to" has a longstanding identification with specialty announcements to the public; therefore, its use could mislead the public. While the phrase "practice limited to" should be avoided, general dentists may use phrases such as "services available in. . . ," "services provided. . . ," "services restricted to . . ." or "practice restricted to. . ." in their announcements.

Board of Trustees Resolution on Commendation of Disaster Victims Loan Program: The Board of Trustees noted that the Fifth Trustee District had submitted a resolution commending the Association's Commission on Relief and Disaster Fund Activities for the great assistance it offered to Mississippi dentists. Further, the Board noted the policy of the House of Delegates on commendatory resolutions which precludes the introduction of such resolutions in the House of Delegates. *Therefore, the Board of Trustees adopted the Fifth Trustee District resolution.*

REPORT 11 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: INFORMATIONAL REPORT ON NATIONAL BOARD EXAMINATIONS

During its October 18–19 meeting, the American Association of Dental Examiners (AADE) discussed development of written examination programs for use in place of National Board dental and dental hygiene examinations. This report is intended to inform the House of Delegates of the results of that discussion and of responses intended by the Board.

National Qualifying Examinations: AADE written examinations, if implemented, would be titled National Qualifying Examinations (NQE) for dentists and dental hygienists. The AADE would develop the NQE with assistance from the Educational Testing Service (ETS). Start-up funds would be provided by ETS and, possibly, philanthropic groups. ETS has tentatively committed up to one million dollars for development with the understanding that developmental funds would be recouped from examination fees.

To date, only a tentative description of the NQE for dentists has been developed. It would be a single, comprehensive examination requiring two days for administration. Examination content would be based on a job analysis and scoring would be based on a criterion-referenced system. The examination fee would be $125. Policy decisions about the NQE would be entirely controlled by examiners and former examiners, but dental educators would be invited to participate as writers and reviewers of test items.

The AADE General Assembly voted to proceed with organization and development of the NQE for dentists and dental hygienists. It was stipulated, however, that the AADE would abide by its agreement with the Association not to implement written examinations in competition with National Board examinations prior to January 1, 1981. Further, the AADE Executive Council was directed not to enter into a contract with ETS until such contract is ratified by the AADE General Assembly.

Board's Position: Although the Board recognizes that the AADE has a legitimate interest in all aspects of state licensure, it believes as well that licensure matters fall within the public domain. The Council on National Board Examinations has been structured over the years to represent not only dental examiners, but also practitioners, educators and, as consultants, hygienists and students. The Board is concerned that the AADE is not structured to represent all of the legitimate interests affected by written examinations for licensure. The Council's basic tripartite structure together with appropriate broadening of membership from hygiene, the public and students clearly shows a realistic balance of the community of interest that should govern the examination programs.

In the Board's view, National Board dental and dental hygiene examinations are of high quality and should be continued. The Council on National Board Examinations has recently completed a two-year self-study which should lead to improvement of already sound programs. The self-study incorporated input from test experts employed as consultants as well as from educators, examiners and practitioners. The Board has already recorded its support for resolutions emanating from this project.

It is understood that the AADE, as an independent agency, has a right to develop written examinations to compete with National Board examinations. It is the opinion of the Board, however, that such an action would be counter to the best interests of the profession and the public. Competing written examination programs would cause confusion for licensure candidates and divisiveness within the profession.

Clarifications: From discussions with individual members of the AADE, the Board believes that rumors and misunderstandings contributed to the decision of the AADE to proceed with the NQE. A partial list of Association positions and facts not fully appreciated follows.

1. National Board programs over the last ten years have generated no significant net income for the Association. Apparent income is a result of the Association's accounting system which has not allocated expenses for such things as data processing services to the budget of the Council on National Board Examinations.
2. The Board would be willing to consider requests for financial support for AADE activities under the Association's grant policy. The only change in financing is that the Board will no longer authorize annual, unrestricted grants.
3. The Council on National Board Examinations, in the Board's view, has been responsive to concerns expressed by and suggestions of the AADE.
4. The Board is open to negotiations with the AADE concerning written examinations and other topics of mutual interest.

The Board strongly supports the concept of licensure at the state level and believes that the AADE must be an effective voice in support of this concept. It is the goal of the Board to resolve differences with the AADE as rapidly and with as little rancor as possible.

Planned Action: The Board intends to express its support for National Board programs to the AADE and to individual state boards of dentistry by letter. Letters will include rationale for supporting National Board programs and information needed to resolve apparent misunderstandings. Similar information along with a description of the current situation will also be provided to constituent and component societies and to other interested organizations, such as the American Association of Dental Schools. It is the hope of the Board that these actions will lead to the AADE's uniting with the Association and other organizations in support of continuing and further improving National Board programs.

Index to Resolutions

Resolutions 126–129 and 134 will be published and indexed in *Transactions, 1979*.


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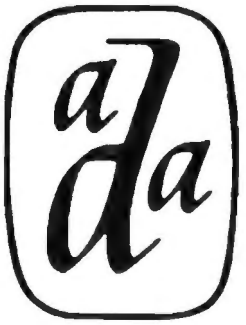
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